Case Studies in Infant Mental Health: *Risk, Resiliency, and Relationships*

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Learning to See Her Son: A Baby and His Mother

Gregory A. Proulx

Summary

An isolated young mother is referred to an infant mental health (IMH) program by a hospital social worker because it was reported that she was not following recommendations for feeding her 6-month-old son, who is failing to gain weight. Of additional concern, an older child had been removed from the home for neglect. The IMH specialist, relatively new to the field, works hard to establish a working relationship with the mother that is based on non-judgmental listening and respect, rather than uninvited "solutions." Supported by reflective supervision and group consultation, the IMH specialist realizes that effective intervention is not a matter of technique alone; equally important are the clinician's sensitivity to what is happening around him and his understanding of his reactions to it. During their yearlong therapeutic relationship with the IMH specialist, the toddler begins to thrive and his mother realizes that her child needs and loves her, and that she can meet his needs.

Uncertain Beginnings

My first meeting with Rebecca, the single mother of two sons, was on a dull, gray day. The shades were drawn in the dimly lit living room of the old house where the family lived. In the adjacent dining room were two automobile tires, a broken bicycle, a broken lamp on a beat-up chair, a pile of newspapers, a stack of boxes, and an ironing board. There was no dining room table. Six-month-old Curtis sat next to his mother on the worn living room sofa, bundled in a car seat. He was an attractive but small baby, with a wisp of blond hair and a perfectly round face. He was quiet, displaying a pensive, almost worried look.

Rebecca and Curtis had been referred to our IMH program by a

social worker from the regional hospital, where a respected neonatologist and the hospital dietitian were treating him for nonorganic failure to thrive. The social worker expressed concern that Rebecca was "resisting" their recommendation that she feed Curtis at regular intervals with a fortified infant formula. The social worker worried that Curtis's condition had been exacerbated by two serious ear infections during the past 4 months, one of which had required hospitalization. The social worker complained, "I don't think Curtis's mother really cares about him. She only visited once during the whole week he was on the ward. And you know, her first son got taken away from her because of neglect."

On our first visit, I told Rebecca that I was there to listen, to try to find the best way to help Curtis grow, and to act as her assistant in this process. Rebecca began speaking almost immediately of her unpredictable relationship with Curtis's father, Steve. She complained, "He's never around when I need him." She also spoke of her distrust of hospital staff who "would not listen when I tried to tell them that Curtis made it really hard to feed him. He won't be still."

As I drove away that day, I felt alone, overwhelmed, emotionally empty, and uncertain. The gloomy weather and the shadows of Rebecca's home intensified the experience. I wondered, "How in the world would I help this mother and this infant? What am I going to say or do that will make a difference? She has some of the most respected professionals in the area providing treatment to her son."

During our weekly session, I conveyed my feelings of helplessness to my supervisor. We reviewed the family history provided by the hospital. My supervisor listened very carefully to how I described my experience of meeting Rebecca and Curtis. She wondered how Rebecca might understand the people and relationships in her life. Sensing my uncertainties, she observed, "This surely was an overwhelming situation." She suggested that I try holding on to what I would see and hear. "Be patient," she advised.

Listening and Wondering

When I met with Rebecca the following week, Curtis was lying on his tummy on a blanket. Toys were carefully arranged around him on the living room floor. He cooed and reached for a squeaky duck. Rebecca moved busily about the room, picking up clothes and clutter. When she left the room, Curtis's gaze followed her. He began to fuss at her absence. Rebecca returned with a diaper and began to change him on the floor. He quieted and focused on her. She talked to him as she worked. "Your momma does everything for her little mouse. Those bad people think I'm not feeding you right. They just don't know. They just don't listen." She helped him roll back over to

his tummy and moved his duck within reach. He grabbed it, examined it, vocalized, and put it in his mouth. Overall, his behavior—his hand-eye coordination, inspection of objects, vocalizations, and rolling over—seemed on track developmentally.

Rebecca returned to sit next to me on the sofa. There seemed to be an edge of anxiety in her voice as she spoke further of her situation. She seemed to be uncertain about whether I would really listen to her, or if I would turn out to be just another person who would tell her what she needed to do. Rebecca was afraid of "the system." After all, Children's Protective Services had removed her first son from her care because, she explained, "They didn't think I was a fit mother. When they thought I needed help cleaning my house, they sent workers over from a local parenting program to show me how. They changed things all around. Nicky was just 3 months old then. I never asked them to start coming over. At first, I thought it was kind of cool, having free help. But then they started seeing me as bad." I nodded, saying, "You must be even more worried than ever now, with Curtis's getting all of this attention." She answered, "Yeah, I never asked for all *this* help either."

