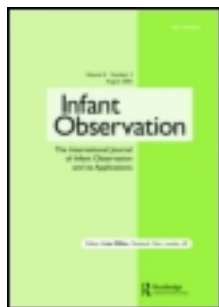


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# Parent-infant therapy as an application of the Esther Bick method of infant observation

A. Watillon-Naveau\*

Translated by Susan Coulson

In this paper the author explains how, besides her psychoanalytic experience, the practise of baby-observation following Mrs Bick's method allowed her to construct her technique in therapies of parents-baby relationship. After a short description of this method, the author details every aspect of the observation and her application in the therapies. Some clinical vignettes are included.

**Keywords:** baby; observation; therapies of parent-infant relationship; importance of babies' participation in this work

## Introduction

I took the bold step of using what I had learnt and experienced from my training and work as a psychoanalyst and my long experience of being an Esther Bick method infant observation seminar leader to work with parents and children who were having difficulties in their relationships. These therapies mostly focus on emotional difficulties usually arising either from a transgenerational problem or as a consequence of a traumatic experience. I include in this sleep difficulties, feeding problems, problems with toilet training, tantrums, excessive excitability or instability, crippling anxieties, etc.

## Technique

My technique, which is inspired by the work of Lebovici (1983), includes having the child present at all consultations. Starting with the first appointment I see father, mother and baby. It is increasingly common for fathers to be present and to be active participants in therapeutic work. The setting is the same as the psychoanalytic setting with some adaptations such as the length and frequency of sessions. The classic three quarters of an hour is not sufficient to give everyone

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the opportunity and space to say what they want to and I often devote between sixty and ninety minutes to these discussions. The timing of the second session depends on how urgent the situation is and how much work has been done. Everyone – the parents, the therapist, and the child – voices their opinion. I recall that little Carol, who was 30 months of age, came and leant her back firmly against my knees while her parents were hesitating about future appointments. Thinking about Grotstein's (1981) background figure of (projective) identification I said that Carol was showing us that she still wanted to lean on Mme Watillon. Her parents immediately took up the offer of another appointment. The initial contact is frequently overwhelming and exposing for the parents and I think that a period of working through and digestion is needed for the work to be effective. From then on appointments are at intervals of two or three weeks.

There are, of course, toys available for the child, and I try to make contact and interact with him very early on, while at the same time listening to the parents' story. It is in some ways a semi-directed conversation as the parents speak initially about the symptom and why they have come to see me. I then ask about the pregnancy, the birth and the child's development, allowing the parents to associate freely. While they speak I observe the child's play and his reactions attentively, occasionally intervening to facilitate his play and his participation. The child can be a very active participant in telling the story and can take part by what I call 'staging a production' just at the moment when the parents are speaking about what is troubling the child, often without them being aware of it. So when Nina's mother tells me in a very low voice that she has recently made a suicide attempt, which she is certain was not been a contributing factor because the children knew nothing about it, Nina begins to beat her fists on a wooden seat, while up to that point, she had been playing peacefully at our feet. Mother had to accept that this was an important event and this prompted her to make numerous associations and gave us a way of understanding the child's symptoms.

I would like to pursue the comparison I was making with the analytic setting and speak about the transference and its use. The child's transference to the therapist is generally immediate and intensely positive. It is as if he has an idea that this adult, who his parents are consulting, is there to help him understand his difficulties and to re-establish a less conflicted relationship with them. However, when the parents are ambivalent about their commitment to the therapy, the child may find it hard to feel free to put his trust in the process. It is natural for parents to be slightly defensive, because having to consult a mental health professional about the difficulties they are having in bringing up a child constitutes a narcissistic wound. The status of the person who has recommended this course of action can soften the blow. In most cases it is parents who have already had to resort to seeking my help, who advise others to see me. The positive transference, which allows a therapeutic alliance to be established, is not named or used in interpretation. Interpretations focus on the direct relationship between the parents and child or on the parents' history with their parents.

If resistance is high I take time to say so and to understand the reason why from the parents' point of view. For this kind of work the parents need to feel completely confident in the therapist.

Having given a brief description of my technique I will now consider the role that my practical experience of infant observation has played in its development.

## **Development of technique of parent-infant therapy**

### ***The ability to observe objectively***

Firstly, I would like to consider the development of the ability to observe as objectively as possible. Looking seems to be simple and uncomplicated. However, even scientists admit that observation can never be totally objective. We tend to see what we are expecting to see, in line with our theories and the aim of our research; or we see what we want to see in keeping with our unconscious desires which have their origins in our personal history; or else we do not see what we fear seeing – the outcome of repression which has marked our development. What is more, experience tells us that looking at what happens between a mother and a newborn baby awakens in us feelings which have been unconscious. There are also memory impressions, which persist from our earliest years, which have no concrete representation but all the same influence our perceptions and behaviour. Training in the Esther Bick method of infant observation allows us to become more aware of these involuntary intrusions, which alter our objectivity. It is important to put aside one's theories, to be a 'tabula rasa' and to develop the capacity to be astonished as Esther Bick recommends (Bick, 1964).

