10

Infants in Multirisk Families: A Model for Developmentally Based Preventive Intervention

In the previous chapter, we described how children with neurodevelopmental disorders of relating and communicating require a team of professionals who can each address different aspects of the child's development and who meet regularly to coordinate their services and assess the child's progress. A team approach is equally important—and even more complex—for what are sometimes called "multirisk" or "multiproblem" families. These terms refer to families who face a host of challenges that contribute to developmental difficulties in the children and that complicate the treatment of such difficulties. Although each family is unique, common problems include lack of basic resources such as food and affordable shelter, untreated psychiatric illnesses in one or both parents, maladaptive patterns of interaction among family members, and lack of connection to the traditional array of social services available in the community. To effectively address developmental deficits and challenges in such families, a truly comprehensive, coordinated program of services is essential.

Recruiting and Engaging Families for a Preventive Intervention Program

In the mid-1970s, we developed a Clinical Infant Development Program (CIDP) for infants in multirisk families residing in Prince Georges County, Maryland. This program, which we operated into the 1980s, has been replicated and adapted by agencies in several other counties and cities in the United States. We recruited pregnant women who had already shown severe difficulties in fulfilling one of the primary maternal functions or both of the secondary maternal functions for an older child and who seemed likely to repeat the pattern with the new infant. (*Primary maternal functions* are the ability to provide physical care and protection, the ability to read an infant's signals of pleasure or displeasure, and the ability to provide sufficient emotional nurturing for a human attachment between mother and infant. *Secondary maternal functions* are the ability to discern a child's changing developmental needs during the first 2 years and the ability to respond promptly, effectively, and empathically to the child's signals.)

Because multirisk families tend to remain outside the traditional mental health system, rarely seeking appointments and generally distrusting service providers, we launched an extensive outreach effort to recruit mothers. We stationed clinicians at prenatal clinics, where they made presentations about the program to groups of women and approached individual mothers directly. We called on social service agencies, the courts, child protective services, state mental hospitals, community mental health agencies, and the police, asking them to send us their most difficult and challenging clients. We made it clear that no family would be turned away because of the severity of its problems. Soon calls started coming in from prenatal clinics regarding mothers who had missed appointments, appeared confused, or were not following medical guidance as well as from child protective service and court workers involved with families in which an older child was neglected and the mother was pregnant again.

Identifying potential participants was only the first step. In some cases, repeated visits and outreach were needed before mothers consented to sign up for the program. The key to recruiting and engaging the families was our staff's ability to deal with patterns of avoidance, rejection, and anger as well as illogical and antisocial behavior and substance abuse. We selected experienced clinicians who were not frightened by such behavior and who could sensitively but persistently pursue mothers while resisting the impulse to conclude, "she just doesn't want help," or "they told us they don't want us, we're just being a burden to them." In the early phases of working with a family, it was sometimes necessary for the clinician to make five or six home visits, knock on the door, hear someone walking around inside, make a few comments through the door, get no answer, and then return 3 days later to try again, until the person inside felt comfortable enough to open the door and let the clinician in. Even more difficult were mothers who eagerly em-

braced the program and then disappeared. In many cases, the clinician's continual outreach and offering of an interested ear eventually met with success. Sometimes, a year would pass before a consistent pattern of relatedness evolved.

Sixty-one women were eventually recruited. (An additional 29 women signed consent forms but immediately or shortly thereafter refused to participate in the program.) Evaluation of prospective participants was based on clinical interviews with the mother, clinical assessments of existing children, observations of maternal and child functioning, free-play observations at home and in our office, psychological testing of the mother, and the records or reports of other agencies.

The initial evaluations were conducted not in the traditional format of psychiatric interviews in an office setting but instead during the process of engaging and forming relationships with the mothers. We asked what help they needed and tried to be useful so that they would permit us to visit and observe again. Because so many were struggling with survival, we could always find ways to help with concrete services. While driving clients to health or social service agencies and while meeting with them in their homes, our clinicians could ask questions and make observations of general and maternal functioning. Once a relationship was established, clients were more likely to agree to formal interviews, testing, and observations in our office. Each contact with a client was recorded in narrative process form. Although the course each evaluation took varied somewhat from mother to mother, the information gathered, when summarized, resulted in a complete psychiatric evaluation and a clinical team consensus on the mother's risk level and diagnosis. (For details on the research protocols, validation procedures, and clinical rating scales used in the evaluations, see *Infants in Multirisk Families* [Greenspan et al. 1987]).

Based on the evaluation, 47 of the mothers recruited were considered at significant risk for failure to provide adequate mothering for the children they were carrying at the time of evaluation. Another 14 were determined to be at low risk. The low-risk mothers were assigned to Group A. The high-risk mothers were assigned to one of two groups, Group B or Group C. Families in Group B received clinical, developmental, and psychosocial assessments and feedback and were then referred to the community agency or agencies best suited to meet their needs. Group C families received the same assessments but were then offered the intervention resources of the CIDP. The index children of all three groups were systematically assessed at regular intervals with the identical research protocol (Greenspan et al. 1987).

The 47 high-risk mothers we worked with had anywhere from one to six children already born; lived in communities in Prince Georges County, Maryland, that range from urban to rural; and were mostly married or involved in an ongoing relationship with the fathers of their children. They ranged from 18 to 36 years old (median age 23.9), with 27 identifying themselves as black and 20 identifying themselves as white. More than half of the mothers had not graduated from high school. Only six mothers were employed; most depended on more than one indi-

vidual or system to meet their own and their children's needs for food, clothing, shelter, and other necessities. Sources of support included families of origin, the fathers of their children, government programs, and nongovernment agencies such as churches or the Salvation Army.

We were extremely interested in understanding the histories of the mothers; we hoped to identify the antecedent factors that may have contributed to their high-risk status and maternal difficulties. We quickly learned, however, that traditional interview techniques would not yield the information we sought. We were reaching out to women who had not sought psychiatric services and were often suspicious or scared of "helping professionals." As described earlier, we began by offering the mothers help with immediate needs and gathered information gradually as we built a relationship with each mother. Because many of the mothers had great difficulty revealing aspects of their histories that were shrouded in secrecy or shame—such as early abandonment, family mental illness, abuse, or incest—such information often emerged only after a strong therapeutic relationship had developed, a process that in some cases took years.

We discovered that all the mothers had had difficult lives and many problems before their children were born and that their difficulties did not go away. The profile of the typical mother in our program revealed a woman who was born into a family experiencing psychiatric dysfunction, who displayed marked impairment in her own social and emotional development as a child, and who, as an adult, bore children whose functioning seemed already compromised in the earliest years of life. To capture, if only in a limited way, the degree to which multiple risk factors or antecedent variables came together for each participant, we constructed an index of misfortunes experienced by the women prior to their entry into the program. Each woman's score was obtained by counting the number of misfortunes, out of a list of 18, that she had experienced and dividing that number by 18 to derive a percentage. A score of 0 would indicate that the person had experienced none of the 18 misfortunes; a person with a score of 1 would have experienced all of them. The misfortunes, or antecedent variables, are listed in Table 10–1.

We found that the median value of the index for the high-risk women was 0.49. That is, half of the 47 high-risk women had experienced nine or more of the misfortunes before entering the program. Fifteen percent of them had experienced close to 12 of these events. In contrast, the median value of the index for the low-risk women (Group A) was 0.09—that is, the women in the low-risk group generally had experienced none of these misfortunes in their lives. The maximum value for the index in this group was 0.21, or 3.7 misfortunes. There was a moderate relationship between the index of misfortune and the rating of maternal functioning (r=–0.34, P=0.01) and also between the index and the participant's capacity to engage in a therapeutic relationship (r=–0.34, P=0.01). The fact that our index correlates, although moderately, with these two independent measures of psychiatric status at entry to the program leads us to believe that the index may

TABLE 10–1. Maternal risk factors used to calculate index of misfortune

1. Psychiatric illness in family of origin
2. Psychiatric hospitalization
3. Physical neglect experienced before age 18
4. Physical abuse experienced before age 18
5. Sexual abuse experienced before age 18
6. Witnessing abuse of others before age 18
7. Physical abuse by mate
8. Physical abuse or neglect of own children
9. Disruption of significant relationship before age 12
10. Impaired functioning in family before age 18
11. Impaired functioning in peer group before age 18
12. Impaired functioning in school before age 18
13. Impaired functioning in family at or above age 18
14. Impaired functioning in peer group at or above age 18
15. Impaired functioning at work at or above age 18
16. Chronic antisocial behavior
17. Expulsion from school
18. Chronic violation of rules at home or school before age 15

have some predictive utility. (For a full statistical presentation of the demographics and antecedent variables that characterized our participants, see Greenspan et al. 1987).

Essential Components of Preventive Intervention

Because the families we recruited had not found it possible to use the standard, often fragmented array of social services in their communities, the CDIP combined, either directly or through collaboration with other agencies, services seldom found in a single organization. Our approach had three major components:

1. We had to support basic survival and help clients meet concrete needs. This meant searching for apartments with participants who were facing eviction, making clinic appointments and providing transportation so mothers would keep them, and delivering emergency food and diapers. It also meant working in collaboration with other agencies and authorities on behalf of the families.
2. We had to develop some regularity and continuity in our contacts with the mothers in order to build trust and a healing relationship. We needed to con-

sider the nature of each mother's pathology and the impact of her past relationships as we persisted in our outreach in the face of avoidance that, in many cases, lasted for months.