Rebecca and I talked for another hour. To gather information, I asked questions, in as gentle and nonjudgmental a manner as I could. I wondered if Rebecca would put me in the same category as those uninvited "helpers."

I asked Rebecca how she was making ends meet. She said that she had a part-time job and that her parents helped out with food and baby supplies. "Do you have someone you can trust to watch Curtis?" I continued. "Yes," she answered, "But I'm getting really frustrated. My mom takes care of him, but she doesn't follow my instructions, like how and when to feed him. Last week she let her sister take Curtis to the store without asking me first. That made me so mad." I felt the urge to shift into my problem-solving mode and to suggest a different child care arrangement. Then an equally strong feeling came over me, reminding me that she was not asking for a solution. I held these feelings for a moment and said, "It must be very frustrating when people won't listen and respect your feelings."

Caring and Holding

Before leaving, I told Rebecca that I was trying to listen to her very carefully and would continue to do so if she would permit me to visit again. She agreed. I expressed an interest in visiting during one of Curtis's mealtimes so that I could understand this experience better. A visit was set for the following week.

Rebecca was not home when I arrived. Within the clinical con-

text, I generally interpret "no-shows" as being directly related to how a person is feeling—either about what happened on a previous visit (for example, "I shared too much, I need to hide" or "What we talked about made me feel anxious"), or what they expect to feel on a visit to come (for example, "I can't trust anyone," "I'll be hurt," or "If I'm not home, I won't get hurt"). From what I already knew about Rebecca, I guessed that she might be expecting to be disappointed by yet another person who wouldn't listen. She might assume that if she were not home for our scheduled visit, I would not come back again, proving that I, like other "helpers," wasn't interested in listening to her. This sequence would confirm her well-developed model of how people do not care and do not listen. But I persisted, believing that I might begin to erode this model by demonstrating consistency and caring. I left a handwritten note expressing concern for Rebecca's and Curtis's well-being, saying that I had been thinking of them and specifying another time for a visit.

When we met again—after another no-show and another note from me—Rebecca was visibly distressed. She told me the doctor threatened that, if Curtis did not gain an ounce per week for the next 8 weeks, he would make a referral to the local Children's Protective Services office.

She said, "I tried to tell the doctor that I was doing all I could. I even went over, step-by-step, what I was doing, how I was fixing up the formula. I tried to tell him that Curtis would not be still when I try to give him his bottle. He squirms all over the place. It gets interrupted. Sometimes we can get started again right away, but sometimes Curtis won't take it. I tried to tell him that. He just said, 'You have to make sure he is eating. If you can't make sure of that, then we'll have to find someone who can.'" She began to cry. "Why won't anyone listen?"

Curtis slept throughout this visit. I was unable to watch or support the feeding process. I was transfixed by Rebecca's story, feeling that she was being treated unfairly. I badly wanted to jump in and fix the situation, to make everyone understand the truth. I sensed, though, that I would not be heard if I directly confronted the other professionals working with Rebecca and Curtis. I thought that they would see me as overinvolved and lacking in judgment. When I discussed all this with my supervisor, she encouraged me to be patient, to continue holding on to what I was feeling and seeing, and to keep listening.

Holding—as the term is used in IMH practice—involves being aware of feelings (our own and those of the family), understanding affective aspects of communication, formulating sensitive and empathetic responses, and connecting to the family by articulating

understanding. It is very difficult to hold what we feel and see in the midst of complex and confusing circumstances and relationships. It takes great self-awareness, control, and mindfulness of the moment to absorb the impact of another's feelings and organize an empathetic response. More often, we get swept up in the moment, moved by the experience of powerful emotions; we are dumbstruck. This is why reflective clinical supervision is such an essential part of IMH practice: It allows the IMH specialist to explore his or her feelings about the work and examine critical information about the family and their feelings. In supervision, the IMH specialist can work on how he is in relation to the family. As Pawl (1995) points out, it is "how" and "who" we are that ultimately determine the effectiveness of our interventions.

