THERAPISTS' EXPERIENCES OF MOTHER–INFANT PSYCHOANALYTIC TREATMENT: A QUALITATIVE STUDY

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ABSTRACT: As part of a larger research project in Sweden, a qualitative study investigated psychotherapists' experiences of mother–infant psychoanalysis (MIP). A randomized controlled trial compared two groups of mother–infant dyads with psychological problems. One had received Child Health Center care, and the other received MIP. Previous articles on long-term effects have found that mothers who had received MIP were less depressed throughout a posttreatment period of 3½ years, and their children showed better global functioning and psychological well-being. The present study's objectives were to describe the therapist's experiences of MIP and deepen the understanding of the MIP process. Six months after treatment began, all therapists were interviewed. Transcribed interviews with therapists from 10 (of 33 total) MIP treatments were randomly selected and analyzed in detail by thematic analysis. Therapists worked successfully with mother and infant together and found different ways of cooperation during MIP sessions. Therapists reported overall positive experiences; however, in cases where mothers needed more personal attention, it would be important to adapt the method to them.

Keywords: mother–infant psychotherapy, postnatal distress, therapist interviews, thematic analysis

RESUMEN: Trasfondo: Como parte de un proyecto de investigación mayor en Suecia, un estudio cualitativo investigó las experiencias que los sicoterapeutas tienen de sicoanálisis madre-infante (MIP). Un ensayo controlado al azar (RCT) comparó dos grupos de díadas madre-infante con problemas sicológicos. Uno había recibido el cuidado del Centro de Salud Infantil (CHCC) y el otro, el MIP. Artículos previos sobre efectos a largo plazo encontraron que el grupo de madres que habían recibido el MIP estaban menos deprimidas a lo largo de un período de 3 años y medio de tratamiento posterior y que sus niños mostraron mejor funcionamiento global y bienestar sicológico. Los objetivos del presente estudio fueron describir las experiencias del terapeuta con el MIP y profundizar la comprensión del proceso MIP. Método: Seis meses después que comenzó el tratamiento, todos los terapeutas fueron entrevistados. De un total de 33, se seleccionaron al azar las transcritas entrevistas con terapeutas de 10 tratamientos MIP, las cuales se analizaron en detalle según análisis temáticos. Resultados: Los terapeutas trabajaron exitosamente junto con la madre y el infante y encontraron diferentes maneras de cooperación durante las sesiones MIP. Conclusiones: Los terapeutas reportaron generalizadas experiencias positivas. Sin embargo, en casos en los que las madres necesitaban más atención personal sería importante adaptar el método a ellas.

Palabras claves: sicoterapia madre-infante, angustia postnatal, entrevistas de terapeutas, análisis temáticos

RÉSUMÉ: Arrière-plan : dans le contexte d'un projet de recherche plus grande en Suède, une étude qualitative s'est penchée sur les expériences que les psychothérapeutes font de la psychanalyse mère-nourrisson (abrégé MIP en anglais, ici PMN). Un essai contrôlé randomisé (ECR) a comparé deux groupes de dyades mère-nourrisson avec des problèmes psychologiques. L'un des deux groupes a reçu des soins au Centre de Santé de l'Enfant (*Child Health Center*, CHCC) et l'autre, la psychanalyse mère-nourrisson (PMN). Des articles précédents sur les effets à long terme avaient déterminé que les mères ayant reçu une PMN étaient moins déprimées à travers la période d'après le traitement sur 3 ans ½ et que leurs enfants faisaient preuve d'un meilleur fonctionnement global et d'un bien-être psychologique. Les objectifs de cette étude-ci étaient de décrire les expériences du thérapeute de la PMN et d'approfondir les connaissances du processus PMN. Méthode : Six mois après le début du traitement, tous les thérapeutes ont été interviewés. Sur 33, des entretiens transcrits avec des thérapeutes de 10 traitements PMN ont été sélectionnés au hasard et analysés en détail au moyen d'une analyse médicale. Résultats : Les thérapeutes ont travaillé avec succès avec la mère et le nourrisson ensemble et ont trouvé différentes manières de coopérer

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durant les séances de PMN. Conclusions : Les thérapeutes ont dans l'ensemble fait état d'expériences positives. Cependant dans les cas où les mères avaient besoin de plus d'attention personnelle il serait important d'adapter la méthode à elle.

Mots clés: Psychothérapie Mère-nourrison, détresse postnatale, entretiens de thérapeute, analyse thématique

ZUSAMMENFASSUNG: Hintergrund: Im Rahmen eines größeren Forschungsprojektes in Schweden untersuchte eine qualitative Studie die Erfahrungen von Psychotherapeuten mit der Mutter-Säuglings-Psychoanalyse (MIP). In einer randomisierten kontrollierten Studie (RCT) wurden zwei Gruppen von Mutter-Kind-Dyaden mit psychischen Problemen verglichen. Eine Gruppe wurde durch ein Kindergesundheitszentrum betreut (CHCC) und die andere erhielt MIP. Bisherige Artikel über Langzeiteffekte zeigten, dass Mütter, die MIP erhielten, während einer Nachbehandlungszeit von 3½ Jahren weniger depressiv waren und ihre Kinder ein besseres globales Funktionsniveau und psychologisches Wohlbefinden zeigten. Ziel der vorliegenden Studie war es, die Erfahrungen von Therapeuten mit MIP zu beschreiben und das Verständnis des MIP-Prozesses zu vertiefen. Methode: Sechs Monate nach Behandlungsbeginn wurden alle Therapeuten interviewt. Transkribierte Interviews mit Therapeuten aus 10 von 33 MIP-Behandlungen wurden nach dem Zufallsprinzip ausgewählt und anhand einer thematischen Analyse detailliert ausgewertet. Ergebnisse: Die Therapeuten arbeiteten erfolgreich mit Mutter und Säugling zusammen und fanden verschiedene Wege der Zusammenarbeit während der MIP-Sitzungen. Schlussfolgerungen: Die Therapeuten berichteten über insgesamt positive Erfahrungen. In Fällen, in denen Mütter mehr persönliche Aufmerksamkeit benötigen, wäre es jedoch wichtig, die Methode entsprechend an sie anzupassen.