3. We had to develop specific clinical techniques and patterns of care suited to the highly varied constitutional capacities of the babies. The infants in the program ranged from the very vulnerable—for example, those with unique tactile or auditory sensitivities—to the very resilient. We set up an Infant Center to provide, at one site, part-time or full-day therapeutic day care for the infant, outreach to the parent, and training and supervision of program staff. As our contacts with the mothers stabilized and attachments formed between the mothers and program staff, we began working to bring the mothers to higher developmental levels by helping them relate to their children's individual vulnerabilities, strengths, and emerging capacities for human interaction, from early two-way interchanges to later representational elaboration.

Staffing the CIDP: The Team Approach

CIDP staff were called "primary clinicians" and "infant specialists" in order to reflect our program's difference from traditional services and to avoid the stigma or fear our families might attach to traditional titles such as "therapist." Mothers in the program were referred to as "participants" rather than "patients" or "clients." This practice reflected our decision not to formally diagnose mothers or require them to identify a problem or need as a condition of joining the CIDP.

We realized that a team approach would be needed to provide effective help to our families. The sheer number of things to be done, agencies to involve, and children present in the families of our mothers required the energies of more than one person. Furthermore, the emotional stress of working with these families was difficult for one clinician to tolerate alone. By assigning at least two staff to each family, we ensured that staff could support each other in the face of multiple rejections as we pursued participants. Once a family began to engage, if the mother was angry with one team member, or if one team member became too overwhelmed and despairing to be effective, the second team member could take over for a time. We found that composing teams of people with different skills and professions facilitated this process: some mothers, for example, felt more comfortable with a nurse than with a social worker. Finally, and most important, a flexible team was needed to give equal attention to the infant, the mother, and the entire family. We found that the mothers, most of whom had never had adequate nurturing themselves, tended to compete with their infants for the attention of program staff. With a team approach, the mother could work through painful issues of her own in sessions with one clinician, while an infant specialist conducted less emotional sessions focused on the baby. In these sessions, the infant specialist could help the

mother recognize and understand her baby's unique capacities and learn to interact with him in ways that furthered his healthy development. If, as sometimes happened, the mother was unable to focus on her infant and the clinician was still in the process of helping her with her patterns of avoidance, the infant specialist could provide the baby with crucial experiences until the mother was more available. If a mother happened to feel most comfortable with her baby and the infant specialist, the more intense therapeutic process emerged between mother and infant specialist; in such cases, the clinician was available to focus on the baby. For other cases, reaching both mother and infant proved so difficult that the additional services of the Infant Center were needed.

Our staff consisted of social workers, psychologists, nurses, educators, and paraprofessionals. As the program progressed, it became apparent that an ability to tolerate the stresses of the work was more important than background in a particular discipline. Successful staff members learned in the course of our program about subtle individual differences in infants and how these expressed themselves in infant–caregiver patterns of interaction. An especially sensitive infant who found his mother's voice noxious, for example, required a staff member who could both coach the mother to try different ways of holding, touching, and vocalizing with the infant and empathize with the mother's feelings of defectiveness, rejection, and anger. Several years of prior experience in some form of outreach or community-based service seemed to be a prerequisite for effectiveness. The only two staff members (out of 16) to leave the CIDP because of difficulties in doing the work had come from academic settings in which their authority derived in part from that of the institution. These clinicians found it especially challenging to function "outside," where they had to represent themselves without institutional backing and where a teaching posture was less effective.

For staff, it was the continual supervision and conferences as well as the team approach that relieved the stress of working in the CIDP. At some stages, just as much time was spent in supervision and support as in direct contacts with program participants. We needed a highly experienced clinical supervisory staff who could pay close attention to the impact of the work on both participants and staff. Each clinician had a weekly session with an individual supervisor. Team meetings, which periodically included the CIDP psychologist and developmental clinician in addition to the team members and supervisor, were held biweekly. Where needed, interagency meetings were held regularly. Finally, all members of the clinical staff, administrative supervisors, and program directors participated in a weekly case conference, which permitted the regular review of all families following each assessment interval. The critical underlying task in all these meetings was dealing with the reactions, or countertransference, stirred up by the difficult work with participants.

Limited caseloads were another element of support for staff. Typically, each clinician could carry only five or six intensive cases in Group C while following about

the same number of cases in Group B, the community-referral group. (The Group B cases at first presented a source of conflict, as staff struggled over just how much help the CIDP should be offering this group. As time went on, clinicians welcomed the lower levels of intervention involved in these cases, despite the difficulty of keeping them engaged, simply because they required less effort than the families receiving comprehensive services.) Caseloads were determined primarily by the amount of effort needed to work with families rather than by an arbitrary number. Fortunately, even the most difficult cases usually stabilized around the infant's first birthday, at which time we would sense a consolidation of our efforts and a shift to easier stages of intervention. As some families achieved stability, clinicians could take on new participants; thus, during the program's first years, caseloads increased slowly as the stage of work with each participant was assessed.

Some of the traditional patient–therapist boundaries were lacking between CIDP participants and clinicians, who needed the capacity to tolerate a certain degree of merging out of which differentiation could grow. This intimacy took very concrete forms, as clinicians joined in participants' struggle for survival, experienced their fears and fury, and became the nurturing figures who slowly helped to create some order in their lives and those of their children, a necessary foundation for growth and development.

The Service Pyramid

As we increased our understanding of the developmental challenges facing young children and their families and the kinds of intervention needed to address these challenges, we also acquired a basis for conceptualizing therapeutic intervention at both the service system level and the clinical level.

The developmental, individual-differences, relationship-based (DIR) model provides the rationale for comprehensive intervention approaches, as opposed to approaches focused on isolated symptoms or behaviors. The CIDP was designed to achieve the same goals as the other interventions we have described in this book: to enable the infant to progress developmentally—that is, to master the capacities of attention and self-regulation, engagement and attachment, purposeful two-way communication, problem-solving communication and an emerging sense of self, symbolization, and building logical connections between symbols. Like the interventions described in earlier chapters, our work with the CIDP families addressed the infant's inborn processing tendencies, the family's dynamics and social context, and the interactions experienced by the infant.

Because the CIDP families faced such a multitude of problems, however, a more complex and wide-ranging array of interventions was necessary to support the mastery of each developmental level. We found it useful to visualize preventive services as a pyramid, with the services that support the earliest developmental stage at the base (see Figure 10–1).

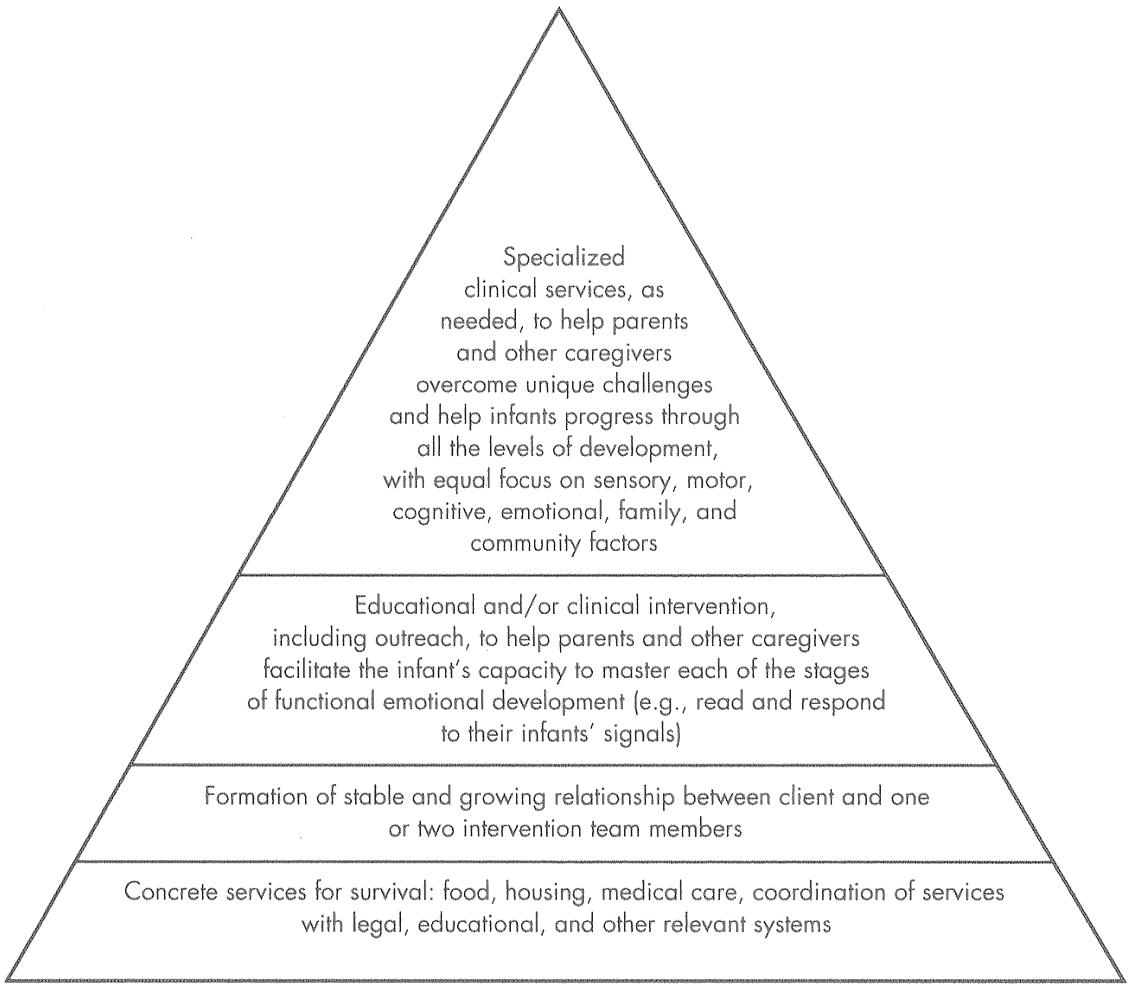

FIGURE 10–1. The service pyramid.
The service pyramid depicts an overall framework for services. Note that the third level up from the bottom of the pyramid refers to facilitating the infant's capacity to master each of the six core developmental capacities.