The Story Deepens

On my next visit, Rebecca was composed and calm. Curtis was again placed cozily between us on the sofa, his cherubic face peering out at the world. Rebecca asked, "Can I tell you about how all of this started?" I said, "Yes, of course." She began to talk about Curtis's first hospitalization. It was following a routine baby checkup at the doctor's office, when Curtis was 3 months old. Rebecca was just beginning to get over her self-doubt about caring for this new baby. The anxiety came rushing back, however, when the doctor noticed that Curtis had an ear infection. "Why didn't I know this?" she thought. Curtis's weight was also dipping below the fifth percentile on the growth chart that the doctor kept but had never showed her before. Rebecca wanted Curtis to be treated for his ear infection, but her heart sank when the doctor ordered Curtis to be admitted to the hospital because he was underweight.

In the hospital, Curtis began to gain weight faster and more consistently than at home. Rebecca said that she had visited once and then did not return. She said, "The nurses and that social worker were talking about me. They thought that I was a bad mom because of Curtis's health condition and what happened in the past with Nicky. They think it's all my fault. I felt awful. I couldn't drag myself back there. But I know they talked about me even more, then. They thought I didn't care about Curtis because I didn't visit and stay with him. But I didn't go because of what they were saying." Rebecca sounded furious. I mustered a response, acknowledging her anger and the great cost to her and to Curtis, who must have missed her.

I began to feel angry, too. This family needed support, not challenges from the outside! I could see the connection between Curtis and Rebecca. His eyes followed and searched for her when she

moved about or left the room. When she held him, the expression in his eyes and the relaxation in his body showed trust. At this point in our conversation, Curtis reached toward his mother. Rebecca said, "He's just like me. When I don't feel good, I want to be cuddled." She picked him up from the car seat and held him close. She then put him on the floor, where she changed his diaper. He was fussy and resistant, arching as if he were uncomfortable. Rebecca said, "I was like that till I was 8 years old. I always wanted to he held." She picked him up and hugged him again.

Being Still

On our next visit, I was in time for Curtis's bottle. I noticed how nicely Rebecca held him, at just the right angle in her arms as they sat on the sofa. He seemed to be interested in taking the nipple and the formula. Rebecca began to tell me about household needs—food and clothing for Curtis. She then got up, holding Curtis, walked over to the desk, and wrote down the amount of formula that she started with. When she sat down again, Curtis resumed feeding, but soon he began to squirm. Then he disconnected from the nipple. Rebecca stopped to reposition him and help him burp. Then he reattached, sucked briefly, arched, and disconnected again. The phone rang. Rebecca appeared disgusted at the interruption, but she got up, answered the phone, talked briefly, and returned to the sofa. She tried to resume feeding Curtis, who seemed unable to get his comfort back. "He really won't be still for you, will he?" I asked. She turned to face me squarely as I sat next to her on the sofa. She blurted, "That is what I've been trying to tell everyone. But no one will listen!" Her words seemed to hang in the air between us.

"No wonder you feel so helpless," I said. Rebecca seemed to soften and relax a bit. I encouraged her to keep trying by saying, "Even though I can't be still for you, Mommy, I need you to be there for me. Keep trying." At this point I was using the strategy of "speaking for the baby"—trying to put into words the things the baby might say if he could talk. This technique works best when the parent experiences the infant's comments as positive, showing the connection between them.

The feeding continued, but with many interruptions. Curtis attached and sucked, then arched and squirmed. Rebecca grimaced, turning red in the face. I was not sure if she was angry or embarrassed. She appeared very uncomfortable. I continued to offer supportive comments, noting that she was doing her best. I said, "It sure would be a lot easier if he would cooperate." She persisted, in spite of her discomfort, and succeeded in getting Curtis to finish the

bottle. Rebecca appeared proud of the accomplishment. I asked her if it would be all right to share my observations with the doctor about how hard she worked at helping Curtis be fed. She seemed to relax. With a smile, she said, "That would really help."

Being Heard

I began to feel relieved. With my supervisor, I wondered what Curtis might be feeling. Could it be that he, like Rebecca, did not feel heard or understood? My supervisor encouraged me once again keep listening. This made so much sense! If I could manage to be a sensitive listener to Rebecca, then she, too, might be still so that Curtis could feel that he was heard and understood.

As I made these visits to Rebecca and Curtis and shared my work in our consultation group, my colleagues also encouraged me. They reminded me to always look for things to like about a family, develop a healthy respect for each of the members, and pay attention to my own feelings and need to feel respected, to be heard, and to help. Their guidance could be summarized as the following: Don't ever forget that it's about feelings, it's about relationships, and it's about family. The feelings you sense inform you about how others feel. They are directly related to the feelings, relationships, and self-understanding models that others display in their relationship with you.

