

THE APPLICATION OF OBSERVATION SKILLS TO WORK WITH UNDER FIVES

The Tavistock Clinic model of Infant Observation is widely recognized as an essential foundation for clinical training of adult, child and infant mental health professionals. In this talk I hope to illustrate how developing skills in infant observation and an understanding of psychoanalytic thinking, attachment theory and child development research, combine to enhance professionals' therapeutic approach to work with families, babies and young children. This approach is described in the book: 'What can the Matter Be? Therapeutic Interventions in work with parents, infants and young children' (2008)

The Diploma/MA in Infant Mental Health by the Tavistock Clinic in London, with an equivalent course in Bristol, and validated by the University of East London, is an exciting new development, which includes a two year Infant Observation Module. The aim of the course is to help students develop their powers of observation and their understanding of both the conscious and unconscious factors that influence infant development. This can make students more sensitive to the interactions they then observe in their everyday professional practice.

INFANT OBSERVATION

Before giving clinical vignettes, it seems important to clarify what it is we mean by Infant Observation, since the term can be used in many different contexts.

We are talking about a particular kind of observation method which we encourage students to practise, in helping us to build up a picture of the infant's and child's internal and external world, his perceptions and interactions with others. In the ordinary busy life of professionals it is sometimes difficult to stop and take note of the minute detail of a child's behaviour and the effect it might have on them.. Having the opportunity to observe in a nursery or home setting, write notes of what one sees to discuss in the seminar group, can provide a valuable insight into infants' and young children's internal worlds and their developing relationships with others.

The observer visits a baby (for infant observation) or young child once a week at a regular time for one hour, at home, a playgroup or nursery, recording a detailed account of the child's activities and interactions. The detailed description of the visit is then discussed in the seminar, led by a child psychotherapist. He/she tries to keep an open, receptive mind describing events as they happen without attempting to theorise or make hypotheses about what he is observing. The fact that the observer has no responsibility for the care of the child and is there simply to observe, is important, because it means that he/she receives the full emotional impact of the experience, which may involve restraining the impulse to rush in and relieve a situation with 'expert' advice.

In the brief extract from an observation done by a student on the Infant Mental Health Course of ten week old baby Jamal the observer sensitively details the mother's attempts to regulate and contain the experiences of the infant.

'Jamal was lying on the bed completely alert. His whole body was moving excitedly, he was straightening his limbs then pulling them back strongly. He was making soft short noises. Mother leaned over him her eyes meeting his: 'Hi Jamal, you're wide awake now aren't you?' He seemed a bit startled by her sudden appearance, his whole body shook, his limbs moving up and down at once, his eyes wide open. He then relaxed back to slower motions, his eyes fixed on mother's eyes. She was smiling at him, speaking softly and caressing his head from his forehead backwards. Jamal, moving his limbs now clenched his fists and was moving his arms up towards his mother, and down. She laughed: 'Oh you're wrestling with your fists you strong clever boy. Mother imitated Jamal's movement using her own fists. Jamal was now moving his right hand and left leg back and forth strongly, his other limbs moving slower. With his eyes still fixed on his mother's Jamal moved his closed mouth in what looked like a smile, then his mouth straightened back and he produced short soft gg.aa sounds. His mother hung a black and white mobile with geometric shapes over him. Jamal fixed his eyes on the moving shapes – he looked curious and a little concerned, his body almost motionless. 'Isn't that interesting Jamal, see how they are all moving and turning. After watching for a while Jamal started to move his head to the left, his eyes looking away, his bodily movements growing stronger and more agitated. Mother immediately noticed it: You've had enough haven't you? You don't

want any more. She turned to the observer saying: ‘ He likes to watch it for a bit but after a while it seems to frighten him.

Just 5 minutes in the life of an infant yet such a rich tapestry of experience. We can see how at moments when he is startled or feeling unheld he becomes more fragmented and physically uncoordinated, and how his mother’s sensitive attunement to his states calms him down and enables him to exert more control over his limbs. In the seminar discussion the observer described how she felt both excluded from and touched by the moments of intimacy and attunement between the couple, and was taken aback as are most observation students, by the intense emotions aroused within her as she watched this intimate scene.