Stichwörter: Mutter-Säuglings-Psychotherapie, postnataler Disstress, Therapeuteninterviews, thematische Analyse

抄録: 背景:スウェーデンの大きな研究プロジェクトの一部として、母親–乳幼児精神分析mother-infant psychoanalysis (MIP)の治療者の体験を質的研究で調査した。ランダム化比較試験(RCT)で、心理的問題を持つ2つの母子グループを比較した。一つのグループは児童保健センターでのケアChild Health Center care (CHCC) を受け、他方はMIPを受けた。長期効果についての以前の論文では、MIPを受けた群の母親は治療後3年半を通して抑うつ状態が少なく、子どももよりよい全般的機能と心理的な幸福を示した。この研究の目的は、MIPの治療者の経験を記述し、MIP過程の理解を深めることだった。方法:治療開始6か月後に、すべての治療者はインタビューを受けた。33MIP治療のうち10の治療者の文字起こしされたインタビューが無作為に選ばれ、主題分析で詳しく分析された。結果:治療者は母親と乳児と共にうまく作業し、MIPセッション中にさまざまな協働の方法を見つけた。結論:治療者は全体的にポジティブな経験を報告した。しかしながら母親がより個人的な注意を必要としている例では、そのような母親のために方法を適合させることが重要だろう。

キーワード: 母親–乳児心理療法, 產後の苦痛, 治療者のインタビュー, テーマ分析

摘要: 背景:作為瑞典較大型研究項目的一部分, 作者以定性研究, 調查了心理治療師對母嬰精神分析 (MIP) 的經驗。隨機對照試驗 (RCT) 比較兩組有心理問題母親和嬰兒。其中一組曾接受過兒童健康中心的護理 (CHCC) , 另一組曾接受MIP。以往有關長期效應的研究發現, 接受MIP組的母親在治療後3年半內的抑鬱程度較低, 她們的孩子表現出較好的全球功能和心理健康。本研究的目的是描述治療師的MIP經驗, 加深他們對MIP過程的理解。方法:治療開始後6個月, 所有治療師接受訪談。在33名治療師中, 隨機選取10名MIP治療師, 轉錄其訪談, 並通過主題分析, 詳細分析訪談內容。結果:在MIP會議期間, 治療師與母親和嬰兒成功地發現不同的合作方式。結論:治療師總體報告正面的經驗。但是, 在母親需要更多個人關注的情況下, 改變治療方法以適應其需要是非常重要的。

關鍵詞: 母嬰心理治療, 產後窘迫, 治療師訪談, 主題分析。

ملخص: خلفية البحث: قامت دراسة وصفية مشتقة من مشروع بحثي كبير في السويد بدراسة تجارب المعالجين النفسيين في تحليلهم النفسي لثنائيات الأم والرضيع (MIP). وقارنت تجربة عشوائية ذات ضوابط (RTC) بين مجموعتين من ثنائيات الأم والرضع الذين لديهم مشاكل نفسية. أحد المجموعات تلقت رعاية مركز صحة الطفل (CHCC) والأخرى تلقت علاج التحليلي النفسي للأم والرضيع (MIP). الدراسات السابقة التي تناولت الآثار طويلة المدى وجدت أن الأمهات اللاتي تلقين (MIP) كانوا أقل اكتئابا خلال فترة ما بعد العلاج لمدة 3 سنوات ونصف وأظهر أطفالهن صحة نفسية أفضل وأداء وظيفي أعلى. تهدف الدراسة الحالية إلى وصف تجارب المعالجين النفسيين لثنائيات الأم والرضع وزيادة فهم عملية التحليل النفسي للأم والرضيع (MIP). التجربة : تمت مقابلات شخصية مع كل المعالجين بعد ستة أشهر من بداية العلاج. وتم اختيار تفريغ محتوى 10 حالات عشوائية من واقع 33 وتحليلها بالتفصيل من خلال تحليل المواضيع. النتائج: تعامل المعالجون بنجاح مع الأم والرضيع سويا ووجدوا طرق مختلفة للتعاون أثناء جلسات (MIP). الاستنتاجات: عبر المعالجون عن تجارب إيجابية بشكل عام. ومع ذلك كان هناك حالات تطلبت مزيد من الانتباه الشخصي للأمهات وكان من الضروري تطويع أدوات البحث لهذه الحالات.

كلمات مفتاحية: العلاج النفسي للأم والرضيع- اكتئاب ما بعد الولادة- المقابلات الشخصية للمعالج- تحليل المواضيع

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Mothers with infants sometimes ask for psychological help when they experience problems in their parental role (Howard, Molyneaux et al., 2014; Howard, Piot, & Stein, 2014). They might be worried about symptoms in the baby concerning sleep, crying, nursing, colic, mood, and regulation of activity. Often, they also experience difficulties in attaching emotionally to their baby and are worried that they impede their contact with him or her. In Sweden, problems of this kind are normally taken care of by

the Child Health Centre (CHC). This form of routine healthcare follows an ambitious program with a series of calls by the nurse and the pediatrician. CHC nurse calls follow a schedule; weekly the first month, monthly up to 4 months, and every second month during the rest of the first year. Checkups then ensue more sparsely at 1½, 3, 4, and 5 years. Nurses are encouraged, in their training and their professional instructions, to attend to the psychological needs of parents and screen for postnatal depression in mothers and fathers.

If the detected problems prove to be more profound, special psychotherapy methods for mothers and babies can be used. During the last decades, several models have been developed (Baradon et al., 2016; Cohen et al., 1999; Lieberman & Van Horn, 2008; McDonough, 2004). They seek to help improve the interaction between mother and child. One model is mother–infant psychoanalysis (MIP).

MIP

The MIP method was developed by the Swedish psychoanalyst Johan Norman in the 1990s (Norman, 2001, 2004; Salomonsson, 2002, 2007a, 2007b) and is based on psychoanalytic theory. The therapist seeks to obtain a dialogue both with the child and the mother, and to take into account the mother's different feelings of distress. Sessions take place with infant and mother together. Session frequency and treatment duration are adapted to the severity of dyadic distress and to the mother's motivation and possibilities of continuing therapy. In general, intensive treatment four times a week is recommended, although this is not often feasible.

For the cases in this study, sessions varied between one and four times weekly ($M = 2.6$). The babies were from 0 to 18 months of age when therapies started. The therapists were psychologists or psychiatrists who trained as psychoanalysts at the Swedish Psychoanalytical Association, which is a branch of the International Psychoanalytical Association. The MIP method was taught and developed at the Infant Centre of the Swedish Psychoanalytical Association (www.psykoanalys.se), to which all the therapists in the present study were associated. Regular and weekly peer-group seminars were held, in which the therapists discussed ongoing casework. This process has been described by Bertell (2013).

THE INFANT STUDY

A randomized controlled trial (RCT) took place from 2005 to 2008 (Salomonsson & Sandell, 2011a, 2011b) in which two groups of mothers and infants (M age = 5½ months) were assigned to either MIP or CHC care (CHCC). Since practically all Swedish mothers visit the CHC during the child's first years, it follows that the MIP group also continued with this routine. Data collected 6 months later indicated that the mothers in the MIP group had better results on self-reported maternal depression, observer-rated mother–infant relationships, and maternal sensitivity, and on a marginally significant level, self-reported maternal stress. A follow-up study of the long-term outcomes for mothers and infants was initiated approximatively 3½ years after treatment termination when the children were 4½ years old (Winberg Salomonsson, Sorjonen, & Salomonsson, 2015a, 2015b).