Level 1: Shared Attention and Regulation

For a baby to achieve self-regulation and develop interest in the world, she must have an environment that is protective and that permits her to engage the world in a comforting and self-regulating manner. This implies that the baby and her parents must have adequate nutrition, shelter, medical care, and basic safety. At the base of our service pyramid, therefore, are interventions that help pregnant mothers and their families with basic survival. Service system planning at this level must be based not on the easiest, but on the most difficult case—that is, on the multiproblem family that does not make itself available to the traditional service system.

In addition to all the social services (including, where needed, child protective services, the legal system, the educational system, and the health and mental health systems) working in an integrated manner, two pivotal components are needed to

support basic security and self-regulation. The first is active and skillful outreach programs with staff who can make daily home visits where needed. The second is a project headquarters, such as our Infant Center, to which the most vulnerable families, often with severe psychopathology in the caregivers, can come every day. Here, other adults are available to meet the infant's need for physical care and protection and to support the infant in developing the capacity to attend and self-regulate. At the same site, staff can engage and support the caregiver. Daily visits to a center like this can help a family avoid the need for foster care. An extensive, well-integrated service system can make it possible for a family to attain the strength to stay together and to avoid later patterns that can lead to debilitating psychological, social, and intellectual difficulties and even to institutionalization of children.

Level 2: Engagement and Relating

When basic survival needs are met, parents can become more available for a relationship with their new infant. Just above the base of the pyramid are services necessary to support the family's capacity to provide a loving, satisfying attachment. All the services supporting level 1 are needed, as well as skilled psychotherapy for the parents. Program staff should, along with offering help with practical issues such as food and housing, make themselves available regularly and consistently to enable a trusting relationship with parents to develop. When parent and clinician have a warm and trusting enough relationship to meet regularly, they can begin working toward the next developmental level.

Level 3: Two-Way Intentional Affective Signaling and Communication

At the third level, staff must use specific clinical approaches to help parents read their infant's signals and engage in emotionally attuned reciprocal communication. Many parents, in order to recognize both cognitive and emotional signals in their infants, must first learn to recognize such signals in themselves. Thus, the opportunity to establish a warm relationship with a skilled clinician, in the context of which the capacity for self-observation can develop, is essential. This relationship must be able to tolerate negative feelings, such as disappointment or anger, without interruption of its reliability and regularity.

Some parents cannot achieve a self-observing capacity at an emotional level. Even for such parents, simple support combined with educative approaches can teach the ability to read their infant's signals cognitively. The optimal goal, however, is to teach both cognitive and affective observation of and response to signals, because this capacity is necessary to support all further stages of development. Infant specialists, nurses, and if necessary, skilled homemakers can facilitate the development of this capacity.

Level 4: Long Chains of Coregulated Emotional Signaling and Shared Social Problem Solving

Parents must now be able to maintain the self-observing function over a wide range of affective experience and complicated behavioral patterns. In working with a woman who had an underlying thought disorder, for example, we observed that she was capable of maintaining a self-observing function and reality orientation during simple communication. Once emotions became complicated, however (e.g., a mixture of love and aggression), she became overwhelmed, and her self-observing capacity and ability to read signals deteriorated. In such a case, the parent must be helped to strengthen her self-observing capacity and to tolerate highly complex emotions, such as ambivalence. The service system must now make available a new level on the pyramid: a specialized clinical team that helps parents learn to observe and understand their own and their child's feelings and communications. In addition, a trained clinician-educator can work with the child, either individually or in a toddlers' group, to help the child deal with complex emotions and social interactions. If the child has sensory, motor, or language lags, remedial occupational therapy or special education services are needed.

Level 5: Creating Representations (or Ideas)

At the next level of the pyramid are services to support the child's emerging capacity for *symbolization*, or the use of ideas to label feelings and guide behavior. The service system must now support the parents' own capacity for symbolization. In many cases, we have found that if we can help the parents represent their own experiences in *words, fantasies,* and *rich mental imagery,* they can then interact with their growing child in this mode. Parents who cannot do this often maintain a concrete way of relating that undermines the natural development of symbolic capacities in their toddlers and young children.

At level 5 of the service pyramid, a therapeutic relationship with the parents must unfold for a long enough time to help the parents develop the capacity for mental imagery, if they never had that capacity before. If the parents' capacity for symbolization is constricted by intrapsychic conflicts or characterological limitations, therapy can help them "liberate" or expand their representational capacity, at least where their relationship with their toddler is concerned. This effort requires sophisticated therapeutic work in which the parents' own fantasies are permitted to emerge. In their relationship with the therapist, the parents are encouraged to observe their own way of handling fantasy and mental imagery and are coached to recognize signs of this emerging capacity in their children. If necessary, while the parents are working to develop their own representational capacity, direct therapy with the toddler in a free-play setting can allow the child to begin to symbolize a variety of emotions through pretend play.

Level 6: Building Bridges Between Ideas: Logical Thinking

The capacity for differentiation, organization, and connection of ideas takes us to the top level of the pyramid. Here, the task is not simply to help parents develop and elaborate mental imagery but also to help them develop a reality orientation—that is, to help them differentiate ideas and imagery that pertain to the outside world from those that pertain to their inner life. With this ability, they can begin to facilitate a similar reality orientation in their young children. The capacity to distinguish reality from fantasy enables parents to make pivotal judgments about when to set limits and point out the reality of a situation and when to support the make-believe play of their children. Healthy, competent parents make these often-subtle distinctions intuitively. For example, a parent with a well-developed capacity for symbolization and symbolic differentiation knows that if her toddler is having one doll hit another, this is make-believe play dramatizing feelings, altogether different than if the toddler were himself hitting another child.

When parents have characterological constrictions, severe intrapsychic conflicts, or tendencies toward fragmentation, intensive therapeutic work may be required. Establishing or stabilizing ego functions such as reality testing, impulse regulation, mood stabilization, and the capacity for attending and concentrating can lay the foundation for establishing these same functions in the child. Preschool programs and one-on-one therapy can provide opportunities for children to practice and strengthen their new capacities.

We have outlined the six steps of a developmentally based pyramid of services for preventive intervention with multirisk families. In cases where financial or other crises are interfering with a family's otherwise healthy capacity to promote their children's achievement of the core developmental capacities, the concrete services and service coordination at the base of the pyramid may be enough. For most of the families we worked with, however, this was not so. Once the family's immediate crises were alleviated and a relationship between program staff and parents began to develop, the more specialized and sophisticated services at higher levels of the pyramid were needed.

In our experience, we have found that the kinds of interactive experiences a family needs to support each level of development can usually be provided through a program that integrates the existing network of community-based social services. However, our experience with the CIDP families demonstrated that the most challenging families often require intensive daily care and, depending on their level on the pyramid, highly specific clinical interventions. An outreach program and an Infant Center are needed to augment more traditional program approaches for such families.

It is worth emphasizing again that strengthening a family sometimes involves working directly with the youngster. If the parents are unavailable during important stages of the child's early development because of their own psychopathology

or other circumstances, direct work with the child can help him become a "stronger team member" in the family. The child can then help his parents help him. For example, an 8-month-old infant who sends his emotional signals in a weak manner, or who has a withdrawn mother who does not read his signals, can be taught by an infant specialist to send stronger signals. As the mother gets stronger feedback from her infant, she may be drawn out of her depression to some degree, allowing her to engage more.

Dimensions and Levels of Helping Relationships

Our experience engaging and developing working relationships with these challenging families helped us to recognize and delineate what we believe are the most basic elements of any helping relationship. We conceptualize four parallel dimensions of such a relationship: regularity and stability, emotional depth, process of communication, and thematic content of communication. Each dimension can be evaluated at any point in the relationship.