It is not such a long step to thinking about clinical work carried out as part of the Under Fives Counselling service, which has offered quick response, relatively brief interventions to families with babies and young children for many years. The underlying technique of applying psychoanalytic understanding within a brief time frame continues to provide an important model for the work offered. The basis for the therapeutic work includes an understanding of psychoanalytic theory, attachment theory, child development research, and observational skills. In practice it involves an ability to be receptive to the powerful projections of parents, and their children, as well as an ability to monitor one’s countertransference responses to the family. An understanding of recent developments in neurosciences research can also be helpful, particularly the autonomic conditioned fear response, if working with children traumatized in infancy, who present as hyper-reactive and are prone to apparently unprovoked outbursts of aggression.

I think the key to the application of these ideas is a deeply embedded understanding of the framework mentioned above combined with a flexibility of approach, allowing for a range of decisions to be made about frequency, duration and type of intervention. Several parents have said they have valued the combination of understanding of the children’s communications, with thoughtfulness about themselves as parents, and practical advice as well.

Before giving some clinical examples, I would like to explore the meaning of young children's verbal and non-verbal communications, their impact on early years professionals and child mental health workers, and the ways in which undertaking an infant observation can enhance this understanding.

We know that from birth (and increasingly even in the womb) environmental and temperamental factors are already influencing the child's reception into the world and child's internal picture of the world. From the first we can see what the essential needs of infancy are, on the physical level, for the baby to survive. These three needs, - feeding, holding and cleaning up, have psychological parallels which are equally important to the healthy survival of the infant. The child's world must offer something adequate in the way of these three things, and then it is up to each individual baby what he or she makes of the care given. I will discuss each in turn, giving examples as I go, of cases where difficulties may have arisen, and of infantile defence mechanisms used to avoid facing painful deprivations in the area of feeding, holding and cleaning up – containment

Firstly, food, is essential and the baby takes in far more than milk from his mother, he takes in the love and attention accompanying the feeding situation or in less optimal situations, he takes in anxiety or even hostility and resentment.

The baby who has enjoyed being fed is likely to remain eager and trusting to open his mind to new relationships and new knowledge. When his appetite and curiosity are stimulated this leads at first to the exploration of his mother's body and later of an ever widening world. For a child who has had unreliable or depriving parenting the feelings of helplessness aroused by not knowing may be intolerable, hence he is not open to learning but puts himself into the position of believing that he knows it all already and has no need of others (see later). If anger and pain have dominated the earliest feeding relationship, taking in may come to be linked to fear, distrust, resentment or mere absence of an appetite for and pleasure in learning.

An example of where resentment and hostility can be fed to a baby along with the milk can be seen with a young mother I saw in the clinic because baby Deniz was waking 8 times a night. There was domestic violence at home and mother was resentful of father who she felt left all the domestic work to her while he worked long hours. Mother was a refugee from another country, had little support and low self

esteem. She seemed to have difficulty differentiating in her mind her vulnerable baby Deniz from her violent husband and complained that her 'dirty stinky baby' was 'God's punishment' to her. Deniz sat and played *behind* mother's chair as if shielding himself by the chair from her harsh words, not allowing them to enter him. When he became hungry he crawled 3 feet in front of mother, turned his back to her and she leaned forward and fed him with his back facing her, at a great distance from her. It was chilling to watch the lack of contact between them. It appeared that Deniz was using a defensive strategy to keep out his mother's projections of hostility and resentment, whilst still taking in his feed. This may be a necessary strategy for survival but we can see how, if he became habituated to always 'closing down' emotionally and now allowing new 'food' or 'food for thought' to enter him, treating any new idea with suspicion, this could affect his capacity to learn. He might approach any adult offering him a new experience, like a teacher with the expectation that he needs to protect himself from an onslaught of negative projections and close himself down to all new input, unable to filter the good from the bad.

The second requirement is being held, and its psychological equivalent: A baby needs holding in mind, he cannot survive if he is forgotten about, dropped out of mind any more than he can if he is dropped off his mother's lap. If they feel unheld they tremble bodily as if they feel they will fall apart, as anyone who has watched a naked infant stripped of containing layers of babygro and blanket being lowered into a bath. We can see how an infant who is overwhelmed by intense bodily sensations of hunger, fear or excitement can feel held by his mother's voice as she attempts to understand his needs. Infants (and children) who feel unheld, where there is no holding maternal mind, or focus for them, find alternative means of holding themselves together.

