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Treating Vulnerable Mothers, Infants and Young Children Living in Poverty: Co-Creating a Psychoanalytic Playground in Various Alternative Settings

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ABSTRACT

The families referred to the Anni Bergman Parent Infant Program (ABPIP) Home-Visiting Project often face multiple, overwhelming stressors embedded within the market-oriented system of poverty and exploitation. These stressors compromise the quality of parental care, which in turn negatively impacts the infant's well-being. These financially vulnerable families are usually in an urgent crisis that needs immediate attention. The author describes the innovative model of this outreach program based on psychoanalytic infant observation that encourages interventions on multiple levels simultaneously. Another unique aspect of the program is its reshaping of the analytic frame. Considering the ever-changing nature of the physical settings, the analyst's internal setting becomes a vital, anchoring, and facilitating factor of therapeutic change. Through two detailed case examples, the author shows how these outreach analysts place themselves in between external and internal realities, recognizing the interdependent nature of both, while also maintaining a psychoanalytic attitude and frame that is primarily situated within the analyst. The author also reflects on her own precarious status as an international, temporary visa holder in the US and the ways this external reality entered into the playground of therapy that allowed the author to understand and help a child in a deeper, more personal way based on the dyad's shared preoccupation with the notion of home.

Introduction

Home visiting has been shown to be one of the most effective approaches of supporting vulnerable parents, and especially first-time parents (Howard & Brooks-Gunn, 2009; Olds et al., 2007). Before delving into the distinctive features of the Anni Bergman Parent Infant Program (ABPIP) Home-Visiting Project, I briefly present the history of home-based programs in the United States.

Home visiting programs in the United States

Home visiting programs in the United States are well-known for assisting disadvantaged mothers in developing a healthy bond with their babies. A home-based dyadic parent-infant therapy model was

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created by Fraiberg (1980), and further developed by Lieberman et al. (1991). Later, the Nurse Family Partnership (NFP) program was initiated by Olds & Kitzman (1993). While Fraiberg's model uses specially trained mental health workers, Olds and Kitzman's model uses experienced public health nurses. Both methods have consistently shown positive results in terms of parent-child relationships and child mental health.

Sadler and colleagues (2013) designed Minding the Baby (MTB), a multidisciplinary reflective parenting home-based intervention program that combines the two models outlined above: mental health care and nursing care. The program's purpose is to address the complex needs of at-risk families through the integration of developmental and mental health care within a relational framework. MTB is provided by a clinical social worker and a pediatric nurse practitioner to encourage the healthy development of infants and young children, while also assisting parents in their abilities to mentalize their children. It is believed that helping mothers in attaining a reflective attitude will allow them to be more containing and sensitive to their children's development. Studies indicate that MTB program participants enhanced their reflective parenting skills and knowledge, and became more attentive and responsive to their infants' cues. In addition, children participating in the program showed higher rates of secure attachment than control groups.

The ABPIP Home-Visiting Project,[1] although similar to the home-based models outlined above, sets itself apart by incorporating a variety of characteristics and principles drawn from psychoanalytic theory and practice.

Home-Visiting Project

Home-based dyadic psychoanalytic therapy

A psychoanalytic approach to treatment generally prioritizes internal, psychic reality over external, physical reality. Yet, the frame or setting in psychoanalytic literature is largely defined in external and concrete terms, such as the office, couch, session duration and frequency, and fees and cancellation policies. Notwithstanding the significance of the physical setting and terms, the analytic process is distinguished, even more significantly, by the presence of unconscious psychological work, for both analyst and patient, but primarily in the analyst's mind.

Beyond the consulting room

I became less preoccupied with the physicality of the frame when I started working with the ABPIP Home-Visiting Project, with mother-infant pairs who were not able to afford commuting to a therapist's office. I work with a group of innovative therapists who created a program to provide home-based dyadic psychoanalytic therapy to parents and children under the age of 3 years in an open-ended, analytic process. In 2015, the Home-Visiting Project was developed by ABPIP, a New York City-based program for mental health professionals, which offers a Three-Year Training Program in Parent-Infant Studies. After receiving numerous referrals for psychoanalytic dyadic therapy for vulnerable parents and infants, ABPIP co-directors (Moskowitz and Reiswig) initiated the Home-Visiting Project in 2015, to meet this demand.