Considering each dimension separately focuses attention on the very earliest stages of human services intervention: capturing a prospective client's interest, establishing a regular pattern of contact, facilitating the development of an emotional relationship, promoting purposeful two-way communication, and helping the client tolerate discomfort without fleeing. Too often, human services professionals and programs neglect these early stages. To use the example of psychotherapy, consider how much must be accomplished by therapist and client before they can begin doing what is typically considered "therapy." First, a prospective client must have some interest in the service offered. Ideally, the client begins to feel emotionally invested in both the therapist and the program of therapy and engages in an organized, purposeful exchange of signals with the therapist, in the process learning to tolerate whatever uncomfortable feelings are stirred up by the exchanges. At higher levels, the therapeutic relationship provides a context in which the client can observe her behavioral and emotional patterns, relinquish maladaptive patterns, and embrace new ways of functioning. It is only at these higher levels that specific therapeutic techniques, such as psychoanalytic treatment or cognitive-behavioral approaches, begin to vary, each taking its own route to helping the patient alter old patterns.

We believe the four dimensions offer a means for understanding and evaluating the progress of relationships not only between psychotherapists and their clients but also between visiting baby nurses and new parents, between teachers and the parents or guardians of their pupils, between doctors and their patients, between public health workers and individuals at risk of disease, and indeed between any helping professional and a person he or she attempts to assist. (In fact, the dimensions appear to characterize the development of *any* relationship between two

people. As we describe the dimensions, we use examples from everyday social interactions as well as from human service situations.)

The First Dimension: Regularity and Stability

In models of service in which prospective clients voluntarily present themselves with a request for help or to enroll in a program, regularity and stability are often assumed. Even when self-referred clients seek help, however, regularity and stability are sometimes disrupted. Clients who feel ambivalent about seeking help may cancel appointments or fail to show up early in the process. Later, when the client–worker relationship stirs up unpleasant feelings that clients have heretofore succeeded in avoiding, they may respond by canceling meetings or by emotionally withdrawing from the worker during encounters.

In any situation in which a helping professional interacts, or attempts to interact, with someone who needs assistance, it is possible to evaluate the regularity and stability of meetings. Where home visiting is involved, for example, a client or prospective client demonstrates her initial interest simply by opening the door and making herself available for a conversation. At this earliest level, one would expect a mother to be able to engage in a simple conversation about occurrences in daily life or about her infant's physical health or feeding patterns. Even at this stage, one can distinguish between a person who will only occasionally appear for a scheduled appointment or let a home visitor in and one who meets regularly. Also vividly apparent is the difference between a client who appears alert, interested, and engaged with the worker and one who falls asleep or withdraws into a state of self-absorption.

Several stages or levels in the establishment of regularity and stability in the helping relationship can be identified:

1. The initial meeting, for example, to discuss needs or for any other purpose
2. The attempt to arrange follow-up meetings
3. Meeting according to some pattern, however unpredictable it may be at times
4. Meeting regularly according to schedule, with occasional disruptions such as a cancellation following a difficult conversation
5. Meeting regularly with minimal disruptions

Progress from one level to the next is not necessarily smooth or linear: client and worker may go back and forth between levels. Some relationships never move beyond level 1 or level 2. Think of the experience of getting to know a new neighbor. One might invite the newcomer over for coffee as a gesture of welcome, or simply exchange introductions upon encountering him by chance. The two of you might never say more than a polite "hi" after this initial exchange. In an alternative scenario, you might arrange to get together again, discover you enjoy each other's

company, and continue to socialize frequently, in the process becoming close friends. If your new neighbor happens to be very shy or guarded, you stand a better chance of getting to know him if you respect his need to go slowly in forming this new connection. You may need to persist, gently and not too intrusively, and to tolerate some awkward silences or stilted conversation before discovering some topic that he feels comfortable discussing. Similarly, for a client–worker relationship to move toward regularity and stability, the helping professional must adopt a stance that supports such movement. A delicate balance of patience and persistence is called for. An outreach worker may, for example, knock on a prospective client's door on several occasions without succeeding in meeting him or her face to face. Perhaps the knock is met with silence on the first several attempts, or the prospective client turns out the lights and hides in a back room. On a later occasion, perhaps the worker is rewarded with a glimpse of someone peeking out a window. Finally, the person inside may feel safe enough and curious enough to open the door. A willingness to meet prospective clients on their own turf, to persist in inquiring what they perceive their most urgent needs to be, and to tolerate their expressions of disinterest, suspicion, or even hostility, are prerequisites for engaging them in a relationship that has the potential to progress toward regularity and stability.

Madeline

Madeline, a depressed young mother of four children, initially told the CIDP clinician to visit her because she liked "a little company sometimes," but rarely could she be found. For months, Madeline moved from place to place with her children, desperately seeking refuge but antagonizing those who took her in. The clinician and infant specialist pursued her with food, diapers, and offers of transportation. Although Madeline never called or informed the staff of her next move, she would be angry if they did not come to see her. There was no regularity in Madeline's life, nor could there be any in the helping relationships at this stage.

Only after 8 months of persistent pursuit did some regularity begin to be established. Madeline grew less frightened and more able to tolerate predictable contacts with the clinician (step 3). These contacts focused mostly on day-to-day survival and helping Madeline acquire some life skills. Madeline never acknowledged that she needed therapy and was not yet able to talk about her life, but she was willing to be with the therapist in order to be nurtured. As regularity of contact stabilized (step 4) and Madeline developed a stronger attachment to the clinician, she began to reveal some of her history.

Suzanne

Suzanne was a bright, articulate woman who married at 17 and proceeded to have one child after another, staying within the confines of a small apartment while her husband negotiated the outside world. She was referred to us after a severe marital crisis that precipitated a brief stay in a women's shelter before she reconciled with

her husband. The CIDP clinician offered concrete help to Suzanne, as well as the opportunity to discuss her concerns. Suzanne never refused and never expressed any suspiciousness, allowing the clinician to schedule meeting after meeting (step 2). On the day of each visit, however, Suzanne would take 20–30 minutes to answer the door. If the clinician called before coming, or from a phone booth because there was no answer at the door, the phone would ring 20–30 times before Suzanne answered.

Once Suzanne finally answered the door, she would graciously invite the clinician to come in and sit down but would then excuse herself and disappear into a back room for half an hour or more. When she finally appeared, Suzanne would ask the clinician questions about the clinician's own past and about problems of the clinician's children. Suzanne would refuse to discuss her own concerns; even the mildest comment by the clinician regarding Suzanne's behavior or feelings was met with denial and even longer waits at the door or on the phone.

The clinician persisted, however, responding sensitively on Suzanne's terms. Soon, Suzanne started to call for rides and accepted our referrals for her children. She started to answer the door in 10 or 15 minutes and took less time to adapt to the clinician's presence in her home. Yet cancellations and interruptions were still frequent, and for every two or three contacts, one was missed (step 3). If Suzanne saw the infant specialist one week, she would not meet with the clinician during the same week. Eventually, Suzanne could meet regularly and twice weekly (step 4). By this time, she had formed a strong emotional bond with the treatment team.

Anita

Another young mother, Anita, was unable to establish regularity and stability despite months of persistence by CIDP staff. Anita had been abused as a child and had lived in several foster homes by the time she reached adolescence and began to have children of her own. When we met her, she was again pregnant, lived in her boyfriend's truck, and had two children in foster care. Anita seemed to accept our help at first, meeting with us sporadically before her baby was born and for a few months afterward (steps 1 and 2). We attempted to arrange stable housing and to coordinate efforts with other agencies. Anita, however, remained distant and unrevealing. Once her son was born, she could not contain streams of projections regarding his "badness, orneriness" and all the "evil" he was doing her. When he turned away, she shook and jostled him in frustration. Despite our many efforts to maintain contact and offer help, Anita fled from address to address. Unlike Madeline, she left no trail to pursue.

Almost 2 years after her son's birth, Anita walked into our Infant Center and asked us to assess him. She would not say why, nor would she reveal her whereabouts. After the assessment, we shared some concerns regarding the severe developmental delays he evidenced and urged her to return so that we could do a more complete evaluation and offer help to her and her son. She did not return. We contacted everyone who had been involved with her case but could not find her again.

As these vignettes illustrate, maintaining even a minimal degree of interest and regularity in a social service relationship is an achievement for many clients that should not be underestimated. Because of their early experiences, fears, and psy-

chological disturbances, many people in need of help cannot make even this level of commitment. Programs that assume that all clients can be responsible for coming regularly for treatment, labeling those who fail to do so "unmotivated" or "untreatable," will fail many clients. Similarly, programs that ignore the first steps in establishing a relationship and instead attempt to engage the patient at higher levels of the therapeutic process, such as discussion of complex feelings, are building a house on a very shaky foundation.

The Second Dimension: Emotional Depth of the Relationship

A client's relationship with a helping professional tends to develop in the following stages:

1. *The client or prospective client is interested only in the concrete services that the worker or program can provide.* At this stage, the client shows little interest in the helping professional as an individual, and it may matter little which worker offers the services. (This stance is common among clients who continually have to meet with different workers to obtain social services.) After repeated contacts with a single worker, however, the client may begin to respond emotionally. He may ask for help and feel dependent on the worker, or feel angry and attack the worker for failing to do more, or vacillate between these two stances. The nature of a client's emotional responses to the helping professional will suggest what kind of relationships that client has experienced during his life. For example, suppose a parent habitually approaches his child's new teachers with a guarded, suspicious attitude and is quick to anger if he perceives they are displeased with his child. One might hypothesize that this man's prior experiences with authority figures, or with relationships involving criticism or evaluation, had been painful in some way.