Infants may resort to holding themselves together in a range of ways, as a defence against falling apart. They may gaze at an object such as a bright light and although it may appear that they are curious, they may not be taking anything in. Conversely, they may be 'gluing' their eyes to the light, sticking to it as if in this way they can avoid falling apart, if left unheld or attended to for too long. Toddlers and older children often keep their thick coats on when they arrive at nursery or insist on having their shoe laces tied tight, as if their clothing can help them feel held together. In the classroom insecure children (or a child who is sensitive to changes in routine,

substitute teacher etc) may use insistent questions to 'hold onto' a teacher and ensure she is held in mind. Sometimes children can use reading as a way of holding themselves together or filling themselves up with words when there has been a loss (the words are not symbolic or meaningful but seem to fill up an empty space where something or someone has been lost (bereavement or separation from parent)). This means of coping with anxiety about falling apart, abandonment, loss, by relying on a 'second skin', an additional layer of protection, can be helpful in understanding a small child's emotional states.

For example: A health visitor (explain) telephoned me for some advice because a mother had consulted her about 3 year old Ben who insisted on being given a nappy to defecate in the corner of his bedroom. There was little information and I discussed briefly with her how some children have anxieties about releasing their faeces, as if they fear their insides may fall out, which touches on early infantile terrors of falling or falling apart. The nappy provides a kind of 'skin' for holding the child together, possibly in the absence of emotional holding and attentiveness in the caregiver.

The health visitor phoned again a few weeks later with a clearer picture of the situation, describing a very neat house, where the children are given star charges for tidying and cleaning. Ben had been suffering from a recurring worm infection which caused itching. I suggested he may feel a sense of persecution, as if something horrible was inside him, and she agreed. I wondered whether there was some rigidity in the home and the health visitor described mother as a 'sensible and organised' professional woman, trying to run a home and business efficiently. I wondered whether mother might treat running the home and child care as a rather 'professional' undertaking, so that she may be out of touch with her child's more messy, upset or frightened feelings. The preoccupation with cleaning might also mean a need to 'clean away' the child's messy feelings and may convey to the child an intolerance of physical as well as emotional 'mess'. Perhaps the child has a need to be held emotionally by mother, as he sounds fearful of his faeces, as well as his messy feelings, leaking out of him.

The health visitor found this interesting and added that the child always insists his mother checks his nappy to make sure there are no holes in it. I said this may suggest

that he has some worries about falling apart, needing a tight, safe receptacle for his evacuations. The health visitor then told me about the family situation: mother separated from father when Ben was a baby, and her current partner, a well loved stepfather, stays for half the week at their home. I linked the fear of faeces falling out of the child into the toilet, with the disappearance of step father half way through the week and we discussed how the fear of using the toilet can often be linked to emotional states of anxiety relating to separation and loss. We discussed how the child might be helped if mother could be encouraged to prepare him for stepfather's weekly departure. She agreed and contacted me some time later to say that she had been able to do some work with mother on these areas, and the problem had been resolved.

In this brief exchange, the health visitor's description of a child's need for an extra 'holding' layer of nappy around him, reminded me of the psychoanalyst Esther Bick's (Bick, 1968) description of what she termed 'second skin' containment, in which the child finds substitutes from its own resources to replace a sense of safety based on dependable relationships. This enabled me to introduce the idea to the health visitor of a toddler who may feel uncontained by a maternal mind, able to process his 'messy' feelings and return them to him in a modified form. (Bion's concept of container-contained). In turn, the health visitor could draw on more detailed observations, and the transformative moment arises when we can shift our understanding from a concrete level, the holding onto faeces, to an emotional level, the fear of losing a loved object, who slips out of the door (hole in the nappy, 'hole in the mind;') and leaves the child feeling abandoned and collapsed.