The families the Home-Visiting Project serves—many of whom are emotionally, developmentally, and financially underprivileged, distraught, traumatized, and disorganized—would not ordinarily be able to afford psychoanalytically-oriented therapy, nor would they be considered families helped by a traditional psychoanalytic approach. My colleagues and I have been treating mother-infant dyads wherever it is convenient for the family: in their homes, in a childcare or foster care agency, in a school setting, and, during the global pandemic, on video. The program is designed to be convenient for families who are not able to afford commuting to the therapist's office.

A new conceptualization of the analytic frame

One of the most original features of this program is the way the analytic frame is conceptualized and utilized. The physical part of the frame is conceptualized as "portable" (Schwartz, 2019) and this portability does not mean that the analytic frame is deficient. On the contrary, the frame is understood as existing within the therapist's mind, which provides stability and reliability in a chaotic external reality. Despite the unusual and sometimes challenging external backgrounds, therapists on our team carry the analytic "setting" inside, or as the founders of this outreach program put it, they "take the frame with (them)" (Schwartz, 2019) as they process and verbalize difficult feelings and help vulnerable mothers connect with themselves so that they can connect with their babies. (Later in the paper I will discuss in detail the importance of the therapist's mind/body in creating a state of mind in the psychoanalytic work.)

Rigid, goal-directed/brief therapeutic approaches with a prescribed time frame only address immediate needs. These structured approaches do not allow enough time and space for play to emerge, which in turn compromises the quality of the therapeutic care and experience (Sanville, 1991). Our program, with its psychoanalytic focus on making long-term change on the psyche, aims to open up the space for freedom and play, removing rules imposed from without. This setting allows for the creation of a playground through the therapeutic relationship, even in dire circumstances. We are committed to working with parents and infants in an open-ended process, without a timetable or protocol, for as long as they need our services. Our psychoanalytic program can thus be differentiated from many other therapeutic approaches serving this population through provision of urgently needed long-term treatment by psychoanalysts trained in infant observation and parent-infant dyadic treatment.

In addition to providing psychoanalytic understanding, our group[2] offers practical support in various crucial areas, such as employment, housing, health, and education. We also integrate other sources of support within the extended family, such as grandparents and siblings, who we invite to join our sessions. In order to process and reflect on the feelings that this challenging work evokes in the outreach therapists, we organize get-togethers, such as group supervision and buddy meetings. Our group, thus, functions as a container for our feelings and experiences so that we can contain the mothers, who will then contain the babies.

The dyadic psychotherapy we provide in our outreach program is rooted in psychoanalytic premises and the infant observation model. We provide a dependable and predictable presence within the changing external context and aim to create a secure space for play and reflection (Moskowitz & Reiswig, 2017). We amplify the positive child-care practices that we observe within the dyad, and we also model for the mothers a containing, supporting maternal presence, since most of them do not have such a figure in their lives. We also foster healthy bonds and communication between parent and child. These aspects of dyadic therapy facilitate infant's development in every way and also provide parents the ability to understand their children.

The target population

Parents and infants living in poverty

The target population we serve involves parents and infants who are from underprivileged groups, mostly communities of color, and are mentally, financially, and sometimes physically vulnerable. Some of them live in homeless shelters, prisons, foster care or other residential care facilities. Reiswig (2017), one of the co-founders of the program, beautifully articulates her experience of home-visiting a mother-infant pair in a homeless shelter, "I am learning things . . . from being in the neighborhood, . . . seeing how few services there are, seeing the cramped confines of the room given to the mother and infant in the homeless shelter. I feel my impotence in relation to the enormity of the actual problems embedded in the lives of the individuals. I see that their lives and psyches are intertwined with and deeply affected by the systems they are part of now and in the past." (p. 3) The homeless shelter offers security, but it is also similar to being in

a prison. In this sense, the system that protects this underprivileged group also restrains them with its uncaring atmosphere and rigid bureaucratic practices.

Poverty, one of the most urgent problems of our society, compromises both mental and physical health. Mental health can be negatively affected by poverty and can also create it. It has been unfailingly shown in social science studies that the lower socio-economic status (SES) of an individual increases his or her risk of mental illness (Pauna et al., 2011). It is also documented that poverty creates negative affective states, which might compromise attention and lead to a preference for habitual behaviors rather than goal-oriented ones. These specific psychological effects can trigger economic decisions or behaviors that perpetuate poverty (Haushofer et al., 2014). Poverty and mental health correlation can create more vulnerability in various aspects of one's life, including access to education, housing, health care, employment, welfare, social security, and community public services might be compromised (Pauna et al., 2011). All of these factors could lead to the experience of exclusion, which in turn creates an even more damaging picture for these already marginalized groups.