Over the next several months, I kept listening, and Rebecca told me her story. She said that she had always felt as if she didn't matter—not to her parents and not to any adults in her early life, except her grandmother. Her parents, she recalled, were too caught up in their own "sickness" of drinking and self-indulgence. They did have the good sense, though, to leave her with her grandmother when a binge was coming on. This happened often, but, luckily, Grandma was kind and sensitive.

As it turned out, from the time she was 2 until she was 10 years old, Rebecca spent much of her time in her grandmother's home. She remembered love-filled days, laughter, the smell of homemade macaroni and cheese, and silly songs. She recalled many experiences of warmth around the dining room table. Rebecca spoke dreamily about this time in her life: "Grandma always had a dessert after dinner. It wasn't always fancy, but I felt like I was dining with royalty. But what was most special was at bedtime. Grandma always kissed my hand right in the middle. She'd say, 'If you get lonely or scared in the night, you just touch your hand to your cheek and I'll be right there with a kiss.'" Rebecca touched her cheek with her hand. There were tears in her eyes.

Painful Losses

In Rebecca's tenth year, her grandmother died. Her life took a downward spiral after this. She grew into a "lost" teen. She began to drink and party. At 18, she became pregnant for the first time by a boy she did not care for. When Nicky was born, she was living alone, depressed and overwhelmed. She realized that she was living the kind of life her parents led—and that she hated them for. "I was a real mess. I didn't know what I was doing," she said.

Warm memories of what it was like to be cared for, combined with feelings of depression and loneliness, prompted Rebecca to accept assistance from a local parenting program. Expecting to be treasured by her home visitor as her grandmother had treasured her, Rebecca soon began to feel betrayed, as if the program staff was "all against [her]." Everyone seemed to know the right thing to do except her. She said, "My worker would say, 'You need to keep all your dishes and baby bottles squeaky clean; you can't let stains soak into the carpeting; you must wash your hands several times each day.' My worker was even better at getting Nicky to stop crying than I was. I hated what was happening, and I hated myself." Rebecca began to feel inept. She withdrew into herself. Her desire to care for herself, her home, and her baby declined, leading to allegations of neglect.

Six months after Nicky's removal and placement in foster care, Rebecca gave up. She never fully understood the charges, feeling she really hadn't done anything wrong. She voluntarily relinquished her parental rights to avoid the anguish of having them terminated in front of everyone in a court hearing. She told me that her child welfare worker had encouraged her in this, saying, "It would be easier on everyone." Rebecca was left with mixed feelings. She thought she had done the right thing for Nicky, but felt demoralized. She said that after relinquishing Nicky, "something [in her] got hot and angry."

Rebecca felt hopeful again when she began a relationship with Steve. He was 20 and had a steady job delivering pizzas. He didn't make much money, but he was a steady worker, and he won Rebecca's heart by singing love songs. He was the one who wanted to move into the house where Rebecca and Curtis now lived, instead of into an apartment. The house was old, but they would fix it up and decorate it. They imagined the dining room with a big table and chairs, filled with people. They talked about marriage.

Rebecca was 19 when she became pregnant for the second time. Feeling supported by Steve, she stopped drinking and began to care for herself. But by the eighth month of her pregnancy, Steve began

staying out later and later. One night he didn't come home. When he didn't show up for a childbirth class, Rebecca felt humiliated. They fought and then separated. Steve moved out, taking much of the furniture with him.

Steve was not present when Curtis was born. Rebecca gave birth to her second son with no support from family or friends. From the hospital, she and Curtis returned to an empty—and emptied—house. Rebecca felt lonely, depressed, and betrayed once again. As I listened to Rebecca, I wondered how Curtis had experienced his first days with his mother. I wondered how long the shades had been drawn in the living room and when junk had begun to pile up in the dining room.

A Therapist Listens and Reflects

Rebecca told me her story over many weeks. I listened. As I had promised, I called the hospital social worker, described the feeding I had observed, and noted that Rebecca seemed engaged in our work together, although she was very worried about what she perceived as the doctor's threat of a Children's Protective Services referral. The social worker asked me to submit a written report to include in Curtis's chart and said she would bring this to the attention of the neonatologist and the dietitian. Fortunately, at this point Curtis began to gain weight. (My supervisor told me about Selma Fraiberg's observation that the push toward healthy development in babies is so strong that "it's a little like having God on your side.")