The third requirement is the process of 'cleaning up the mess' and its vital psychological parallel. Babies do not have the mental apparatus to process the bombardment of sensory data, pleasurable, painful or frightening, they are at the receiving end of and rely on an adult to help them to cope with or 'contain' their overwhelming experiences. If a baby is in distress he needs a containing adult, someone who can pay attention, take in these feelings that the baby cannot cope with, reflect on them without being overwhelmed by anxiety herself, and respond appropriately to his needs. The baby then has an experience of a mother who can think about him, and process his feelings. The baby learns through experience of a

thoughtful attentive parent, how to make sense of his own experiences, to think for himself. He has a model in his mind of someone who can pay attention, be curious about him and to think about him – these are all attributes that the child needs to internalise in order to begin to think symbolically and to talk, learn and read.

What happens when the mother cannot perform this function of containment and “reverie” (Bion 1962) for the baby? The baby's only recourse is to intensify his efforts to evacuate the persecutory sensations which threaten to overwhelm him, to attempt with greater force to gain entry to the mother's mind so that his communications can be received and understood. He may do this by attempting to gain access to her mind with increasing force and hostility. In response to a mother who may be unavailable or inconsistently available to her baby's communications, the baby may attempt to elicit a response from a passive or depressed mother with increased violence, screaming, kicking, scratching or even at times, banging his head against her as if to gain entry in this manner.

The baby may unconsciously experience the mother's inability to receive and contain his feelings because of her depression, as a lack of willingness to do so, or hostility towards him. If his states of persecution are not received by the parent and do not find a ‘home’ in the mother's mind, they rebound off the unavailable parent figure and return unmodified to the infant, whose state of persecution is intensified. A vicious cycle can be set up as the baby pushes back his feelings into mother with increasing force and hostility, attempting to elicit a response. This is often the source of disruptive attention seeking behaviour which can masquerade as Attention Deficit Hyperactivity Syndrome. One could hypothesise that in some cases the deficit in attention may arise from the depression in mother and the infant's increased efforts to elicit a response. It is possible to trace the origins of such behaviour to the early weeks and months of the infant's life . The early pattern of inattentiveness which the child internalises is reflected later in difficulties in concentrating or paying attention for any length of time, and can have detrimental effects of a child's ability to learn at school

In some circumstances, and depending on his temperament, the infant may give up on trying to "get through" to the mother, and may become a bit like a depressed mother himself. In the classroom one can later see an inert, seemingly empty unresponsive child,

whom teachers describe as difficult to 'get through to'. The baby may have internalised a model of a parent figure who is unreceptive to the communications of others, and identifies with this internal model. This often leads teachers to believe that a child operating these 'no-entry' defences, has less intelligence than might actually be the case.

An alternative response to a deficit in attention resulting from depression is the infant's unconscious turning away from states of dependency by becoming precociously self sufficient and controlling, dealing with unmet needs by appearing to require little comfort or gratification from adults. These babies sit up unaided very early, do not mould themselves into their mothers' laps but tend to develop their own muscular strength, standing on well developed legs while very young and occasionally walking by 6 or 7 months. Although perceived as super-advanced, their controlling manner and apparent lack of vulnerability may be seen as a way of coping with disappointment at unmet early needs by refusing to allow themselves to feel any need or any sense of loss or disappointment at what they lacked. Infants who develop this kind of muscular 'second-skin' as a way of holding themselves together in the absence of maternal containment can make a mother feel even more useless and inadequate because they give the untrue impression that they don't really need her.

These early unconscious defences can pose problems for learning too, as children who cannot bear to be in touch with feelings of dependency may have difficulty coping with the fact that the teacher (like a mother) may have something to offer them which they do not have themselves. These children cannot bear to let themselves know that they do not have all the knowledge and answers within themselves but that they may have to really on an adult, a teacher, to show or give them something. This makes them feel small and anxious, stirring up all the helpless unbearable feelings of infancy, when neediness had led to frustration instead of fulfilment. It is often at moments when new tasks or information are given, that children like this either become disruptive or 'disappear' into a day dream, where they can fantasise being in control of all resources, relying on no one.

I will now give an example of how this kind of observational skill might be applied to the Tavistock Clinic psychoanalytic approach to work with under fives:

The following case example describes a brief family intervention, highlighting some 'transformative moments' in the work, which led to a shift in the parental capacity to contain the young child's overwhelming emotional states, facilitating a change in family relationships, and ameliorating the symptom.