I try to make use of this advice when doing parent-child therapy. I am mindful that, although total objectivity is impossible, it must remain both an ethical and scientific aim. Experience gained from observation has enabled me to focus on the child while at the same time listening to the parents' account of their suffering and disquiet. There can be a great deal of moving around in the session if the child seeks their parents' or the therapist's attention or needs looking after. It is worth paying sustained attention to this, too, because it is a vehicle for non-verbal communication in the same way as facial expressions, gestures, vocalisations and shouts are.

The psychotherapist is, for each participant, the object of a multitude of projections, which provoke an emotional reaction in her. Here again infant observation teaches us to understand and manage these experiences better, thanks to the work done in the weekly seminar. The clinician who is being consulted is the third party and, just as when doing an observation, must identify with the parents as much as with the baby, and refrain from making judgements. We know that the universal impulse to look for an ideal mother is suspect and can lead us to be overly critical about the small commonplace failings of all mothers.

Identification also occurs in the other direction: parents observe the therapist interacting with their child and follow her example. I am most aware of them watching me when I am interacting with a difficult child (one who is irritable, disobedient or anxious). One mother made this clear to me when she assured me she would follow my advice carefully. When I showed how astonished I was by this remark she replied, 'I am well aware that you do not give advice but I watch the way you behave with my son and at home I try to do what you do'. We encounter the same phenomenon in infant observation when in a large percentage of cases, the mother not only identifies with the observer who is watching but also with her calm and attentive behaviour. This was abundantly clear to me from the interviews I did with mothers who had been observed (Watillon-Naveau, 2008).

This detailed observation of the child while parents are talking about the symptom will allow the therapist to make links between the content of the parents' account and the child's behaviour. The child's reactions are sometimes very clear: blocking their ears, suddenly needing their transitional object or dummy, climbing on to their parents' knees, wanting to leave the room, hiding behind the furniture, wanting to get into the toy drawer, crying, wanting to eat, to mention but a few. Other reactions are more difficult to understand and have to be interpreted by the analyst. Experience has taught me that when a child frequently lets things fall (a toy doll which is dropped, a car which falls from the top of a piece of furniture) he is referring to an experience of falling resulting from a failure of holding or from a traumatic incident in early infancy. Of course all of this is dependent on context and must not be turned into to a rule of thumb. I have encountered children who symbolised the harm they had experienced by putting themselves in danger of falling, by, for example, jumping dangerously on my couch or falling from it for no apparent reason.

### *The infants' capacity to perceive situations*

From my long experience of training in infant observation I have a fund of knowledge about babies' capacity to register what is happening around them, to sense the changes in their parents' mood and the emotional climate in the family. Young children's ability to adapt and their desire to satisfy the conscious or unconscious demands of those around them, never cease to fill those who care for them with admiration. However when stress is too intense and overwhelming this ability to adapt can flounder and the small child's psychological immaturity prevents him from overcoming difficulties without help from external parents who may be unavailable as they themselves are overcome by the anxiety-provoking nature of the situation. An event only becomes traumatic if it cannot be processed and integrated. The ability to put something into words plays a most important role in this situation and it is essential to be able to explain in simple terms, even to a very small child, what is happening in the family. Babies

are supremely sensitive to the way in which emotional states are conveyed by the sound of the voice (Cullere-Crespin, 2007).

Through observation we can see the unique nature of each dyad. This is determined by the mother's personality and consequently by her early history. It is also determined by the hereditary baggage the child is born with and the way in which this is transformed and developed by his environment. The father's role as the protector of the dyad and the third element of the triangle who helps the pair to emerge from a two-person relationship, should not be forgotten. Currently fathers act as equal partners in relationships and can influence the child's development as long as the mother allows them the space to do so. Neuroscience has made it possible to confirm (by imaging the development of the frontal lobe) what psychology and common sense already knew: the importance of mutual pleasure in mother-baby or father-baby relationships.

### *The importance of accurate, detailed notes*

I have become accustomed, when I do parent-child therapy, in the same way as I did when writing up observations, to making detailed notes after sessions. These are as accurate as possible and are faithful to the sequence of events. I re-read them before each appointment. Recording what happened during the session makes one more aware because writing creates emotional distance. By recalling facts in sequence new links are formed, which facilitate an understanding of what is being played out between the parents, their child, and the therapist. Sometimes the symptom disappears after the first meeting and then some parents return to the second appointment in order to understand how the problem has been resolved. It is important to put into words what has been expressed and relived both through action and through non-verbal communication. Parents are asked to recall what their child 'expressed' by the way he behaved in response to what they said. This is done in order to alert them to the links between the symptom and their family story, to transgenerational communications with which they have unconsciously burdened the child, to the blame projected on to the child, or to trauma which has been denied by silence and forgetting.