I listened, tried to be still, and kept wondering how to respond to Rebecca and Curtis. Although I am a developmental psychologist, I was new to the field of IMH. I wondered how, as a therapist, I would know *when* to say something, much less *what* to say. I came to realize early that, since every family is unique, there is no recipe for treatment that will work in all situations. In this work, each new family is unfamiliar territory. As I approached the home of Rebecca and Curtis for the first time, I was filled with the doubts I often experience when meeting new families. After meeting the family and hearing Rebecca's story of betrayal and distrust, I wondered if I would be able to do anything helpful at all.

Fortunately, I began working as an IMH specialist in a well-established program in which reflective supervision and group consultation form the foundation for all clinical work. It was within this setting that I first experienced the safety net of sensitivity; responsiveness; and concern for families, in general, and for fellow clinicians, in particular. How it feels to be in the presence of the family is of central importance. One's affective experience, I

learned, provides a primary pathway to understanding the internal working models of the family—how it is that they come to think of themselves and their relationships, and why they trust or distrust the world and people. A consistent system of individual reflective supervision and group case consulting provides the secure base from which competent clinicians are able to go out and explore their own skills, and to which they can return to discuss behaviors and feelings that may seem incomprehensible.

I needed this kind of support and opportunities for reflection in order to figure out the relationship between my feelings and those of Rebecca and Curtis. It was within the reflective environment that I was able to understand and develop a respectful way of being while in their presence. Without this type of supervision, I likely would have failed to understand that Rebecca had been trying to tell anyone who would listen just what the trouble really was in her life and in her relationship with Curtis. I would have perhaps attempted to instruct her regarding the "right way" to feed her baby. I probably would have thought of her as being responsible for Curtis's tenuous situation, further contributing to her sense of inadequacy and failing to serve her real need and the needs of her son.

In sum, the experience within reflective supervision provided the milieu in which the following insights were possible: Rebecca and Curtis were attached. Rebecca knew Curtis and his needs better than anyone. Under stress, Rebecca acted in a way that appeared to be harmful to herself and Curtis, but in fact she was desperately trying to convey her own hopelessness. She was trying to let others know how she felt.

In supervision, I learned to listen—to Rebecca, Curtis, and my own feelings. As my supervisor was patient with me, I was able to practice patience, even in a situation where so much was at stake. In the reflective setting, I was able to develop a working hypothesis and a specific set of responses based on my own affective experience. Rebecca and Curtis reinforced in me those very qualities of patience, holding, and understanding that are fundamental to the practice of IMH.

Seeing Her Son

After several months of supportive listening and encouragement, it became clear that Curtis would thrive. I continued to provide IMH services until Curtis was 18 months old. At that time, the family moved out of our service area. Three months later, upon Rebecca's invitation, I visited her and Curtis. Rebecca had moved to a small apartment that was bright, tidy, colorful, comfortably furnished, and filled with stimulating toys. There was a dining room table!

When I arrived, Rebecca and Curtis were listening to a playful children's song. Rebecca said, "I got the music back!" She seemed to have discovered her loving grandmother within herself. Using the gesture she had described to me months earlier, she touched her hand to her cheek and said, "I began to see, as if for the first time, my son right there before me—needing me, loving me, relying on me—reminding me about something within me that went away a long time ago: I'm lovable."

Reference

Pawl, J. H. (1995). On supervision. In R. S. Shanok, L. Gilkerson, L. Eggbeer, & E. Fenichel (Eds.), *Reflective supervision: A relationship for learning discussion guide* (pp. 21-29). Washington, DC: ZERO TO THREE.

Discussion Questions

1. The author identifies intervention strategies as assessment, supportive counseling, meeting concrete family needs, life-coping skills, social support, developmental guidance, infant-parent psychotherapy, advocacy, and crisis intervention. Which strategies were most helpful to this young mother and baby?
2. As described in this article, the true heart and soul of intervention relies on the clinician's sensitivity to what is happening around him and understanding his own reactions to it. Give examples of the author's sensitivity to Rebecca.
3. The author reminds us of the importance of listening rather than speaking. Discuss examples from this case of times when it might have been easier to speak than to listen.
4. The author quotes Jeree Pawl, "It is the 'how' and 'who' we are that ultimately determines the effectiveness of our interactions." What does this quote mean? How does it influence the author's clinical intervention?
5. A therapist's affective, or feeling, response is described as providing a pathway to understanding how the family thinks about themselves, their relationships, and why they trust or distrust the world and people. Describe some of the author's feelings and how they helped him understand Rebecca.
6. The author describes the secure base provided to a therapist by a consistent system of reflective supervision and case consultation. Describe how this secure base enables a therapist, through a parallel process, to provide a secure base for a family.