The follow-up study indicated that the mothers in the MIP group were less depressed throughout the whole posttreatment period and that the children showed better global functioning and psychological well-being at 4½ years of age. In a qualitative study of the mothers' experiences of MIP (Winberg Salomonsson & Barimani, 2017), they reported on how MIP had facilitated their transition to motherhood as well as their relationship with the infant. This study was based on interviews performed 6 months after assignment (i.e., when therapies had been terminated).

Qualitative Methodology in Psychotherapy Research

Quantitative outcome studies of parent–infant psychotherapy have been numerous (Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Cooper, Murray, Wilson, & Romaniuk, 2003; Hayes, Matthews, Copley, & Welsh, 2008; Letourneau et al., 2011; Murray, Cooper, Wilson, & Romaniuk, 2003; Ravn et al., 2012; Robert-Tissot et al., 1996; Santelices et al., 2011; Winberg Salomonsson et al., 2015a, 2015b). Another way of investigating the development of the relationship between mother and child is the single case study of therapy cases (Baradon, Biseo, Broughton, James, & Joyce, 2016; Belt et al., 2013; Downing, Burgin, Reck, & Ziegenhain, 2008; Kächele, Schachter, & Thomä, 2009; Keren, 2011; Tuters, Doulis, & Yabsley, 2011; Willemsen, Della Rosa, & Kegerreis, 2017). Studies applying a qualitative analysis of interview transcripts have become more common (Levitt, 2015), and some studies used such methods to investigate changes due to therapy (Paris, Spielman, & Bolton, 2009). The present study also used qualitative analysis to better comprehend the therapists' experiences of the MIP treatment.

Psychological Theoretical Concepts

This section introduces some concepts that are essential for understanding the interviewed therapists' renditions of their work. Two of them describe the mother's contribution in taking care of the infant. They also are useful in the clinical setting to illustrate the therapist's mode of working vis-à-vis the dyad; Bion's (1962) concept of the "*container/contained*" and Winnicott's (1953) concept of "*holding*."

One intention in MIP is to improve the quality of the emotional relationship between mother and infant (Norman, 2001). Norman describes this in terms of *containment*: "The infant and the mother have a unique flexibility that enables them to repair disturbances in their relationship when the emotional container–contained link is (re-) established." (p. 83)

Bion's theory (1959, 1962) of containment explains how a mother receives unwanted and/or overwhelming projections from an infant, processes them, and then returns the experience to the infant in a modified, digestible form. This process also occurs in therapy with the therapist acting as a "container," taking in thoughts and feelings from the patient, processing them to finally resubmit them that is more understandable to the patient. Through this process, the patient's feelings become potentially less destructive. Malone and Dayton (2015) showed that Bion's concept can be integrated with and complement Fraiberg, Adelson, and Shapiro's (1975) theory of how maternal projections or "*ghosts in the nursery*" may contribute to distorting the mother's attribution of her infant. In the context of parent–infant psychotherapy, this is important to attend to since projections that are processed in a nonoptimal way may contribute to enhancing the risk of a negative development in the child.

Winnicott (1953, 1971) first used the term *holding environment* to describe the optimal environment for "good-enough" parenting. A cornerstone in Winnicott's (1962) theory is the notion that at the beginning of life, the infant is in a state of absolute dependence of the mother. He posited that the infant experiences his or her communication with the mother as if "the breast is created by the infant over and over again out of the infant's capacity to love or (one can say) out of need" (1971, p.11). That is, in the baby's mind, the mother's breast is a "subjective phenomenon" (Winnicott, 1953, p. 94). This is Winnicott's poetic way of describing how the child tries to shape his or her world and how mother attunes to him or her. The word "holding" does not merely denote the mother's "actual physical holding of the infant, but also the total environmental provision" (1960, p. 589). The separating out of mother and infant is possible due to her ability to cope with the infant's dependence; that is, provided she is a "good-enough mother." Winnicott suggested that emotional problems develop when a person has been deprived of such holding environment in childhood. In the psychotherapeutic situation, a certain level of holding by the therapist was considered critical to the clinical progress.

Another way of describing the relationship between mother and infant is in terms of the mother's *bonding* with her child (R. Feldman, Weller, Leckman, Kuint, & Eidelman, 1999) or the infant's *attachment* to mother (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Shaver, 2016). While Klaus and Kennell (1976) elaborated on the term *bonding*, the concept of attachment is rooted in Bowlby's (1969, 1973, 1980) theories on the mother–child relationship.

When describing the relationship between the therapist and the patient, the concept of *therapeutic alliance* is often used. Bordin (1979) defined it as including ''three features: an agreement [between therapist and patient] on goals, an assignment of task or a series of tasks, and the development of bonds'' (p. 253). Contemporary psychotherapy research has emphasized the examination of the relational aspects of the alliance; thus, it has been an important variable in the understanding of psychotherapy process. Aspects such as patient characteristics and therapist activity have been the focus of empirical research studying the relationship between the alliance and therapy outcome (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Falkenström, Granström, & Holmqvist, 2013; Lilliengren, Falkenström, Sandell, Risholm Mothander, & Werbart, 2015; Lilliengren & Werbart, 2005; Lilliengren et al., 2014).

Another concept necessary to explicate to understand how the interviewed therapists conceived of what transpired between them and their patients is *transference*. It denotes the unconscious dimension of a patient's relationship with the therapist, especially what she or he brings into their relationship from past experiences. The concept was introduced by Sigmund Freud (1912) and then studied by him and generations of analysts to come. Transference phenomena have been thoroughly described in adult patients whereas arguments differ whether they also play a central part in therapy with children (A. Freud, 1926; Klein, 1952/1980; Sandler, Kennedy, & Tyson, 1990; Winberg Salomonsson, 1997). Concerning mother–infant work, its existence in the mother has been extensively acknowledged (Baradon, 2002; Fraiberg, Adelson, & Shapiro, 1975; Lieberman & Van Horn, 2008). In contrast, only Norman (2004) and Salomonsson (2013) and, to a modest extent, Watillon (1993), claimed that it also may exist in the infant, provided the analyst pays specific attention to him or her. Transference, both in its positive and negative forms (S. Freud, 1912) is interrelated with therapeutic alliance, but the concepts are not identical (Horvath, 2000). Therapeutic alliance is a narrower term that specifically covers whether patient and therapist feel that they are working toward a common goal in a good atmosphere.

The published quantitative outcome studies (Winberg Salomonsson, Sorjonen, & Salomonsson, 2015a, 2015b) have pointed to certain positive results of MIP on mothers and children. However, there also were some contradictory findings, inspiring us to further explore the therapeutic process. In addition, the therapist interviews enabled us to complement the findings from the earlier qualitative study of the mothers' experiences of MIP (Winberg Salomonsson & Barimani, 2017).