2. *The client begins to show signs of emotional interest in the helping professional.* Perhaps she smiles and looks joyful when the worker arrives. She may tell the worker about a new friendship she has made outside the program, perhaps indicating that she has similar feelings toward the worker. At this stage, the client may perceive the helping professional as someone she feels good with, like a sister or a friend. She may make highly personalized statements, including negative ones (e.g., "You hurt my feelings"), which give evidence of emotional relatedness.

3. *The client engages in purposeful two-way exchanges with the helping professional, using the relationship to communicate in a logical manner.* She may ask for advice or discuss concrete matters such as how to pay bills, purchase food, obtain financial assistance from the government, or diaper a baby. Even the person who sits quietly and passively for most of the meeting but at the end looks up and

asks about the time and date of the next meeting has made a logical, purposeful communication. This stage should be distinguished from higher levels of the relationship, at which more sensitive, private matters and complex feeling states such as love, empathy, and jealousy may be discussed.

4. *The client's relationship with the helping professional is stable enough that the client can experience uncomfortable and scary feelings without fleeing or seriously disrupting the relationship.* Although minor upsets, including missed appointments, may occur at this stage, the overall relationship and the emotional connection survive. For example, suppose a male patient, after several appointments with the same doctor, comes to trust the doctor enough to reveal a secret: a year ago he visited a prostitute, and he fears he may be at risk for AIDS. The doctor schedules an HIV test, but the patient, now feeling abashed at the thought of having shared his shameful secret and fearing that the doctor may judge or reject him, fails to show up for the test. His relationship with his doctor is stable enough, however, that he calls back a week later and makes a new appointment, which he succeeds in keeping. Negative feelings such as anger, remorse, suspiciousness, and feelings of being exploited are the most potentially disruptive to a helping relationship; however, for many clients, feelings of intimacy, warmth, or sexual longing are the most frightening.

5. *The client feels secure in being "known" by the helping professional.* Because she can now allow the worker to know her full range of feelings and characteristics, both positive and negative, the relationship now involves many emotions, allowing the client to compare her current feelings and interactions with other experiences and to work through maladaptive patterns. At this level, one can observe satisfaction and often affection in the relationship, along with a sense of accomplishment in a task jointly well done.

At its higher levels, the dimension of emotional depth may overlap with the higher process levels described later. In evaluating emotional depth, however, one focuses on the depth of feeling and degree of differentiation that characterize the relationship between client and helping professional. At the highest level, the client can acknowledge the depth and meaning of the relationship. One can get a feel for this dimension by considering the steps in the development of a close friendship. On his first day of college, for example, a freshman meets many fellow students, in the process learning their names and perhaps a few facts about each one. He is unlikely to feel a strong bond with any one classmate, but unless he has severe difficulties relating to others, as the weeks pass he will develop stronger and more complex feelings toward certain individuals. Their feelings and behavior will increasingly hold meaning for him and have the ability to affect his emotional state. If an experience of hurt feelings or other painful emotions disrupts one of his new friendships, it may have progressed to the level at which the two friends

can discuss their conflict and continue the relationship. One or more of his friendships may develop to the highest level, at which he feels secure in having the full range of his feelings and qualities known by his friend.

The Third Dimension: Process of Communication

In evaluating the third dimension, one considers the structure, rather than the content, of communications between client and worker. The dimension of process also encompasses aspects of the first two dimensions, regularity and affective investment in the relationship.

We have observed that the structure of communications between client and helping professional, or between any two people, can reach nine stages or levels:

1. *Attention.* One must capture someone's attention before attempting further communication, and that person must be capable of at least briefly focusing attention if further interaction is to occur. (At a party, for example, one is unlikely to attempt conversation with a stranger who has not yet glanced in one's direction.)

2. *Engagement.* Is there some degree of warmth and connectedness between the two people? For example, does a mother greet her home visitor with a warm smile and relaxed physical stance, or does she stare at the visitor with a flat expression or avert her gaze despite an obvious awareness of the visitor's presence?

3. *Purposeful, two-way gestural communication.* From the middle of the first year of life, individuals rely on gestures to communicate. One can evaluate whether two people are using gestures to open and close circles of communication. If the first person smiles, does the other respond with a smile or greeting, and does the first person respond in turn? If so, the two have closed a circle. Consider the case of strangers riding an elevator together. Their interaction is generally minimal, but one frequently observes at least an exchange of slight smiles or nods. Two people who have yet to close a circle cannot proceed to higher levels of communication; a worker and client who have not succeeded in closing circles cannot proceed toward any collaborative work.

4. *Verbal communication.* At this level, we see more complex interactions involving the opening and closing of many circles of communication and the use of words to communicate and to get one's needs met. At this stage in the interaction between client and worker, discussion of practical needs, such as food and housing, and provision of concrete services are often involved. However, communication begins to include verbal support and sharing of information. If our hypothetical elevator riders reach this level, they may carry on a conversation about the weather or other neutral topics that reveal little about the speakers themselves.

5. *Symbolic communication.* Can a client, or any partner in communication, use words or drawing or other media to express feelings and ideas? This level of communication requires that both parties have at least a rudimentary capacity for communicating with words or other symbols. Perhaps a client says, "I wanted my wife to take care of the baby and I got angry. Then I felt scared and ran out and got drunk and came back and beat her up." Two people have clearly reached the level of symbolic communication when their conversation begins to include discussion of their feelings. This level can be divided into three sublevels: a) using symbols to describe only actions, rather than intentions or feelings (e.g., "I hit him."); b) using symbols to describe only a physical state (e.g., "My belly hurts," "My muscles feel like they're about to explode."); and c) using symbols to describe intentions or feelings (e.g., "I want to do it now," "I feel sad.") Describing an intention involves stating what one wants to do, rather than simply what one is doing.

6. *Building logical bridges between ideas.* At this level, a person does not merely report ideas or feelings but can elaborate on these. She can perceive and describe the logical connections between two or more ideas. Instead of simply reporting, "I was mad," a person can say, "I may have gotten mad and so I withdrew from my boyfriend. I can see why this might have made him feel sad and perhaps discouraged." Here we see a capacity to perceive the interactions between different feelings—in this case, the interactions between one person's feelings and another's.

7. *Multicause and triangular thinking.* Does communication include exploration of multiple reasons for a feeling, comparison of different feelings, and evidence that the parties understand triadic interactions between feeling states? A person who can communicate the idea, "I feel left out because Sharon likes Teresa better than me" is functioning at this level of the process dimension.

8. *Gray-area and comparative thinking.* Does communication include descriptions of gradations among differentiated feeling states? At this level, a person says things like, "When he said that, I wasn't just a little bit mad anymore—I was furious!" The communication also may involve comparisons between different feelings, relationships, and so on.

9. *Thinking from a stable sense of self and an internal standard.* People functioning at this level can reflect on and discuss feelings in relation to a stable, internalized sense of identity. For example, a client might say to his therapist, "I felt so hurt and rejected when Mary turned down my invitation. I don't get it—it's not like me to feel so upset about something like that."

By attending to the process dimension, a helping professional can evaluate whether he and his client are communicating at the level required to achieve the

particular goals of the intervention or program. Suppose, for example, that a social service agency offers classes to prepare clients to get a job and function well enough in the workplace to keep the job. A participant who is so distractible that she cannot attend and focus in class will need help with her distractibility first. This may seem obvious, but in many classroom situations, an instructor simply lectures on and on without evaluating whether students are actually taking in the information. A counselor or therapist who has not considered the process dimension may persist in trying to explore feelings, or the connections between feelings, with a client who has not yet mastered symbolic communication and can only report events and behaviors, not internal states. By asking himself at what process level he and the client are actually functioning, the therapist can avoid giving up in frustration and instead reframe the task as first developing a relationship with the client through simpler two-way gestural and verbal exchanges and then helping the client develop the capacity for symbolic communication.

The Fourth Dimension: Content of Communication

Which emotional themes predominate in communications between client and the helping professional as their relationship develops? During the journey from infancy to old age, certain themes predominate at each stage of life. The client–worker relationship, with its inevitable power imbalance and echoes of early relationships with parents, teachers, and other authority figures, cannot help but evoke core developmental themes. One can arrange possible themes in a hierarchy, beginning with those that characterize infancy and childhood:

1. Dependency/safety/security
2. Autonomy/independence
3. Curiosity/exploration/expansiveness
4. Power/grandiosity
5. Competition/rivalry/intrigue
6. Containment/control
7. Collaboration/cooperation
8. Experimentation
9. Self-awareness/consolidation of identity

One can observe the interactions and listen to the conversation between two people and ask, which of these themes seems to predominate at this moment? Of course, a relationship of any duration and complexity will involve fluctuation among themes, including a revisiting, at times, of themes that predominated earlier in the relationship. When a new mother first opens her door to the visiting baby nurse sent by the hospital where she gave birth, their initial glances and exchanges are likely to involve the theme of dependency and security, although nei-

ther may state this explicitly. The mother is wondering: can I trust this nurse with my baby? Will she think I'm a bad mother because my house is messy and my baby is crying? Is it safe to let her see how overwhelmed I feel right now? The nurse, if she is sensitive to these unspoken concerns, will attempt to convey her acceptance and understanding as well as her confidence in her ability to evaluate the baby's health. If she wins the mother's trust, on a future visit the pair may progress to the theme of autonomy and independence, with the mother feeling free to explain why she has made some parenting choices different from those the nurse recommends.