Mattias– 3 years - Being Held or holding on?

Mattias and his parents were referred to the Under Five Service service, because of M's severe constipation, which was reportedly dominating the family and causing great stress. I undertook to see the family as part of the Brief Intervention project (BIP), offering up to 7 psychodynamically based family sessions. I will summarise the meetings, highlighting several transformative sequences which may have contributed to the diminishing of the symptom in Mattias, and a shift in the parents' capacity to observe and attribute meaning to their child's communications.

In meeting one I had a sense of intense entanglement between mother and son, with father rather excluded, and also had a momentary thought that mother might be pregnant. I heard how M M had difficulty 'doing his poos' and held them in for up to 8 days. Mother described how M became increasingly uncomfortable and listless and that as the days went on, M became more irritable and aggressive – father said with some incredulity that he had even bitten another child at nursery. I sensed that they might attribute any hostility to where he was in the 'cycle' of constipation. As the parents described their hectic work lives including unpredictable travel abroad without M, I had the impression that M was desperately using sphincter control as a way of holding himself together in the absence of parental holding in mind. It transpired that, to evade feelings of abandonment and loss, he had taken control of weaning and potty training, pre-empting his parents' plans. This gradually unfolded in his play with the doll doing poos in the potty, his interest in baby toys in the room as he felt his infantile needs increasingly attended to and his communications understood in the sessions.

I will give an extract from the first session as an example of the flow of observational detail and conversation between parent, therapist and child:

'M had difficulty 'doing his poos' and held them in for up to 8 days. Mother described how M became increasingly uncomfortable and listless and that as the days went on, M became more irritable and aggressive – father said with some incredulity

that he had even bitten another child at nursery. I sensed that they might attribute any hostility to where he was in the 'cycle' of constipation. Meanwhile M had found the pens and began to draw oblong shapes in green, some big, others small. I stopped and asked about the drawing, wondering whether they were poos perhaps? (I wondered to myself whether they might be 'poo babies', but did not raise the idea, which was to emerge as a central theme in the review session). He mumbled, 'no'. I commented on how he was filling up the whole page with his large shapes. His parents went on to tell me that they encourage him to hold tightly onto the handle of what they called a 'poo door' at home, at least once a day. As they described this, M moved towards the door and touched the handle, as if demonstrating what they were talking about. He looked stricken and anxious standing there, and I wondered aloud if he thought he was going to have to do something right here in the session. Mother talked to him warmly, and he returned to the sofa. Mother now went over to the door, holding onto the handle and bending down to demonstrate how he strains to poo. I said it seems that M needs to hold on tight to something. His parents both nodded, and we watched M sitting on the floor holding a baby rattle in one hand, with his dummy in his mouth, looking like a much younger child, as if comforting himself after his anxious moment.

Father interjected, saying what a 'nice and intelligent boy he is', but that he is very cautious. The parents spoke at great speed about their rather driven work life, mentioning frequent trips abroad without M for 3 or 4 days, sometimes together or separately. I wondered if M is quite anxious about these comings and goings which are out of his control. Father described M needing to know exactly what is happening, and where his parents are. I said it sounded as if he was anxious about things getting out of control, maybe he felt that he couldn't control his poos when they came out of him. Father said that was right, M seemed to want to hold them in very tight, and when they suddenly rushed out he seemed frightened. I said, it can be scary for children to feel as if a part of them is falling out of them, and getting lost down the toilet. Father agreed. Mother sat back, silent and watchful, with a rather detached demeanour.

By now, M had found the baby doll and the potty, saying, indistinctly, that baby was going to do a poo. He wanted mother to remove its 'nappy' lining. I said it seemed as if M didn't want the baby to make a mess, perhaps he doesn't like mess? Mother agreed,

saying that if he gets his hands dirty he is horrified and needs them to be quickly washed. I suggested he fears the mess of poo getting out of control too. Father added that he keeps things very neat at home, and at nursery he doesn't seem to play much, but rather to sort and tidy things away, even before an activity is completed. I suggested that mess seems to overwhelm him, and he seems anxious about it spilling out everywhere – it feels frightening.