AIM

The aim of the study was to describe the therapists' experiences of working with mothers and babies in MIP treatment. A second aim was to obtain a richer picture of the therapeutic process in MIP.

METHOD

Data Collection

Six months after the treatments (MIP or CHCC) started, all mothers and therapists were interviewed (*Outcome interview*, see Figure 1) a second time. Data were obtained from 33 mother–child dyads in MIP treatment who participated during in the infant and the follow-up studies. To examine the experience of MIP as a treatment mode, transcribed interviews with mothers from 10 MIP treatments were selected with the help of a random number generator on the Internet and then analyzed in detail (Bryman, 2016), as reported

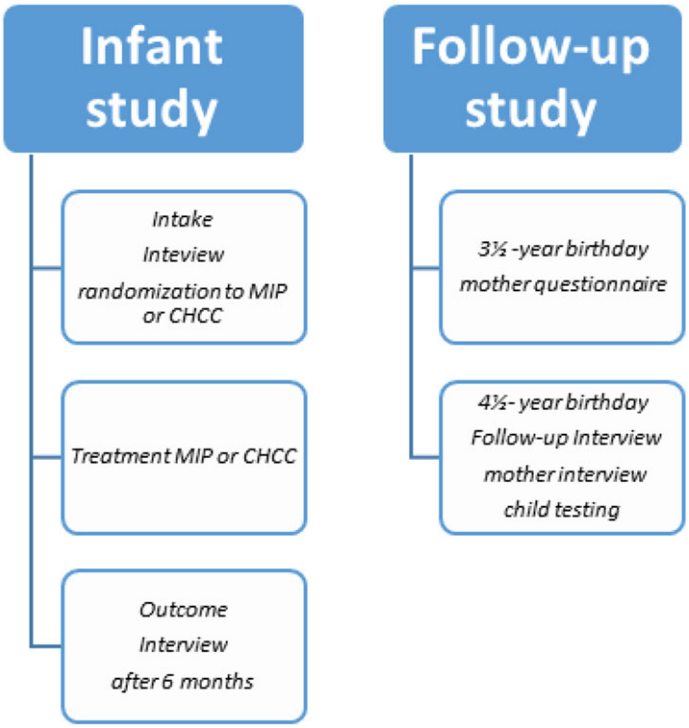

FIGURE 1. Design of the infant and the follow-up studies.

earlier (Winberg Salomonsson & Barimani, 2017). The present 10 therapist interviews correspond to the cases reported in that study. The treatment frequency was one to four sessions per week ($M = 2.6$). The number of sessions varied between 7 and 64 sessions ($M = 40$).

Interviews

The interviews with the therapists (and the mothers as well) were conducted by the researcher who initiated the RCT, an M.D. and an experienced psychoanalyst. He was not involved in MIP or discussions concerning MIP treatment. A semistructured format (Bryman, 2016) was used, which was expected to generate spontaneous emotional expressions and enable systematic data collection. Questions were posed in an order that suited the situation since it was important to follow the participants' lead to understand their experiences of MIP. The interviews were audio-recorded and transcribed verbatim by a project assistant. Each interview lasted around 1 hr.

The interviewer's questions were based on an implicit agenda that covered various areas: (a) how the therapist had experienced what was facilitating and obstructing in the MIP method, (b) how she had experienced the contact with the mother and the results of MIP, (c) what had emerged during sessions and how the therapist implemented MIP, and (d) what she thought about the contact with the infant and how she or he might have experienced the sessions. If the therapist expressed doubts or uncertainties, the interviewer explored these questions further to uncover latent ideas, positive as well as negative, about MIP.

Participants

Eight psychoanalysts (1 male) were involved in the RCT, of which data from 6 were used in this study. There were 5 psychologists and 3 psychiatrists. One therapist worked with four mother–infant dyads, 1 with two dyads, and 4 with only one mother–infant dyad. Since they conducted 89% of all treatments, they can be said to be representative of the entire therapist group. In this study, the participants are called "therapists." For the sake of confidentiality, all therapists are called "she" throughout this study.

Analysis of Data

Thematic analysis (TA; Braun & Clarke, 2006, 2012) was used. This is a method for identifying, analyzing, and reporting themes within data. A theme captures something important about the data in relation to the research questions. In this study, the themes thus were supposed to give information on the therapists' experiences of working with mothers and infants in MIP. In TA, themes can be identified in two ways: in an inductive or "bottom-up" way, or in a theoretical, deductive, or "top-down" way. Inductive analysis is a process of coding the data without trying to fit it into a preexisting coding frame (Patton, 1990). The themes are identified within the explicit or surface meanings of the data, and the analytic process involves a progression from description to interpretation, including an attempt to theorize the significance of the patterns and their broader meanings and implications (Patton, 1990). A simple example is when a child observes creatures in the air with flapping wings and learns that they have something in common: They are called birds. Deduction is a process of verifying data originating from theory. To continue the example is when the child sees an airplane, says "bird," and then learns what distinguishes birds from airplanes. In the analysis, we used a recursive process where movement back and forth was applied throughout the phases. In this way, both inductive and deductive ways of analyzing data were used. In the coding procedure, we used Open Code Version 3.6 (ICT, 2009). This software facilitates creating and organizing codes and themes, and to go back and forth in the material.

Braun's and Clark's (2006) TA phase description was applied in the analysis. In Phase 1, *familiarizing with data*, a research assistant transcribed verbatim the audio-recorded interviews. When uncertainties emerged during transcription, the first author compared the transcripts with the original audio recordings. In Phase 2, *generating initial codes*, around 200 codes were constructed and analyzed. They were then categorized into approximately 40 subcategories. In Phase 3, *searching for themes*, we discerned two main themes, "mother and infant together in MIP" and "cooperation in MIP," with three and four subcategories, respectively. This process is summarized in Figure 2. In Phases 4 and 5, *reviewing*, *defining*, and *naming themes*, the two main themes were