By understanding the dimension of thematic content, a helping professional can avoid moving too fast or leaping ahead to themes that cannot yet be explored with a particular client. For example, in the CIDP we encountered some participants who expressed great enthusiasm about the program upon enrolling but then disappeared almost immediately. With such participants, it was easy to make the mistake of assuming that the theme of collaboration and cooperation already predominated in our relationship. In truth, the earlier themes, beginning with dependency and safety, had not been negotiated, as became evident when the clients fled. In some cases, persistent but sensitive pursuit enabled the client to return and begin to establish a sense of safety with one or more members of the treatment team.

The Value of the Four Dimensions

The four dimensions just described define where the helping relationship begins, what the subsequent tasks of the client and professional must be, and when their work is complete. Unlike assessment of individual client variables relevant to the particular service being offered—symptoms of psychopathology, ego strength, educational level, parenting style, awareness of children's nutritional needs, or any other characteristic of the client as an individual—assessment of the relationship dimensions directly defines what work needs to be done. Profiling a client according to the levels she has attained on each dimension suggests which intervention approaches—outreach, home-based treatment or instruction, provision of services at a clinic, school, or other central location, and so on—may be most effective at a particular stage. Because use of the dimensions allows helping professionals to recognize the steps most basic to a worker–client relationship and to appreciate even small improvements, it may help workers to feel more sanguine about the abilities and "motivation" of many people needing help.

An appreciation of the multiple steps involved in each relationship dimension also enables helping professionals to work patiently toward gradual progress. Many agencies and third-party payers require systematic documentation of goals and progress. Understanding the complex steps involved in the four components of relationship-building enables one to document both the goals and the progress more clearly. What at times may appear to the untrained eye as merely a "holding

pattern" may in fact represent the mastery of critical steps in a relationship leading toward substantial overall progress. For research and program evaluation, clients' progress in each dimension can be rated and compared with predictions of treatment outcomes.

Understanding the dimensions also enables helping individuals to appreciate the value of their own work. It is easy to become demoralized or, at minimum, discouraged, if one has no way of comprehending the important steps toward progress that one is a part of. Repeatedly, we observed in our work with multiproblem families and their babies that these important dimensions of the helping relationship took a long time to master, sometimes a year or two or even three, but we were able to show that they had a substantial long-term positive impact on the lives of the families. For example, many of the mothers who had been neglecting or abusing their infants learned how to be nurturing and supportive. Equally important, when they had their next babies, many began that new relationship being extraordinarily warm and nurturing and appropriately interactive. We were initially surprised to see how fundamental the changes were for many of our participants. When we examined their progress through the steps of the relationship dimensions outlined earlier, however, we could understand why the changes were substantial and enduring. For an outline of the four dimensions and the steps involved in each, see Table 10–2.

A Case of Double Vulnerability: Louise and Robbie[1]

The case of Louise and her infant son, Robbie, provides a vivid illustration of the principles of intervention described in this chapter. Louise and Robbie both needed our treatment team's help to negotiate the very earliest developmental levels: self-regulation and attachment.

Louise was an attractive African-American woman in her mid-20s who had a 6-year-old daughter and was 5 months pregnant when she entered our program, which she learned about at her prenatal clinic. Louise had had a chaotic childhood marked by abandonment, psychological rejection, and physical abuse. Records from a mental health center she had contacted a few years before starting the CIDP indicated she had been diagnosed with "schizoid personality with paranoid features and periodic transient psychotic states." Louise's initial hostility and intense suspiciousness toward the clinician, combined with the disorganization of her thinking under stress and her difficulties with impulse control, made us consider very seriously the possibility that this diagnosis was accurate. This worrisome

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[1]The team that provided the clinical services and worked on the initial case report included Delise Williams, Robert Nover, Joan Castellan, Stanley Greenspan, and Alicia Lieberman.

TABLE 10–2. Dimensions and levels of helping relationships

Dimension 1: Regularity and stability

1. Initial meeting
2. Attempt to arrange follow-up meetings
3. Meeting according to some pattern, however unpredictable at times
4. Meeting regularly according to schedule, with occasional disruptions
5. Meeting regularly with minimal disruptions

Dimension 2: Emotional depth of the relationship

1. Client interested only in concrete services
2. Client shows signs of emotional interest in helping professional
3. Client engages in purposeful two-way exchanges with helping professional
4. Client can experience uncomfortable feelings in helping relationship without fleeing or seriously disrupting relationship
5. Client feels secure in being "known" by helping professional

Dimension 3: Process of communication

1. Attention
2. Engagement
3. Purposeful, two-way gestural communication
4. Verbal communication
5. Symbolic communication
6. Building logical bridges between ideas
7. Multicause and triangular thinking
8. Gray-area and comparative thinking
9. Thinking from a stable sense of self and an internal standard

Dimension 4: Thematic content of communication

1. Dependency/safety/security
2. Autonomy/independence
3. Curiosity/exploration/expansiveness
4. Power/grandiosity
5. Competition/rivalry/intrigue
6. Containment/control
7. Collaboration/cooperation
8. Experimentation
9. Self-awareness/consolidation of identity

picture was compounded by Louise's overt ambivalence, first toward the pregnancy and later toward her child; by her anger that her baby's birth interfered with her working; and by her warnings to the treatment team that she became depressed

when she stayed at home and spent "too much time" with her children. In the context of Louise's own experience of rejection and abuse as a child, these feelings conveyed to us Louise's fears that she could not nurture her child, and her fears became our concerns.

The First Stage of Treatment: The Prenatal Period

Louise told us that she was joining the program to help us in our stated goal of better understanding parent–infant relationships. She did not mention any problems or concerns of her own. However, the clinician immediately suspected that Louise did have difficulties, based on her flat affect, suspicious glances, fleeting eye contact, constantly fidgeting hands, evasiveness in answering questions, and halting yet sarcastic speech.

The beginnings of our intervention were not promising. Louise failed to keep appointment after appointment. On some occasions, she was clearly at home but refused to open the door to our clinician. Yet she phoned us regularly, often calling after a missed appointment to request another one, which she then failed to keep. We interpreted this pattern as an expression of her simultaneous wish for contact and fear of closeness. She seemed to be testing whether the clinician's interest would persist in the face of her elusiveness.

The clinician's interest did persist, and long phone conversations eventually gave way to appointments that were kept. This shift occurred about 6 weeks before Louise's due date, perhaps indicating that as the delivery approached, Louise felt more keenly the need for support.

In these initial sessions, Louise was frequently angry and withdrawn. She sullenly refused to speak about the pregnancy and showed no joyous anticipation of the new baby. She was most communicative when expressing anger, which she did in long tirades. She raged against her baby's father for his failure to provide emotional and financial support. She complained bitterly about the indifference of welfare caseworkers. Although her anger often seemed justified, Louise gave the impression of struggling with global, barely controlled rage. At such times, the clinician sympathized with the intensity of Louise's feelings and tried to provide boundaries for her anger by making suggestions about concrete steps that Louise could take to feel more in control of the situation. Louise often turned her anger toward the clinician, either challenging every question she asked or refusing to be drawn into conversation.

Occasionally, however, Louise showed signs of a greater ability to experience and communicate warmth and engagement. She told the clinician that it felt good to have such a reliable visitor. She showed a surprising ability to respond to the clinician's cautious attempts at emotional exploration, and she expressed a wish to understand her feelings better. At one point, she even volunteered that the events in her past had "made it hard to trust people now, and that is bad." These rare moments of reflection gave us hope that Louise could be helped to have better mastery of the feelings that so troubled her.

The main task of these prenatal sessions was to establish regularity and stability and to facilitate the development of a therapeutic relationship that would eventually permit emotional exploration. The clinician absorbed Louise's angry outbursts, encouraged the verbal expression of disappointment and anger Louise felt in her,

and kept appearing, week after week, regardless of Louise's behavior. The surprise and relief often evident on Louise's face when she saw the clinician at the door were an eloquent testimony to the absence of such sustained relationships in her past.

Slowly, Louise began to confide the many fears that plagued her. She was afraid to use the bus, because she considered buses to be dangerous places where she could be attacked. The darkness terrified her because she thought that menacing figures lurked there. She needed a nightlight to fall asleep, but she never slept well because she saw unidentified "things" moving in her room, and she feared being attacked by them. Louise was afraid that these experiences meant she was "crazy." The clinician assured Louise that she could learn to deal with her fears. Perhaps most important, the clinician kept coming to visit, providing Louise with concrete proof that the emerging information would not scare her away.

Robbie's Birth and After: Infant, Mother, and Their Interaction

Robbie's delivery presented no medical complications. He was of average height and weight, and his scores on the Apgar scale and other indices of newborn functioning were in the normal range. However, it quickly became apparent that this baby would make difficult demands even on a mother with unconflicted nurturing resources. Although Robbie was a cuddly baby, he easily became irritable and was difficult to console. His own attempts at self-soothing (for example, by taking a hand to his mouth) were mostly unsuccessful. He exhibited muscle tension, tremors, and startles, although these were not severe enough to be a cause for worry in their own right. He showed poor orientation to faces and voices. A month after birth, his orientation had deteriorated further—a reversal from the expectation that a baby will orient better with increased maturity—and he had become more physically tense and less cuddly. We began to observe gaze aversion. Such deterioration in an infant's capacity for regulation and interest in the world is, in most cases, an extremely worrisome early sign.