We all admired the pretend poo in the potty and I commented on how M seemed interested in babies, nappies, rattles, things for younger children. As I spoke M asked for another dummy, climbing onto mother's lap and lying there cuddling her proprietorially. The parents described, with great intensity, how their anxiety rises with each passing day until the tension at home becomes unbearable, relieved only by the eventual joyful defecation. I commented on this cycle of anxiety being passed back and forth between them, and father said they feared their feelings were transmitting themselves to M and making it worse for him: 'We may need more help with this than him! I suggested that M appeared to be organizing the entire household with this problem, ensuring their minds are fully occupied with him.

Now as he lay spread across his mother, I said he seemed to like being a baby. Father said he asks often about babies and I suggested it could be in his mind, as parents of children his age are often having second children. Father mentioned that M's child-minder is pregnant and his interest in this. I said I understood M likes to hold onto things, doesn't like separation and change: perhaps he feels he needs to hold onto his role as the baby, and not give this. Father agreed, commenting on how closely attached he is to his mother.

At this point M complained of being hot, and took his shirt off, lying pale and thin while his mother stroked his white skin. I asked about their home lives and heard that they have a 'very open household', that M is curious to watch his mother in the bath, and he comes in while they are in the toilet, urging them on. I said he seemed to feel that he could get in everywhere. They said they they have a small open plan flat, so he is everywhere near them.

M began to scratch his arm and back, looking miserable, and mother said he often complained of itchy skin. I asked about him as a baby and they recalled that he had

suffered from bad eczema on the back of his legs for several months. His skin is very sensitive and he insists on labels being cut off his clothes. I suggested that perhaps since infancy he had manifested irritation or frustration through his body, it seemed to erupt through his skin. I suggested that difficulties with eating or pooing can be somatic signs of anxiety; he sounds like a worried little boy, struggling to hold onto things, his poo, perhaps also his parents, without losing control. Small children often feel that so much is done to them, they feel so helpless, that they try and keep control over some things, as a way of holding on.

I asked about feeding and weaning. Father described how much M had loved breast feeding, then, just when they were beginning to think about weaning, he stopped; M 'decides everything'. The same happened with the bottle – he turned away from it just as they were thinking he should give it up. He was the same with wees, just when he needed to be toilet trained for nursery, he decided to do it on his own; he is not messy, has never had an accident and very precise in his aim! I said that he whenever he sensed something was about to be 'done to him', he decided to 'do it himself', take charge.

My impression of the parents was that they were hoping for practical strategies to implement with M, so that he would fit more easily into their hectic work lives, and reduce tensions at home. I began to sense that M's difficulties, were linked to a need to be held in mind, and emotionally contained; in the absence of this parental attentiveness, he seemed to have developed a muscular second skin container, relying on his own resources, to hold himself together, to evade the primitive terror of falling apart or fragmenting. In this way, his tight sphincter control provides the substitute holding he lacks, especially when unpredictable change or transitions occur. His itchy, sensitive pale skin gave the impression of a rather permeable, skinless child, whose overwhelming infantile states erupted somatically through his skin, in the possible absence of mindful maternal containment. I sensed that the parents were on one level invested in perceiving this as a physical problem, and although they mentioned their concerns about transmitting their concerns to him, I think the notion that he might need to cope with anxiety by holding onto his faeces, as well as onto his place as the baby at home, had not occurred to them.

One transformative moment occurred during a parent meeting when Father said testily that last time I had asked about their own parenting, and that he couldn't recall anything

about how he was brought up, he had no model in mind at all. He seemed quite distressed, saying 'there we were, the kind of parents you read about all the time – you go into hospital and come out with this tiny baby, not a clue what to do'. I said how helpless that could make them feel. Father said irritably: ' Look the only reason we are here is for help with this 4th day in the cycle, the first 3 days in the cycle are fine, we are all living happily at home, but the 4th day it all goes wrong, there is a build up of tension and irritability... ' You couldn't help us so that he poos every day could you, he asked rather desperately?'