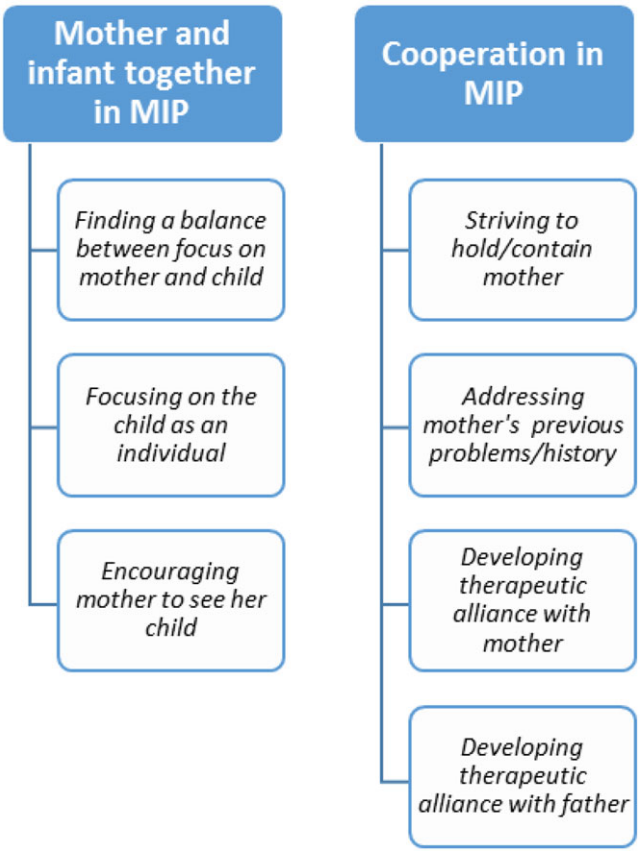

FIGURE 2. Mother and infant together in mother–infant psychoanalysis and cooperation in mother–infant psychoanalysis.

maintained. In Phase 6, *final analysis*, the analytic narrative was formulated and illustrated with examples.

Ethical Approval

The project was approved by the Regional Ethical Review Board in Stockholm, Dnr 2009/1334-32. Audio recordings of the interviews with the therapists were made only with their consent. Details have been changed in the text to safeguard anonymity for therapists and mothers.

RESULTS

Study participants reported that they felt *satisfied* with the MIP therapies in 5 of the study's 10 cases and *rather satisfied* in 4 cases. In 1 case, the therapist was not very satisfied and was critical of her own work. These assessments were similar to the mothers' attitudes toward MIP, as previously reported (Winberg Salomonsson & Barimani, 2017).

MIP

This section explains the main themes and subthemes and displays quotes from the therapists.

Mother and Infant Together in MIP

Finding a balance between focus on mother and child. Both mother and child took part in MIP. This implies that the therapist interacted with two separate individuals. The interviews revealed that the therapists (a) often turned toward the children in direct communication, (b) felt comfortable using this method, and (c) explicated that mothers and children could catch sight of each other during MIP sessions. Taken together, these factors were felt to have promoted a more optimal balance between the mothers and their babies:

> I said [to the baby]: "Now you are looking at mom. You are listening carefully to what she is saying . . . . Both of you are so clever and independent. You want to handle everything yourselves. And then your mom wonders if you are too independent. She also wonders about herself. She was wondering if you could be more close to each other." Then I said, "Now I see how you look at mom and listen."

One concern among the therapists was that they might have paid too much attention to the child. Sometimes, they perceived that the mother competed for space with the child. In these situations, the therapists felt that it was not easy to stay focused on the child:

> It has been difficult to work with the child. The mother interfered. It was like having two screaming kids in the room. It was as if I must give something all the time to the little one **and** to the mother.

At times, the therapist experienced some dissatisfaction in the mother due to the focus on the child:

> She had very high expectations of the meetings with me. So, she was disappointed that the child took up so much space. Her own needs were so vast. She didn't express her needs, and I didn't capture them. Yes, there was a reconciliation afterward. But the mother was still disappointed. She decided that she wanted to go back to her previous therapist.

Focusing on the child as an individual. The therapists described how the mothers initially seemed to project their fears onto the children. Such projections were thought to eventually diminish in parallel with the mothers beginning to regard their children as individuals in their own right. Some mothers expressed an unrealistically powerful anxiety that the child would die. In some cases, this seemed connected with the mother's firm feeling that she was incapable of taking care of and protecting her child. During treatment, some mothers came to understand that this was actually an extension of their own anxiety and that they had to manage this by themselves instead of projecting her fears onto the child.

The therapists reported that some mothers tended to see their children as narcissistic extensions of themselves. In other words, the child's individuality was thus denied:

> He was some kind of narcissistic extension of her . . . . It restricted him. In the beginning, it seemed as if she didn't want me to have contact with him. Either she held him in her lap, facing away from me—or she put him

in his baby seat to have eye contact with him all the time . . . Complete control of him! And it felt as if he didn't get any air—no space of his own. I talked a lot with him about this as well, that it's exciting to discover, to look around. "It looks like you're wondering what's behind this . . . you seem to be curious about who it is." That way, I could release him a little from her control.

The therapists noted the children's curiosity and interest when they spoke directly to them. They said the child looked with interest at them and seemed to understand some aspects of the communication:

I talked about the bottle and suggested that the boy might have to eat something else than breast milk in the evening. I said something positive about the gruel in the bottle. And then the boy protested immediately. It was so clear that he understood what I was talking about!

Several therapists said that during direct communication, some children manifested what they termed an *instance of a transference* from the baby to the therapist:

The girl and I made contact. But after Christmas, after we had been apart for a while, she became very indifferent toward me. Then I talked a lot with her about it. She demonstrated transference toward me. She had been so attached to me, and now she didn't want to come near me. This was an intense experience also for the mother. She said: "Yes, this can happen when you're separated for too long. It's incredible."

The therapists thought that for mothers who were prone to project their distress or unresolved issues onto their children, the technique of focusing on the children helped them relinquish their projections and understand more clearly who their children actually were. Mothers then saw them as individuals in their own right:

She understood that the girl did not have to feel like her. They were really two different individuals. We worked a lot with this—to regard each of them as an individual. Her feelings were one thing—those of the child another thing. Mother and child were similar but also different in many ways.

Sometimes, the therapists tried to help the children out of situations in which they had become involved, although the immediate point of concern actually did not center on the baby:

The mother started crying. Then I spoke to the child, who looked at the mother. I explained to the child that mother told me about her own problems and that was why she was sad. The child calmed down. It was as if the baby understood what the mother and I were talking about . . . . This occurred several times.

When the therapists were *focusing on children as individuals*, (a) the children were reported to be able to sleep in their own beds, and (b) the mothers began to see how their children were developing a broader range of emotions—they were no longer just "angry screaming kids."

Encouraging mother to see her child. Sometimes mothers expressed concern that their children would reject them. They often felt very guilty for feeling that way, and they also thought that the child's reason for rejecting them was some fault that they had committed. The therapists reported that they worked with these feelings. They also could detect a mother's ambivalence toward her child and help her understand it:

I think an underlying hatred existed [in the mother] toward the child. I connected it to the mother's hatred of her younger brother. And I could interpret [to her] that connection.

The therapists could expose the mothers' anxiety in situations in which the child expressed despair. One therapist said that a boy cried all the time because he was anxious that his mother was afraid of hurting him and that he would die. Another therapist worked via the child to reduce the mother's guilt feelings:

I wanted to get the mother to stop rocking him so rapidly. I tried to talk about it without blaming her. I told him: "Mom wants you to be calm and safe in that way but it seems difficult for you."