### *Counter transference as a tool for understanding*

As I have already implied, training in observation also aims to increase the analyst's capacity to be aware of her counter transference (which is by definition unconscious) and to process it. This is in order to avoid acting out in the counter transference so that it can be used as a tool for understanding. In parent-child therapy countertransference is particularly tested by the multiplicity of projections, to which the therapist is subjected by the three participants. We also know that infantile suffering can stir up in us, along with painful memories of our own infancy, violent feelings of impotence and anger. Children can also

be extremely seductive and one has to take particular care not to wound the parents' narcissism and further destabilise their already shaky confidence.

Work in the seminar, including help from the other members and the seminar leader, enables us to become aware of any lack of objectivity stemming from the observer's emotional responses, whether they are conscious or unconscious. I miss these group discussions when doing parent-child therapy. Taking notes replaces them partially but not totally and for this reason discussion with colleagues is important.

### *The capacity to be surprised*

Mrs Bick's recommendation to keep alive the capacity to be surprised is useful in parent-child therapy. Even if symptoms are frequently related to identical causes as far as the parents are concerned, each dyad or triad has individual characteristics. Sticking to theoretical ideas is often the analyst's way of defending herself, something that led Bion to say we should eschew memory and desire.

### **Conclusion**

To conclude, I am going to give a detailed clinical example, which, I hope, will illustrate the points I have made.

### *Celine at 16 months*

Celine is 16 months when I meet her for the first time with her parents. When mother made the first appointment on the telephone I noticed she was extremely anxious. Celine has been refusing to eat and has been sleeping very badly since her mother returned from a stay in hospital. Mrs X adds that her little girl is avoiding her and hates her. Father is carrying Celine because mother's leg is in plaster and she is on crutches. Celine is a pretty little girl, delicate, pale and a bit shy in the beginning, although she soon becomes interested in the toys and interacts with me . . . when her mother lets her. In fact Mrs X is 'on her starting blocks' ready to respond to Celine's every wish, even though her mobility is restricted. The least demand from her daughter is responded to with a false sounding, 'Yes, my darling'. Mrs X starts to reiterate the eating and sleeping problems, but emphasises the fact that what affects her most is her daughter's rejecting and hostile attitude. I notice that Celine turns more readily to her father and I am shocked by the harshness of mother's words.

Mrs X had a serious car accident when Celine was two months old and has, over the past year, undergone a significant number of planned operations on her legs. With the help of her own mother she succeeded in making her many absences bearable for the baby, warning her of what was going to happen and explaining things clearly. Celine was a baby whose development was advanced until recently. Mrs X was sorry that her mother was not sufficiently tactful, when

helping to care for Celine, to let her to do what she was able to despite her crutches. Grandmother and mother competed to be the quickest to meet Celine's wishes. I am aware that Mrs X is creating the same competitive relationship between us although I am being as reticent as possible with the baby. Father intervenes little; he is none the less attentive and occasionally adds some detail. He attends to Celine only when necessary and leaves his wife plenty of space.

Mother's last admission to hospital was unexpected, caused by the unfortunate development of a pseudarthrosis. This was the last straw for mother. She was stressed and demoralised which meant she could not face Celine's reaction to her state of mind and also that she could not face up to the way Celine reacted to the event.

I return to the words mother used: rejected and hated by her daughter. Mrs X makes an immediate association to the story of her marriage. Her parents did not accept her choice of a husband because of his nationality (he is Italian) and because he has not been to university. Until Celine was born the parents no longer saw the maternal grandparents. At this point Celine is playing with a packet of tissues and is trying but failing to open it. I offer to help but mother rushes to take the packet and opens it abruptly. The resealable opening makes a ripping sound and Celine jumps and takes a step back. I say that Celine does not like things which break and Celine murmurs 'Mummy gone'. There is a brief silence and mother dissolves into tears, understanding that her little girl is fearful of her broken legs and that this is not about hatred or rejection. This is truly a very moving and revealing moment.

The parents accept a new appointment during which I learn that Celine has gone back to being a calm baby who sleeps all night and has found her appetite again. The discussion was devoted to mother's problems with her parents.

I see Celine again when she is six and has just had a little sister who is two months old on the day of the consultation. After a long discussion with Celine I see her mother alone. She is wearing very dark sunglasses although the weather does not make this level of protection necessary. After a few exchanges I ask mother why she is wearing these glasses. Mother starts and asks me if they bother me. I reply that they stop me seeing her eyes, then, thinking of the newborn baby, I ask if she keeps them on all the time . . . even when tending to her second little girl. Mother realises that she is unconsciously placing an obstacle between herself and her child and understands that it is her feelings of guilt about not having been able to care for Celine all the time, which make her behave in this way.

To conclude, I think that the practice of infant observation has developed my capacity to create, in parent-child therapy, an atmosphere in which the child feels welcomed, understood and contained. He can then, in complete confidence, express through his behaviour the difficulties he is having in his interactions with those around him. It is for the therapist to make sense of these and to articulate them, not just for the child but also for the parents. The therapy rarely lasts long



but it enables the parents and the child to re-establish a more satisfactory relationship and it lightens the atmosphere in the family considerably.

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