The interaction between Robbie and his mother was far from optimal, and we hypothesized that this was an important factor in Robbie's failure to become better organized. Louise had difficulty looking at her baby and held him in a wooden posture, with a striking lack of accommodation to the baby's body. These qualities seemed to be mirrored in Robbie's behavior.

Given Louise's suspiciousness and already intense ambivalence, we feared that she would interpret the baby's behavior as a rejection of her as a mother, setting up a dangerous cycle in which the mother's pain and anger led to rejection of and withdrawal from the child. This appraisal led us to formulate a treatment plan in which the clinician would engage Louise in psychotherapy and an infant specialist would work directly with Robbie. We adopted this strategy because we thought that Louise's own primitive neediness was of such proportions that she would feel rejected and jealous if she had to share a single therapist's attention with her baby. Having her own therapist would help Louise feel she had value in her own right and would provide her with the experiences necessary to help her become the clinician's ally on behalf of her child; meanwhile, the infant specialist could provide Robbie with specially designed patterns of care and relaxed interpersonal experiences until the mother became able to do so, thus helping him to achieve developmental milestones despite his mother's difficulties.

Over the next few months, we gradually discovered that the periods of greatest detachment between Robbie and his mother occurred when Louise was feeling exploited or rejected by "Big Robert," the baby's father. At such times, Louise could become downright neglectful. Although she once remarked that she disliked the baby's name, she emphatically denied any connection between her feelings toward Big Robert and her ability to care for Robbie. The clinician had to postpone exploration of this very sensitive, yet central issue. (Big Robert never responded to our invitation, through Louise, to participate in the program. He visited Robbie at Louise's home once a week at most and less often when his relations with Louise were stormy.)

In-Home Intervention With Robbie: The First 4 Months

While Louise began, in her own therapy, to speak of her fears of rejection, the infant specialist began working directly with Robbie during home visits. In attempting to reverse Robbie's persistent gaze aversion, she noticed that although he avoided eye contact with people, he gazed at inanimate objects for long periods. Capitalizing on this tendency, she drew a face on a piece of paper that she wore as a mask, enticing Robbie to follow her with his eyes as she slowly moved her head up and down in front of him. After several such trials, she lowered the mask and greeted Robbie with eye contact while smiling and talking to him. At first, Robbie shifted his gaze; slowly, he was able to sustain eye contact for a few seconds. As this game was played again and again, with much animation and in various forms—such as playing peekaboo in different contexts and with different masks—Robbie started responding more and more. He appeared to find the human face first interesting and later, we surmise, pleasurable. It is worth noting that the infant specialist's affective expression could be enlarged only gradually, because Robbie started out finding all human affective exchange so frightening.

Vocalization—another area in which Robbie lagged severely—was encouraged in the most natural of ways: by making simple but playful sounds until Robbie could imitate them, then elaborating on the original sound by adding new vowels and consonants. Talking warmly to the baby, greeting him on arrival, and saying good-bye on departure—in short, relating to him as a person who was a legitimate partner in social speech—were also part of the infant specialist's approach.

Finally, Robbie's stiff muscle tone, uncomfortable posture, lack of cuddliness, and difficulty with cross-sensory and sensory-motor integration were addressed through interactive floor games. Activities included playfully rolling Robbie on the floor, rhythmically extending and flexing his arms and legs while singing or making rhythmic sounds, playing pat-a-cake and other games that encourage midline reach, and playing games like "This Little Pig Went to Market" to entice Robbie to reach for his toes and play with his feet. The specialist placed her attractive toys just out of Robbie's reach, to encourage reaching and holding, which seemed to be restricted by the tightness of the muscles in his shoulder girdle and upper arms and by the fact that his hands tended to fist when he reached or brought the hands to midline. When Robbie seemed tired after all these activities, he was encouraged to cuddle in the arms of the infant specialist, who sang a lullaby until his body relaxed or he fell asleep. When Robbie's disorganized body motion prevented him from falling asleep, he was swaddled, enabling him to relax and nod off.

Note that these interventions were never mechanical: they were unobtrusively built into affectionate exchanges with Robbie. The goal was not global stimulation per se, but rather to encourage internal regulation and interest in the world, specifically in interaction with human partners, in order to build the basis for human attachments.

Every attempt was made to encourage Louise to participate in these sessions and to take over the infant specialist's role. Her reaction varied according to her mood. Sometimes, she looked on with interest and entered into the games, showing considerable ability to be in tune with Robbie. At other times, she simply stared out the window with a sullen expression. Occasionally, she made a comment that reflected some longing to have had in her own childhood the kind of attention Robbie was now receiving. The infant specialist felt worried and discouraged, recognizing that Louise was limited in what she could offer her son.

All this time, Robbie's health and nutritional status were carefully monitored. Staff spent many hours advocating for Louise and Robbie to ensure that they received food from the Women, Infants, and Children (WIC) supplemental food program. Appointments were made for Robbie at a well-baby clinic, and staff drove mother and baby to appointments when no other transportation was available.

The Therapeutic Infant Center

A formal 4-month developmental assessment suggested that more intensive intervention was needed to get Robbie on track developmentally. With Louise's agreement, we arranged for Robbie to spend at least part of each week at our Infant Center, where the infant specialist could work with him and other staff could care for him in ways that reinforced the specialist's work. Louise sometimes met him at the center at the end of her workday; she spent some time finding out how he had spent the day, chatting with other mothers and with staff, and watching what were, for her, novel ways of interacting with children. This plan remained in effect throughout treatment, with modifications and interruptions that mirrored the changes in Louise's life. When no babysitter was available (Louise worked long hours at two part-time jobs), Robbie might spend the whole day at the Center for weeks at a time. When Louise was angry with her clinician, she sometimes "took revenge" by not bringing Robbie in for a few days. During a few months when Robbie had a babysitter who was especially nurturing and responsive, we ourselves reduced his hours at the center. As Robbie grew older, we added a new task to help him negotiate the fourth developmental level: problem-solving communication and an emerging sense of self. We worked on reading Robbie's changing affective signals, providing purposeful feedback, and facilitating his persistence.

Louise's Treatment: Ongoing Course

When Louise requested the clinician's help in finding an affordable apartment so she could move out of her foster father's home, the two women began spending many hours driving to look at prospective apartments. The car provided a physical proximity that seemed to promote intimacy without arousing fear. It was in the car, talking about the pressures of finding a place to live, that Louise voiced her wish to be taken care of and her simultaneous fear of getting too close. She illustrated these tendencies by talking of the many men who had given her money, food, and

clothes, and how she had used them until "they got too close," at which time she abruptly told them to leave. Exploration of what "getting close" meant revealed Louise's fear that people would become too involved in her "business." She was reluctant to elaborate on this term, but we gradually learned that it referred to secrets involving a psychiatric hospitalization, involvement with prostitution, and an episode of venereal disease. We surmised that these events represented for Louise proof of the dreaded "badness" that she attributed to herself, her deep shame about aspects of her feelings and wishes, and her fear that discovery of these feelings by others would lead once again to abandonment and rejection. Although at times she was able to explore these feelings and withstand the pain they elicited, Louise often turned to intense rage as her most potent defense. On these occasions, Louise often repeated a simple sentence, as though trying to encase in words, and thus get control of, her disorganizing anger.

The clinician started with very structured interventions aimed at clarifying and providing labels for feelings. What did Louise feel, toward whom, for what reasons? As Louise herself became more skillful in these tasks, the clinician could move on to show her the common element between the different situations that elicited certain feelings. In this way, Louise gradually became aware of her tendency to set up chaotic external circumstances to escape inner turmoil, of how she used rage as a defense against feelings of helplessness, and of how she tried to fend off rejection by rejecting others first. Ultimately, Louise also became aware of her deeply rooted perception of herself as "evil." The prevailing theme in the sessions was a constant reworking of her fear that people would leave her once she exposed her worst side, that is, her rage.

This process was filled with turmoil. At many moments, we wondered whether Louise had learned more about herself than she could tolerate. However, as this material emerged and the implications for the therapeutic relationship were explored (i.e., Louise's fear of hurting the clinician or being rejected by her), Louise's bond with the clinician invariably seemed to become more stable. The therapeutic relationship seemed to provide the support Louise needed in order to begin identifying patterns in her life. During this time, an unexpected avenue emerged to explore painful feelings: the daily soap operas, which Louise watched avidly, often leaving the television on during sessions. The clinician used Louise's identification with certain characters to explore her feelings in greater depth and also to show her that these feelings were experienced by many people and were not a sign that Louise was "strange," "crazy," or "stupid," adjectives that recurred in her attempts to clarify for herself who she was.