Often, the therapist acknowledged emotions and behaviors in both mother and child. The aim was to enable the qualities of their relationship to develop in a more warm, genuine, and sincere way. Some therapists described this work specifically in terms of strengthening the attachment:

It has been hard work to facilitate the attachment, working with the boy's separation anxiety that was aggravated by the mother's separation problems. Toward the end, the mother said: "Now he relates to me in a different way." The mother acknowledged that we did a proper job. I think she was right.

Cooperation in MIP

Striving to hold/contain mother. Therapists expressed an extensive understanding of the mothers' situations. Sometimes they described impulses to hold the mothers' emotions, which in turn could enable the mothers to hold those of their children. In this way, the therapists could help the mothers accept their children; they spoke about this phenomenon using phrases such as "She could lean on me," and "She triggered my caretaking or nurturing impulses." One therapist said:

I helped her reflect upon what had happened before and after the delivery, how stressful it was when the baby arrived. She got help to contain her threatening thoughts . . . . She had felt that the baby invaded her.

The therapists could often help reduce mothers' anxiety and thus become more relaxed in how they regarded their children. Several described how therapeutic support seemed to increase mothers' sensitivity to their children. One therapist talked about how the mother could listen to her baby's signals when she herself was supported in feeling more confident as a caretaking mother.

In several cases, the therapists were attentive to transference manifestations in the mothers. Sometimes it was about critical comments directed toward the therapist. More often, however, the therapists experienced a transference that was colored by the mother's longing for maternal care:

The mother yearned for a mother. Also fear but mostly yearning. She directed these emotions toward me. Our professional approach helps us interpret this as an instance of transference.

Addressing mothers' previous problems/history. Mothers' problems could sometimes be linked to the new situation of having become a parent. Often, however, the difficulties were deeply rooted in the mother's past, and now these earlier problems had surfaced again. Therapists talked about how they worked with depressive feelings and thoughts that emerged in the mothers with renewed energy:

She had such a low self-image, it had been that way as long as she could remember ... all this depressive darkness. She thought she could not bond with her child; she felt empty. Rather quickly, it became apparent that she felt very rejected by her little 6-month-old baby. That's how she interpreted it. She often perceived her baby's actions as rejections.

Therapists described how the mothers' depressive moods were alleviated during treatment and thereby triggered other changes such as feeling less anxious and becoming less controlling or terrified:

We worked with these monster images in her head, images not only of her child but also of herself as a monster. She was extremely frightened that she might repeat her own childhood history [when she remembered feeling nasty and rejected].

Some therapists mentioned that they were able to approach material that was not directly available at the conscious level, but deeper probing was not always easy during a series of sessions that was often limited:

She felt that she had to deal with what she described as a great sorrow within herself—and that she must do it for her daughter's sake. She couldn't identify the sorrow, but she cried when she talked about it. Then she was in touch with her feelings of abandonment, and she could see that the child might feel abandoned . . . . She could recognize it, and that was an important step.

Most mothers were reported to have talked about their own history, especially the relationships with their mothers. Some understood how they tended to reiterate their own mothers' way of caring for the child. Therapists reported that the mothers could look upon their early life histories in new ways. The mothers often showed insight and interest in how they carried childhood memories that now affected them in their motherhood. The therapists reported that they sometimes helped mothers see how problems due to early separations in their own lives could be associated with their present life situations:

I linked the mother's worries about having to eventually separate from her daughter to her own childhood [when she had had several separations]. Then she began to cry, and something was released inside of her.

Developing a therapeutic alliance with mother. The contact between mother and therapist developed during treatment, and both seemed to experience that they were doing a meaningful therapeutic work:

There was ambivalence, yet she was genuinely grateful when she ended treatment. A certain warmth developed between us. I believe the sessions meant a lot to her. She said: "I'm so happy and so tired." She didn't expect life to be nice or to spare her. Now she trusted that she could get help from others.

In some situations, therapists experienced a turning point in treatment when the mothers could talk directly about their deep anxiety:

And suddenly she said she had thought about killing herself. Then I reacted and got alert. I conveyed the seriousness of what she had said to me. It was a major turning point.

At other times, therapists described situations in which the therapeutic alliance was not optimal, which led to complications in treatment. In some cases, mothers' sensitivity required that therapist had to proceed with caution:

I've had to be careful with the mother; she was very easily offended. She had to have super-control of me and of her child. She set very high standards for herself; she must do things right all the time. As soon as I said something, she experienced it as negative criticism.

Therapists experienced that mothers sometimes expressed their negative transference by canceling many appointments. The clinicians now and then reported self-critical reflections such as having put too much pressure on the mothers or not being sufficiently empathic. They expressed disappointment when the mothers were unaccepting and shut out the therapist:

She was a professional and accustomed to being in control of situations and to tolerating a lot. She had gone through very difficult things, and she wasn't very open about it. I cannot say that I really understood her. There was no close and intimate contact with her. I never reached her.

Therapists also expressed frustration when they experienced that the mothers were insensitive and did not listen to their children's signals:

She did many things that irritated me. She was too fast with her son. As soon as he wanted something, she was there and gave it to him. As soon as he tried to make a single movement, she was there ahead of him.

Several therapists had greater ambitions than did the mothers about continuing treatment or increasing the frequency:

I'd been happy to continue working with her. I didn't think that we had come far enough. But she was satisfied. She wanted to quit and start working.

Developing a therapeutic alliance with father. Sessions often included work with the partner relationship. In half of the cases, the father took part in one or more sessions. The initiative could come from the therapist, the mother, or the father. The therapist experienced that a good alliance was established with the fathers and that the partner relationships deepened:

When the mother spoke up, then the father became even more sarcastic, and she said she did not accept these sarcasms. And when he came to me, he started talking about how sarcastic he could be—in an honest, sincere manner. He did not want to be like that. He didn't think it was good for their relationship and for their son.

In some cases, the therapists described how the mothers had difficulties letting in the father, to allow him to have a relationship with the child. Sometimes they could work on these situations with the father present:

The mother imagined that she had to protect the father from getting tired when the son cried at night. We discovered this in the session with the father present. He said he thought it was amusing: "Of course you get tired when you have children!"

MIP sessions sometimes took place with the entire family present, which helped them to develop as a family:

We arrived at a point when breastfeeding was working. The baby was on a pillow at the breast—and then breastfeeding worked. The father sat next to her. He was present but tired. They had just talked about fatigue and how fun it is to have a child. The father adjusted the pillow a little, and I felt that I wasn't needed. She was sleepy, so they talked about how nice it is to be in a baby carriage—and then the father joked and said that it would be nice to have a carriage for them both "so I could pull both of you!"