I suggested that perhaps it is not only the faeces that build up, but a build up of feelings which are difficult to manage until they eventually explode out; all his feelings of anxiety, distress, about being left at school, having to be a 'big boy', may build up as they cannot be held in any more . Neither parent seemed very sure about this.. I suggested that poo is like messy feelings which are held in, then suddenly explode out, like his tantrums perhaps. It is difficult to verbalise these states. Mother was dubious, saying he is very articulate. I suggested that, it is the very baby like, vulnerable feelings that he may not be able to put into words. Father said irritably: ' Look I know I want to be in control; I know that we are high achieving, highly driven people, - you can see we cant bear to be on the underground waiting passively to be transported, here we are on our bikes, we travel a lot.. I would like to know, I NEED to know, how I can help, what tips I can have with this difficulty; I want to help my son.' In my counter-transference I felt intense pressure, and a sense of desperation. I said I knew father wanted strategies, but I wanted to suggest that what he was expressing was a feeling of helplessness; he can't seem to do anything to help M. He wants me to give him a strategy, which he hopes will take away that unbearable feeling of helplessness.

Both parents were still and attentive. I said I thought that what M needed from his parents was for them to empty their minds of their anxieties enough to let in some of his feelings, and allow them to stay there, long enough to feel what it might be like to really be helpless. Eventually father said: ' well yes, I can see what you mean... he needs us to understand this... this helpless feeling, he needs us to empathise.' I agreed, talking about how this model child who tidies up so carefully, might struggle to allow himself to let go and show his messy vulnerable and helpless feelings. They acknowledged this, quietly reflective. I said it was interesting that father told us he couldn't recall anything about his own childhood; perhaps he didn't want to remember those feelings of helplessness. He

said ' that's interesting, because thinking about it now, that's what my mother was, she really seemed to be helpless, even when looking after M, she didn't seem to know what to do. We often wondered, how did she look after us, what did she do? I have no idea, she always seemed to not have a clue.' Mother added that she still doesn't know how to cook.. I talked about the mixed feelings one can have when starting to be in touch with feelings of helplessness. Father said he thought I was onto something there. I wondered about father sometimes feeling excluded and incompetent, and suggested that bed time, which has always been mother's domain, might include father, who could also read to M. They both reacted by saying M was sure to make a fuss and demand mother, but I wondered whether they might be able to support each other in setting a boundary, and offering a more united parental front. It was time to end, mother was counting the sessions, have had 3 and 3 to go. I suggested keeping our meetings at weekly intervals, to maintain a clear structure, and they left.

Time does not allow for further description of this case, but M began to defecate more frequently and the parents, particularly father, reported being more able to understand his son and identify with him. Only in the review meeting did mother reveal that she had been pregnant, but had lost the baby. The poo-baby drawing in session 1 made more sense, as I explored his symptoms in the light of this event and mother confirmed that M believed he had a baby in his tummy and that he 'can't poo because the baby will come out!' I was left feeling that mother's withholding of this information, as a powerful form of control, had hindered my capacity to explore further some of the issues that I had sensed in our first meeting.

I hope this example illustrates the transformative process which takes place over a piece of brief work. The process underlying each 'turning point' relies on close observation, awareness of the clinician's counter-transference experience in the here and now of the session, and a recognition of the infant in the child and the child in the adult.

CONCLUSION

The challenge facing the clinician offering brief psychoanalytic interventions is to maintain a flexible approach, to facilitate a 'slow unfolding, at double speed'. This requires a clear internal framework, in order to provide a containing setting

for a family in distress, and we need to recognise that brief work does not mean 'simple'; one is often touching on deep, primitive states of mind in parents and young children. Invariably most of the interventions will involve a combination of roles and approaches, but the fundamental framework of observational skills, psychoanalytic understanding and knowledge of child development remains constant.

References

- Bick, E. (1968).** The experience of the skin in early object relations. *International Journal of Psychoanalysis*, 45, 484-486. Reprinted in: Briggs, A (Ed) 2002: *Surviving Space: Papers on Infant Observation*. The Tavistock Clinic Series, Karnac Books
- Bion, W. R. (1962b).** A theory of thinking. (Ch 9. Pp 110 – 119) In: *Second Thoughts* (pp. 110-119). London: Heinemann, 1967.
- Emanuel and E. Bradley (Eds.) (2008)** *What can the Matter be? Therapeutic Interventions with Parents, Infants and Young Children*. The Tavistock Clinic Series. London: Karnac.