Being mindful of these systemic problems and the excruciating effects of multiple stressors (poverty, mental and physical illness, systemic/social neglect and abuse, etc.), the therapists of our program intervene from multiple avenues simultaneously. Parents' ability to contain, regulate, and organize their affective states is severely compromised when there are numerous disruptors within their physical spaces (Moskowitz & Reiswig, 2017). For the population we serve, the presence of external and internal stressors—including lack of financial or emotional support, and the existence of trauma in the past and present—can be obstacles in caring for their children. Since these conditions create a sense of urgency, we sometimes intervene concretely, by providing actual/physical help with these multiple stressors while also maintaining our psychoanalytic understanding. We've noticed that bringing organization to the chaotic external space can also create organization within the psyche of both the parent and the infant. We've also observed that when we help parents to resolve their problems, they can then attend to their children's difficulties and bond with them. As Fraiberg et al. (1975) beautifully state, "*When this mother's own cries are heard, she will hear her child's cries*" (p. 396, original italics).

Clinical vignette: Sergio and Emma

I turn now to a clinical vignette to illustrate our therapeutic processes. An 8 1/2 month old baby (whom I will call Sergio) was referred to our outreach program for dyadic therapy by a nurse practitioner who thought that he might be at risk for or suffering from failure to thrive, as he had delays in his motor development. A colleague and I made a visit to Sergio's home and we observed that his mother (whom I will call Emma) was feeling severely depressed and, thus, could not attend to his emotional needs and could not interact with him. Due to lying on his back and not being picked up, Sergio's head became flat and his hair at the back of his head stopped growing. Emma was leaving him lying in his crib to watch a cartoon on a tablet. We noticed that Sergio was extremely sensitive to sounds, easily overwhelmed by stimulus, reacted to any stimulant by withdrawing, and showed a rather intense stranger anxiety reaction to us.

My colleague and I helped Emma to express her feelings of depression, which started soon after Sergio's birth. Noticing the baby's similar state of mind in his crib, my colleague encouraged Emma to pick up Sergio and we all sat on the floor together. Reading Sergio's gestures that communicated his readiness to crawl, my colleague provided instructions to Emma who helped him crawl, sit, and practice movement. His body seemed very stiff, and the way he held himself looked a bit shaky, which made us think that perhaps Emma was not holding him securely, and in turn might have affected the way Sergio carried himself.

As this was happening, we also listened to Emma talk about the source of her depression: She was not getting any support from her husband (who also seemed to be having a difficult time with the baby's coming into their lives) and was also not feeling good about gaining weight. She cried intensely and expressed not being able to focus. We normalized her state of mind explaining that many women

who give birth feel this way. Emma also spoke about not being able to breastfeed her baby, which contributed to her sadness. She expressed her worries regarding Sergio's delayed development.

In the meantime, Sergio was smiling and interacting with us, and his responsiveness made us feel that the failure to thrive was perhaps not due to a problem in the baby, but due to a problem in the dyad, namely the mother's difficulty attending to the baby due to her own need for mothering and nourishment. Although his responsiveness to our interventions looked promising, we still referred Emma and Sergio to an early intervention evaluation and a neurological exam. We were impressed by the cleanliness of Emma as well as the good physical environment she created for Sergio despite the family's lack of financial resources, and we shared this observation with her. Emma described Sergio as "very easy" and we wondered if the baby was falsely complying with his depressed mother.

We began to regularly visit this mother-infant pair in their home each week (same day of the week, at the same time of day), for about an hour. During these meetings, Emma expressed that talking with us about her feelings had helped and that she was not feeling "alone" or "crazy" anymore. She instantly began to feel lively, and Sergio, in turn, became fussy. Emma complained about not being able to calm him down. We wondered if as Emma became more receptive, Sergio was able to protest. We observed that when Sergio fussed, Emma did not notice what his discomfort was, and instead did random things to calm him down. Although he would stop fussing for the moment, he became overstimulated by these aimless actions. Emma had big, intrusive movements and a loud tone of voice, which seemed to disturb him even more. Sergio became scared when he came too close to us. We communicated these observations to Emma and we helped her to observe Sergio and his reactions and to respond accordingly. We supported her actions that seemed to calm him down, such as his being close to her body soothing him and helping him to fall into sleep easily. Emma, in response, became gradually more attuned to her baby's state of mind and picked him up if he was tired or sleepy, and allowed him to fall asleep naturally on her arms in the rocking chair rather than leaving him in his crib. We encouraged Emma to see that when Sergio was not stimulated, he was an alert, peaceful, and oriented baby.