DISCUSSION

The results yielded two main themes around which the therapists' descriptions of the process evolved: (a) mother and infant together in MIP and (b) cooperation in MIP. In their work, the therapists addressed both participants and often felt comfortable in doing this. They thought it worked well to obtain a dialogue with both mother and child while also taking into account the mother's feelings of insufficiency and anxiety. The therapists also turned to the child in direct communication to help strengthen his or her sense of being a separate individual. They noted the child's curiosity and interest when they spoke directly to him. They also expressed that the baby seemed to understand some aspects of the communication. Several therapists even said that in these situations, some children manifested *transference* toward the clinician. Such manifestations contained positive elements such as the baby's interest or joy when looking at the therapist. There also were negative elements such as what was interpreted as fear of and anger with the therapist. The therapists addressed such reactions as transference manifestations by verbalizing them in direct communication with the baby. This is in line with findings by Salomonsson (2013) stressing that "the more we observe a direct negative infant transference, the more we need to address the baby" (p. 788). The interviewed therapists also observed that the mothers developed transference reactions toward them. Sometimes the therapists just noticed these reactions. Here, too, there were positive manifestations such as gratitude and trust. At other times, negative attitudes dominated, which made it necessary to make direct interpretations of the mother's suspicion, irritation, disappointment, and so on. As already mentioned, mother's transference can be described both in relationship to the child (Fraiberg et al., 1975) as well as to the therapist (Baradon, 2005).

One of the therapists' major aims was to try to help the mothers develop a more optimal balance in *bonding* with their child. This is in line with several studies that have shown the risk for the infant's further emotional development if the mother is unable to bond optimally with her child, for example, when she suffers from postnatal depression (Giallo, Woolhouse, Gartland, Hiscock, & Brown, 2015; Goodman et al., 2011; Moehler, Brunner, Wiebel, Reck, & Resch, 2006; Stein et al., 2014). In this sample, the difficulties in bonding appeared to be of a different kind than that in the referred studies. In some cases, the problem in the relationship was not the mother's depressive affect, per se; rather, she seemed to look at the child as a narcissistic extension of herself. Similar processes were described by Cramer and Palacio Espasa (1993) as the mother's projections onto her child of various personality traits. Such projections made it difficult to see the child in his or her own right. In other cases, mothers seemed distanced from their children and expressed the apprehension that it was actually their children who were rejecting *them*. To describe the projections onto the child, Silverman and Lieberman (1999) use the concept "negative attributions." The impact on the child was noticed by Lieberman (1997): "Gradually, the maternal attributions shape the child's sense of who he is. When this occurs, children come to see themselves and to behave in the ways their mothers see them and expect them to behave" (p. 286).

Therapists also focused on the child's expressions of *attachment* toward the mother. They mentioned that many mothers had difficulties in helping the child establish a secure attachment. In contrast, they did not detail the children's attachment patterns. Modern attachment theory has posited four patterns; secure, avoidant, ambivalent (Ainsworth et al., 1978) and disorganized attachment (Solomon & George, 1999; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). It is important to observe that although the therapists in this study used the term *attachment*, they did not apply the subcategorizations when they described the infant's clinical disorders or the therapeutic technique that they used. Instead, they tended to describe the infant's mood and behavior in everyday terms such as "anxious," "cautious," "vigorous," and "confident." When defining their technique, they rather relied on concepts from object relations theory, such

as holding and containment, and from classical psychoanalytic theory, such as projection and transference.

It is possible that the therapists' use of the term *attachment* when describing the clinical work tallies with a comment by Everett Waters, a renowned attachment researcher, and his coworkers (Waters, Corcoran, & Anafarta, 2005). They reiterated that "attachment theory is rather limited in the domain it addresses, focusing only on the secure base facet of a specific subset of relationships" (p. 81), for example, between the infant and the caregivers. The interviewed therapists said they heeded the importance for the child to develop a more secure attachment with the mother. An important question is whether they used the attachment concept in the same way as it is being used by attachment therapists and researchers. First, they were trained in the Freudian and British object relation tradition (Britton, 2004; M. Feldman, 1994; Joseph, 1985) whereas the attachment literature played a minor role in their education. It is thus reasonable to assume that they were less familiar with and knowledgeable about attachment theory. It also is possible that they subscribed to the quite common critique among psychoanalytic authors that attachment theory does not sufficiently take into account "the mother's unconscious conflicts and fantasies" or the intrapsychic processes involved in "the infant's interpersonal behavior" (Blum, 2004, p. 548). Other articles arguing that this theory downplays nonobservable, unconscious motivations beneath human behavior have been published by Gilmore (1990) and Zepf (2006).

In parallel to speaking about the infant's attachment to the mother, one also could conceive of mother's attachment to the analyst. Bowlby's (1988) notion, that the therapist optimally should provide a "secure base" for the patient for therapy to be successful, has been emphasized by researchers in the field (Farber, Lippert, & Nevas, 1995; Farber & Metzger, 2009; Mallinckrodt, 2010). The link between the patient's attachment to the therapist, therapeutic alliance and outcome of treatment has been studied (Lilliengren et al., 2015). However, in this study, the clinicians only talked about attachment in the mother–infant relationship, not in the mother–therapist relationship. The fact that the latter relationship was conceived of in terms other than attachment concepts did not imply that the therapists neglected the implications of this relationship. They tended rather to word it in terms of therapeutic alliance and transference.

Most often, the therapists expressed that they had succeeded in obtaining a balance in their focus on mother and infant, respectively. However, sometimes they noticed that a dominant focus on the child could lead to competitive actions from the mother in striving for individual attention and emotional space. This phenomenon also was reported by some mothers (Winberg Salomonsson & Barimani, 2017). As one of the mothers in the referred study expressed: "There was so much focus on the boy . . . I felt a need to talk about my feelings. I had thought that I would talk more about myself. I'm the one with problems."

Most therapists indicated that they focused on the mothers' depression. Their guilt-feelings, common in mothers with newborn infants (Rotkirch & Janhunen, 2010), also were addressed. These feelings could sometimes be linked to the new situation of having become a parent. At other times, they were deeply rooted in the past, and now problems had surfaced with renewed force. During sessions, mothers worked with issues relating to their early history and were helped to look at it in a different way. In an earlier study (Winberg Salomonsson & Barimani, 2017), mothers reported similar experiences from their therapies, and in this way, they could liberate themselves and break a transgenerational pattern (Fraiberg et al., 1975; van IJzendoorn, 1992). Fonagy, Steele, Steele, Moran, and Higgitt (1991) reported on how parents' capacity to reflect on their own childhood predicted the child's attachment mode at 12 months.