We noted a marked parallel between Louise's relationship with the clinician and her ability to care for and engage her son. As Louise began to make use of the clinician as a partner in a stable relationship, as well as an auxiliary ego and a figure for identification, she became more reflective and started to discuss her plans for the future instead of implementing them impulsively. She began to imitate the clinician's style of dress. With Robbie, she began to express genuine pleasure in his relatedness to her and to others. She showed more patience and tenderness toward him, responded far more promptly and effectively when he was distressed, cuddled him more often, and spoke to him playfully and lovingly for longer periods of time. We believe that her emerging capacity to establish an enduring relationship with the clinician was directly responsible for her progress in nurturing and interacting with Robbie more consistently.

A Crisis

This progress was interrupted by Louise's reaction when, at Thanksgiving and again at Christmas, the clinician declined invitations to dinner at Louise's home. Old feelings of loss, rejection, and abandonment were triggered, and Louise retreated to her previous sullen guardedness. The clinician's attempts to address Louise's disappointment in her met with denial. Louise's behavior with Robbie illustrated how deeply the child was still enmeshed in his mother's internal conflicts. She threatened to abandon him ("You will find him on your doorstep," she told the clinician). On meeting Robbie one day after a long separation, she stared at him from a distance, as if seething with rage, and brushed aside his hand when he persistently tried to make contact with her. She did not, however, quit the program, and she continued to keep her appointments. Robbie's 8-month assessment revealed that he had made impressive strides: with the exception of vocalizations, which had increased but were still below age level, the major areas of cognitive and sensorimotor function were adequate. Most important, Robbie now engaged in organized and sustained social interactions. Far from averting his gaze from his mother, he now sought her out by looking and smiling at her, cooing to her, and grabbing her hand. Louise repeatedly ignored these overtures, but Robbie showed impressive persistence, finally eliciting a response from her after a great many attempts.

The clinician attempted to show Louise how her feelings of anger and rejection spilled over into her relationship with Robbie, but all such attempts were met by a blank stare and a refusal to discuss any negative feelings Louise might have toward her child. As though to underscore her determination to escape the feelings that threatened to overwhelm her, Louise moved abruptly from her cozy apartment to a noisy, overcrowded household. Instead of being the only child in the home of a caring and affectionate babysitter, Robbie, at 9 months, was now cared for by whomever was available. The infant specialist soon noticed that his activity level was increasing and his attention span was declining. He became less available for play, and his vocalizations decreased. We decided to increase Robbie's hours at the Infant Center to 4 days a week, 4–6 hours a day.

Louise's Treatment Continues: Addressing Themes of Loss and Separation

Louise's flight to a chaotic household was addressed by the clinician as an attempt to escape from the feelings of disorganization that she experienced when she perceived that others abandoned or rejected her. While persistently denying this connection, Louise implicitly confirmed it by beginning to talk about her inability to sustain long-term relationships. She then spontaneously began to talk about her 6-year-old daughter, Terry. Although Louise often demonstrated an ability to respond appropriately and with empathy to Terry, she said that she sometimes treated Terry in ways that she did not like—ignoring her, scolding her, or responding abruptly to her approaches. She spoke regretfully about Terry's becoming an adult and leaving her. It was important for the clinician to listen to Louise's discussion of this core theme in the context of her less conflicted relationship with her daughter. As Louise began to acknowledge her fears of being left, the clinician sensed that the time was right to point out to Louise how she often retreated from her children in order to forestall the future pain of separation.

Louise began spending more time with both Terry and Robbie. She also began speaking directly about her fondness for the clinician and asked for some sort of guarantee that their relationship would continue. The clinician responded by expressing empathy for Louise's desire for reassurance now that she was taking the risk of showing love and concern for her children. Here again, a further deepening of Louise's relationship with the clinician allowed her to become more psychologically available to her children. Louise seemed to have reached a new level of development, in which experiencing and expressing warmth were less frightening and fears of loss could be verbalized, rather than avoided through preemptive action. Her progress was vividly reflected at Robbie's 12-month assessment. She began the semistructured play session by picking up the play telephone and saying, "Robbie, are you there?" This simple action eloquently expressed Louise's core conflict: reaching out, coupled with fear that Robbie might not be there to respond. Robbie was very much there, turning to his mother repeatedly, giving her toys, and returning for a hug after exploring at a distance from her. This time, Louise was able both to allow her son to explore and to welcome him back when he returned. This interactive pattern showed clearly the beginnings of an organized pattern of reciprocal behavior as well as initiative and originality.

During the following 6 months, Louise began spontaneously to link her ever-chaotic relationship with Robbie's father to her feelings toward her biological mother, who had placed her with another family when she was 6 months old. She noted a resemblance between her sense of unsatisfied need for Big Robert and her own mother's unavailability. She could not yet see, however, how she triggered her boyfriend's absences through her paroxysms of rage; she could only see herself as a victim of abandonment. Her inability to see herself in an active role interfered with her ability to empathize with Robbie's feelings when she was unavailable to him. (She had an easier time imaging the feelings of her daughter, who was less identified in Louise's mind with her boyfriend.) Despite this limitation, however, Louise's ongoing therapeutic work enabled her to see herself, for the first time, as a mother responsible for the well-being of her children. She now spoke of how her actions would affect her children. She anticipated Robbie's discomfort on being left with a new babysitter.

At his 18-month evaluation, Robbie again showed steady improvement. Mother and child were clearly able to address core conflicts adaptively through play. In one videotaped sequence, Louise chases Robbie, who runs away; she catches him, and both laugh. Louise then teases Robbie by going out of the room and closing the door, but she immediately knocks to signal that she is still there (i.e., this is only a "pretend" desertion); Robbie attempts to open the door, and his mother returns. Louise then leaves again. This time, Robbie does not seek her out but hides instead, under the table. Louise seeks him out, but he flails at her. She laughs and hugs him. We interpreted this sequence as a symbolic enacting of Louise's central conflict, the theme of abandonment and rejection. Whereas earlier in the treatment, this theme was acted out through actual neglect and all-too-real threats of abandonment, it was now expressed through a richly organized symbolic game. We also saw an integration, rather than a splitting off, of the theme. In contrast to earlier one-sided attempts by one partner to woo the other, Louise and Robbie were now taking turns pursuing each other. Finally, we saw a new ability on the part of each partner to recover from rejection and reach out anew, instead of withdrawing or becoming disorganized. Their ability to deal with this central conflict at an emerging symbolic level was truly impressive.

A second indication of Louise's progress in addressing her core conflict was her handling of the clinician's announcement, when Robbie was 18 months old, of her own pregnancy and plans for maternity leave. Louise's strong bond and identification with the clinician, who was now to become a mother herself, seemed to permit Louise to strengthen her own identity as a mother. Whereas she had previously been reluctant to "share" her therapy time with Robbie by departing from her own issues during sessions, she began using some sessions to ask for advice about child-rearing issues, such as how best to respond to Robbie's tantrums. She showed a more active interest in how Robbie spent his day at the Infant Center and even proposed that she and the staff each keep a baby diary to keep each other informed of day-to-day occurrences in his routine. In anticipation of the clinician's absence, she started cultivating a relationship with Infant Center staff and became more involved with Robbie's infant specialist. In these adaptive maneuvers, Louise showed a new ability to reach out to others, instead of fleeing and becoming disorganized at the prospect of loss and separation.

As the clinician's pregnancy progressed, Louise became more solicitous toward her. She also spoke openly of her longing for the clinician's eventual return, repeatedly shortening her estimation of the length of her absence, reducing it from an original 8 months to "2 or 3 weeks." Gradually, Louise became aware that these behaviors signaled her sadness at the clinician's anticipated absence and her wish for a speedy reunion. She then started writing down how she felt about loneliness and what friendship meant to her, and she showed these writings to the clinician. At no time did she relapse into the angry outbursts and sudden withdrawal that had characterized her earlier responses to separation and perceived rejection. During the clinician's absence, Louise kept on good terms with Infant Center staff. She phoned the clinician every week, but limited her calls to asking how she and the new baby were and kept each call appropriately brief. Although this was a poignant illustration of Louise's enduring need for a concrete presence, it also showed her new ability to take the lead in establishing contact and to subordinate her own needs to someone else's.

When the clinician returned, the therapeutic relationship was reestablished with minimal difficulty. Louise's pattern of introspective self-examination continued, and many traumatic early memories emerged. As Louise vividly recalled these memories and shared them with the clinician, she stopped having "hallucinations" at night, slept better, and seldom needed a nightlight. When she did have trouble sleeping, she now considered what feelings might be troubling her until she arrived at some understanding that was comforting for her. She found a new freedom of movement: not only did she begin using the bus system, but she learned to drive and bought a car, which she used for errands and to take her children on family outings. Clearly, Louise had learned to use introspection, instead of acting out, as a means to protect herself against becoming overwhelmed and disorganized by her feelings.

As Louise's participation in our program drew to an end, she continued to make strides in her relationship with her children. She still withdrew from Robbie on occasion, but far less than she used to. She continued to have some difficulty controlling and regulating her anger, but she now acknowledged that this difficulty lay within herself rather than in her children, and she actively attempted to find ways of protecting her children from her anger.

The case of Louise and Robbie illustrates the fruitfulness of the comprehensive assessment and treatment planning approach we have described in this book. It also vividly illustrates the need for a dual approach in cases where both parent and child exhibit severe developmental lags. Intervention with only one party would likely have limited value, because the vulnerability in the other party would persist, preventing the two from building the kind of relationship that can promote developmental progress.

Reference

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