After two and a half months of working with this dyad in weekly home visits, we observed that Sergio became livelier as Emma got livelier and made constant progress in terms of his interaction with his mother and with us (Sergio made more eye contact; smiled and engaged more; began to crawl and vocalize; and had new movements in his repertoire, such as grabbing and shaking his toys). Emma became more attentive to Sergio and began to have a better understanding of his sensitivities and needs. As her mood lifted, Emma expressed playing with her baby more, which we supported.

As can be seen in this vignette, our therapeutic stance involves a multi-level approach. One of the basic assumptions of our outreach program is that babies need to have a relationship with their mothers and that they develop within this immensely important early connection. As Winnicott (1971) astutely describes, this bond is a "psychosomatic partnership"—a relationship that is both psychological and somatic at the same time. As we see in this vignette, our helping the mother attend to the bodily needs of her baby, leads to a change in the baby's psyche, since fulfilling the baby's physical needs is a message to the baby that the mother understands him (Waddell, 2002). Both the physical and psychological aspects of this care are gradually internalized by the baby, which progressively organizes his psyche and body.

The therapist's *internal setting*

Earlier I mentioned that the therapists in our program carry the analytic setting inside. In this section, I will clarify what this *inside* consists of. Parsons (2007) refers to the analyst's *internal setting* and argues that the analytic frame is not only an external structure, but also an internal one, which lives in the analyst's mind where reality is characterized by unconscious symbolic meaning. He highlights that the external setting can be damaged (for a variety of reasons including a construction, an interruption, or even a pandemic), but that if the setting inside the analyst is undamaged, then the meaning of everything (including the changes in the external frame) can be understood from a psychoanalytic

perspective. Conceptualizing the frame in this way, in fact, suggests that the internal setting has priority over the external setting.

Freud (1914) famously stated that the therapist *welcomes* what the patient repeats "into the transference as a playground in which it is allowed to expand in almost complete freedom" (p. 154). He then conceptualizes the transference as creating "an intermediate region between illness and real life through which the transition from the one to the other is made" (p. 154). It seems that Winnicott (1971) expanded Freud's "playground" idea by including the therapist in his well-known postulation of psychotherapy as taking "*place in the overlap of two areas of playing, that of the patient and that of the therapist*" (p. 38, original italics). Winnicott initially envisioned transitional space as involving the mother and the infant in between external and internal reality, marking the infant's growing capacity to have symbolic representation. His depiction of how this transitional space is created also resonates with psychoanalytic work that inherently involves play. Thus, for Winnicott, the playground of psychoanalytic therapy is a relational, intersubjective area.

Sanville (1991), expanding on Winnicott's notion of play, argues that a child's capacity to play can develop within a good-enough-mother-infant relationship. She sees the therapeutic situation similarly in that the presence of a good-enough-therapist who creates play and illusion within the therapeutic relationship facilitates emotional healing. She regards pathology as resulting from a lack of play and illusion.

In line with this idea of our need for playfulness and illusion for our psychological growth, Civitarese (2016a, 2016b) argues that we need to mitigate the harshness of reality through reverie. According to this model, which reinterprets the mother's/analyst's reverie function by integrating Bion's ideas and field theory's concepts, reality is too harsh and painful as it is; therefore, we need some cover to go near it. By transmitting her way of dreaming/thinking to her baby, the mother provides this necessary cover, "the psychic skin that protects the baby from the trauma of reality" (Civitarese, 2016a). Considering the harshness of the external circumstances of the population we serve; we can imagine how the external reality can be experienced as extremely traumatic and how the reverie function is as vital as basic physical needs. The infants in these vulnerable families particularly need an illusionary play space to gradually digest the external reality and to symbolize it. In this sense, the mother's dreaming ability/reverie function is like "the dark glasses that enable us not to be burned by the light of the sun" (Civitarese, 2016a, p. 40).