Study participants often talked about an impulse of *holding* (Winnicott, 1960) the mother. This, they thought, could in turn lead to the mother being able to hold her child. The terms *to hold* and *to contain* were used both in the mother's relationship to her infant and the therapist's way of relating to the mother during sessions. When we compare with interviewed mothers' views (Winberg Salomonsson & Barimani, 2017), they often perceived the therapist as being compassionate, warm, and listening. This seems to be the mothers' way of describing their feeling of being held by the therapist. One of the mothers in the referred study expressed it in these terms: "She was like, well not a mother, but a bit like a mother could be."

The therapists also talked about *containing* (Bion, 1962) the mothers. In Bion's theory, the infant is aware of the maternal object from early on and can use primitive mechanisms positively or negatively when interacting with it. He stated that it is in the "interplay through projective identification between the rudimentary consciousness and maternal reverie" (p.309) that the infant's development is played out.

This leads to different ways of describing the clinical situation. The therapists used the terms *holding* and *containing* alternatively to describe how they related to the mothers. Sometimes these two terms are looked upon as very much alike. Ogden (2004) concluded that both concepts "represent difference analytic vertices from which to view the same analytic experience" (p. 1362). Another view was presented by Caper (1999), who claimed that in holding, the analyst identifies with the patient. In contrast, he suggested that containment goes one step further and "presents the patient with an object that through the use of interpretation has gone beyond identifying with him" (p. 154). Containment thus implies not only receiving the patient's anxiety but also translating it back to him (Salomonsson, 2007a). Instances of this process were when the therapists verbalized the mothers' feelings of rejection and sorrow and of having a monster inside.

A positive *therapeutic alliance* was often described by the therapists as an important aspect of the treatment. In some situations, however, the alliance seemed less optimal, which led the mother to wanting to end treatment early or to seek another therapist. Such situations also were described in similar ways from the mother's point of view, as reported earlier (Winberg Salomonsson & Barimani, 2017). The work in analysis also included the relationship to the father, and in half of the cases, he

took part in analysis during a shorter period. In these cases, therapists often found that a therapeutic alliance with the father also developed.

In a majority of cases, the therapist reported a positive alliance with the mother, but in a few cases they reported disappointment. This occurred, for example, when they reported difficulties in reaching mother or vexation with her ways of handling the baby. Maybe this phenomenon could be linked to the fact that in these cases, the mother was frustrated that the therapist's attention was directed toward the baby, at her expense. To be true, the constructor of the MIP method (Norman 2001, 2004) emphasized the contact with the infant. In these cases of mutual disappointment, one might speculate that the therapists followed his writings at the expense of their clinical intuition.

It seems obvious that therapeutic alliance is important to achieve good results in treatment. Indeed, therapeutic alliance has been found to predict psychotherapy outcome in numerous studies (Falkenström et al., 2013; Falkenström, Granström, & Holmqvist, 2014; Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). This has often been interpreted that a good alliance is causing better outcomes, and that it is important to work directly in the session with the alliance, especially if it is poor (Safran & Muran, 2000). However, we may notice that rupture in treatment, defined as "a tension in the collaborative relationship between patient and therapist" (Safran, Muran, Samstag, & Stevens, 2002, p. 236) is not always noticed by the therapist (Hill, Thompson, Cogar, & Denman, 1993). In their review, Ackerman and Hilsenroth (2003) reported on therapists' contributions to the development of the alliance. They found that a therapist's personal attributes such as being flexible, honest, respectful, trustworthy, warm, interested, and open were found to contribute positively to the alliance. Therapist techniques such as reflection, facilitating the expression of affect, and attending to the patient's experience also were found to contribute positively to the alliance. Ackerman and Hilsenroth (2001) also reported some personal attributes in the therapists and activities during sessions that negatively influence the therapeutic alliance, such as being rigid, uncertain, critical, distant, and distracted. Moreover, therapist techniques such as overstructuring the therapy, inappropriate self-disclosure, unyielding use of transference interpretation, and inappropriate use of silence also were found to contribute negatively to the alliance.

In the present study, each therapist–mother pair seemed to assess their satisfaction/dissatisfaction with treatment in a similar way. Note that the two adult respondents reported similar feelings toward each other and also the results of the therapy. One difference was salient, however; the therapists often expressed that they would have preferred longer treatments with a higher frequency. This could imply that they had higher ambitions than did the mothers. They noted positive changes in the mother's handling of the baby, which of course was an important aim of the treatment. In addition, they sometimes would have taken one step further, that is, to more firmly consolidate mother's internal representations of her child. Some therapists also expressed a wish to work further with mother's personal problems that had existed for a long time and now had emerged with renewed strength in connection with parenthood. The mothers had different motives for ending treatment (Winberg Salomonsson & Barimani, 2017). Sometimes they were content with what therapy had given them. They could now better cope with their new life with a baby and did not want to go deeper. For some mothers, it was time to reenter the workforce, and they had to adapt to society's demands.

Methodological Considerations

Concerning the trustworthiness (Lincoln & Guba, 1985) of findings, the present study applied credibility and dependability concepts (Graneheim & Lundman, 2004).

Credibility. To deal with how well the themes represent the data, the two authors worked independently with the data until agreement was reached; quotations from the transcribed text further illustrate the study's credibility. The study was limited to 6 of 9 therapists in the whole group. On the other hand, these therapists analyzed 89% of all MIP cases. In the present study, participants were both male and female, psychologists and psychiatrists. The amount of data was sufficient for fulfilling the research objectives.

Dependability was substantial because the same interviewer interviewed all therapists and used the same guide for questions. The interviewer was not in any way involved in treatment or discussions concerning MIP.

Limitations. If several interviewers had been employed, this might have yielded further insights and influenced follow-up questions from more vantage points. The first author and the interviewer are psychoanalysts, and their allegiance (Luborsky et al., 1999; Markin & Kivlighan, 2007) should be taken into account. Interviewers with other professional backgrounds might have been able to apply a more fresh and naïve perspective on the therapists' reports. On the other hand, the second author is a midwife and thus contributes with an "outsider" perspective. A detailed interviewer's guide was developed, and the data analyses are described in detail with numerous quotations. The interviewer did not analyze the data. All these arrangements were made to reduce allegiance effects. During the analysis, another research team member participated in the coding procedure together with the two authors. This member is an experienced psychologist who is proficient in qualitative research.

Conclusions and Clinical Implications

The therapists reported that the MIP method with its focus on the infant worked well in most cases. However, some mothers seemed to need more individual space and attention from the therapist. In these cases, it would be important to adapt the method to these mothers. The MIP method could probably benefit from more active attempts to develop a therapeutic alliance with mother.

According to the therapists, the father had an important function for mother and child. In those cases where a therapeutic alliance developed with the father, this contributed to the

development of the whole family. It would be useful to develop the method to also take the father into account to help in the development of the entire family.

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