Similarly, Caron and Lopes (2015) emphasize the significance of the analyst's internal setting in psychoanalytic work. Being trained in Bick's (1964) method of infant observation, which allows for a more refined capacity to receive and contain primitive psychic states, these analysts argue that the analyst's internal setting involves her reliability and preoccupation, which can be considered even more essential than the analyst's interpreting capacity. They also claim (and demonstrate through a case example) that the analyst's internal setting, when enhanced by the experience of infant observation, may enable developmental growth processes and integration.

I believe that as psychoanalysis evolves to incorporate a deeper understanding and acknowledgment of the intersubjective nature of therapeutic dialogue and change, the playground concept is becoming less dependent on the physical setting and more connected to the internal setting of the analyst.

Co-creation of a particular state of mind between mother-baby/therapist-patient[3]

The intersubjective nature of the psychoanalytic playground

Mother-infant research and theories show us that in order to feel, and be in touch with, their own experience, babies need another psyche—an unconscious—to receive and hold their experience and give meaning to it. Gradually the mother transmits her way of emotionally digesting or transforming reality to the baby, and the baby internalizes the ability to think, to make sense of the world in his or her own way, which leads to psychic growth (Civitarese, 2016b). The infant-mother relationship,

which is characterized by these processes—mainly emotional, non-verbal interaction—is similar to the patient-analyst relationship. Like a mother who is sensitive to her baby, an analyst who is attuned to the emotional states of his or her patient facilitates the process of connecting "unspeakable" experiences with words. Winnicott's (1956) concepts of "primary maternal preoccupation" and "holding" (Winnicott, 1955), Bion's (1962) concept of "maternal reverie," and Stern's (1985) concept of "attunement" all highlight not only the importance of the other mind, but also the quality of it—a certain state of mind that is created between a mother and her baby.

In psychoanalytic process, too, a similar state of mind emerges in the relationship between therapist and patient. Our unconscious complements our patients' conscious: when our patients do not have words or cannot generate meaning about their experiences, we willingly and unconsciously offer our psyche to receive their emotional truth. This emotional transmission occurs through projective identification, and we become open to the impact of affective tides from our patients within the intersubjective space of the analytic relationship. In this way, the emotional life of our patients that has been rejected and blocked in their previous relationships reveals itself initially and essentially in our psyche—in our experience—both consciously and unconsciously. We are usually the first to sense those emotions that our patients don't allow themselves to feel in our own experience, which allows us to introduce them to our patients, or in other words, to translate this nonverbal experience into words. This process has been depicted by many analysts: Bollas's (1987) concept of "unthought known," Casement's (1985) "communication by impact," and Bion's (1962) "container model" all point to similar phenomena.

Tronick (2003) also describes a certain permeability and co-creation that tends to develop within emotionally meaningful relationships, but with a different language. Tronick et al. (1998) argue that the social emotional interactions in all relationships, including those of mother-infant and therapist-patient, can expand each participant's state of consciousness in an experientially powerful and growth-promoting way. These co-creative, meaning making processes shape the infant's/patient's making sense of the world and relationships (Tronick, 2003). In other words, when two people effectively collaborate in their emotional interactions, they each enhance their coherence and complexity. When a dyadic system as such is created, both participants feel an expansion of their own states of consciousness. It feels as if "one becomes larger than oneself" (Tronick et al., 1998, p. 296). The concept of dyadic states of consciousness is also helpful in understanding how change occurs in therapy. According to Tronick et al. (1998), dyadic expansion of consciousness is an emotional/experiential process that may or may not involve interpretation. Once this kind of a process emerges in the therapeutic relationship, then it becomes a powerful vehicle for change in and of itself.

As mentioned earlier, Bion's (1962) concept of "reverie" is another term that refers to the mother's/analyst's state of mind that allows her to unconsciously connect with the infant's/patient's bodily feelings to receive, contain, and process them, and if necessary, transform them. The maternal reverie particularly demonstrates how the therapist's mind/body is vital in creating this particular state of mind in psychoanalytic therapy. *With this conceptualization, we can expand Freud's initial hypothesis by asserting that all of the feelings and experiences of the patient are accepted/received within the therapist's mind/body and that perhaps both transference and countertransference (the therapeutic relationship itself) become the psychoanalytic playground.*

I would now like to show how these complex processes emerged in my work with the Home-Visiting Project.

Clinical vignette: Camila

When children are referred to our program without a caretaker who can receive and contain their emotional experience, then the therapists in our program fulfill this function. Camila was one such child. Having witnessed multiple traumas and having parents with several mental health, social, and financial struggles, she left her original home when she was just 3 years old. She was referred to us so that we could help her make a smooth transition to her foster home. My colleague and I began to see

Camila with her different caretakers in weekly dyadic therapy sessions in various settings. We continue to meet with her regularly every week for almost an hour.

Working with Camila has been challenging because there is almost no consistency in the external setting: the places we meet with her and her caretakers, with whom we have been doing dyadic therapy, change regularly. Camila initially exhibited a somewhat rigid posture and fixed facial expressions, as well as repetitive play, all signs of her being traumatized in her original home. We thought that Camila was suffering due to not having had the chance to experience and express her feelings in relation to the traumas she went through. My colleague and I became in touch with the difficult feelings that emerged in Camila's play (such as loss, separation, helplessness, and longing for home) and began to verbalize these feelings to her. This translation process gradually allowed Camila to expand her emotional repertoire and soften her posture and her facial expressions.

A countertransference dream and its relation to the internal setting

Working with Camila has been stirring up very powerful feelings in me and my colleague. Our countertransference became a compass, guiding us deeper into parts of Camila's experience that were previously unexplored. As an analyst who lives abroad, I was able to relate to Camila on a number of levels. Her lack of stability echoed my own feelings of being in a foreign land, far away from my own roots. This shared sense of relocation, displacement, and rootlessness created a strong sense of empathy, connection, and identification with Camila's struggles. I recalled my initial feelings of helplessness, frustration, and longing for a sense of belonging as a result of being physically separated from my own familiar environment and support system when I first relocated to New York. Helping Camila brought these emotions to the surface, heightening my awareness of the challenges she would face at such a young and vulnerable age.

Perhaps as a result of my preoccupation with Camila and her difficulties, I once had an unsettling dream about her in which I am trying to find Camila and my colleague for our dyadic session in a big building; however, I cannot find them. I desperately search for them in various places throughout the building, and I feel terribly anxious and sad. Eventually I find my colleague; however, she, too, feels powerless because she was unable to find Camila.

When I had this dream, I was going through an uncertain and stressful process of getting an extension for my work visa during the 2017–2021 administration when these kinds of bureaucratic processes had become extremely demanding and challenging. As the process of getting an extension for my visa took longer than expected, my anxiety about whether I would be able to continue working with Camila grew stronger. Perhaps living with a visa in a country creates a situation similar to that of Camila: being a "guest" in a foreign country, not having a permanent home, not knowing where home will be in the future, and holding on to relationships when everything else feels shaky and uncertain. Perhaps my particular situation made me more receptive and sensitive to Camila's painful preoccupation with the notion of home—as if the key had found its lock.

Although my dream involved *real* concerns about my visa status, I believe it also functioned as a window into the experience of Camila. In every session, my colleague and I were playing hide and seek with her: She was hiding from us and when we (as opposed to her birth family) found her each time, she responded with enormous joy. Perhaps my dream also conveyed Camila's anxiety that we might not be able to find her one day based on the recurrent changes that have been happening in the case. When I shared my dream with my colleague, she related to me that she also felt anxious and distressed in working on this case. My colleague interpreted my dream as reflecting not only my visa concerns, but also the fears in relation to working with children and families who try to cope with severe deprivation and loss in their lives.

My dream allowed me to understand Camila's struggles around the notion of home from a closer, more emotional place *within* myself. I believe that reflecting on my own experiences of dislocation and rootlessness enabled me to understand Camila's challenges and helped me to provide a containing presence for her, assisting me to share these insights with her in a way she could grasp. The dream also

led to my talking with my colleague about the intimate experience of working with Camila at a deeper, more personal level. When my colleague, who is much more experienced than me, also expressed feeling anxious in the work with Camila, I thought that perhaps the anxiety was a form of communication to us via projective identification regarding Camila's experience. Perhaps the dreams about our patients can be understood as a natural extension of the special state of mind I am exploring in this paper: the permeability that develops between the therapist and patient within the intersubjective space of therapy, as well as the particular receptivity of the therapist. Perhaps our dreams about patients are a product of the psychoanalytic playground that includes the transference/countertransference matrix, in other words, the therapeutic relationship.

Brown (2016) also highlights the importance of the analyst's emotional involvement with the patient as a crucial aspect of the therapeutic process. He analyzes the notion of the analyst's receptivity from various theoretical perspectives and concludes that receptivity is not merely a trait possessed by the analyst, but rather a part of an intricate intersubjective network that operates unconsciously at all times. Similarly, Ogden (2004) exquisitely describes the complex intersubjective process that gradually develops between the analyst and patient: "*The patient and analyst engage in an experiment within the terms of the psychoanalytic situation that is designed to generate conditions in which the analysand (with the analyst's participation) may become better able to dream his undreamed and interrupted dreams. The dreams dreamt by the patient and analyst are at the same time their own dreams (and reveries) and those of a third subject who is both and neither patient and analyst*" (p. 862; original italics). Ogden also seems to refer to the special state of mind or the internal setting that I am elaborating on here. Using the ideas explored in this paper, dreaming can be understood as a natural extension of this unconscious state of mind. When we enter into that state of mind (which I believe has elements of both Bion's "maternal reverie" and Winnicott's "primary maternal preoccupation"), we are also allowing our patients into our bodies and minds, and we carry them within us no matter where we meet with them physically.

With the pandemic, our work with Camila was moved to an online platform. Camila was about 5 years old when the epidemic first started and was far more expressive, both verbally and emotionally. During one of our sessions at that time, she took me (I was on the phone, and thus more *portable*) and put me in a tent she built where she also had her favorite toys and her blanket. She lay down and wrapped her blanket around herself, cuddling her toy. Camila has been preoccupied with building tents, perhaps due to her wish to have a permanent home for herself. I communicated to her the cozy atmosphere—a home she had created in her tent—which involved her favorite things. Perhaps due to the regularity of our meetings, our stable presence, and most importantly our processing, verbalizing, and *dreaming* her experience, and giving meaning to it, Camila managed to carve out a *playground* in the physical world, which might also have a counterpart inside her.

Conclusion

We know that poverty is one of the biggest stressors that causes underdevelopment in infants and children. It is crucial to address the psychological impact of poverty in care givers and children in situations of extreme financial need. As a response to the huge need for long-term, sensitive, and psychoanalytic care for parents-infants and young children who struggle with poverty and other interrelated stressors, ABPIP designed a home-visiting community outreach program that aims to address the specific needs of this underprivileged population. As detailed in this article, the program is innovative in various respects, including, but not limited to, its open-ended commitment to providing care, its unique conceptualization of the frame, its focus on play and illusion even when circumstances are dire, and its recognition of the mutual interrelated nature of external and psychic realities.

When working with these vulnerable families, we position ourselves at a transitional place and try to maintain our psychoanalytic frame/internal setting at the juncture of external/physical and internal worlds. We bring our psychoanalytic knowledge and skills and our internal setting, to the ever-changing physical settings where we meet with the vulnerable families and try to bring some order,

structure, and meaning to the overwhelming internal and external challenges they encounter on a daily basis. The work we do provides access to marginalized communities who are commonly deemed not appropriate for psychoanalytic therapy. As I tried to convey in this article, play, illusion and reverie are not luxuries but necessities for our emotional growth and psychic development. And perhaps people who are faced with extreme physical conditions need these psychic functions even more urgently. This article also aims to reassess and expand the analyst's internal setting, which involves a special, unconscious state of mind that naturally emerges in parent-infant and therapist-patient relationships and becomes a powerful force for change.

Notes

1. The Anni Bergman Parent-Infant Program's Home-Visiting Project is supported by The Margaret S. Mahler Child Development Fund and The Girard Fund.
2. Please see the Anni Bergman Parent Infant Program website (Anni Bergman Parent Infant Program, 2023).
3. Several of the ideas in this article originate in three papers I wrote in Turkish: "Analitik yakinligin dogasi uzerine" (On the nature of analytic intimacy). Psikanaliz Yazilari 34, Baglam Yayincilik, Spring 2017; "Iliskiyle buyumek: Bilincdisi/duygulanimsal iletisimin ogrenme surecindeki rolu" (Thriving in a relationship: The role of affective/unconscious communication in the learning process). Psikanaliz Defterleri 3 – Cocuk ve Ergen Calismalari, YKY, November 2019; and "Psikanalitik surecte ayna islevinin rolu" (The role of mirroring function in psychoanalytic process). Suret Psikokulturel Analiz, #12. Ithaki Yayinlari, January 2022.

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