THE "HOLDING RELATIONSHIP" IN INFANT MENTAL HEALTH

(or) THE "HOLDING RELATIONSHIP" IN WORK WITH YOUNG CHILDREN AND THEIR PARENTS

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Abstract

If we had to distill all that we've learned from our work of the past 80 years—in dyadic psychotherapy, child and adult therapy, casework, or in any of the several fields allied to infant mental health—into the single thing that matters most, what would it be? The author proposes one idea so simple it scarcely seems worthy of great intellectual or clinical consideration, while simultaneously standing as the thing we cannot live without. Or, perhaps more to the point, it's the one thing our patients and other service users cannot live without: "holding."

The author tracks its emergence in the work of others, from Winnicott to the present; gives it practical definition; and offers examples of it from our work with babies, young children and their parents, in the hope that little doubt will be left about its meaning.

Our Odd Psychoanalytic Heritage

When D.W. Winnicott traveled to Oxfordshire each Friday to consult with the staff of one of the hostels that had popped up to look after children whose parents could not care for them under the awful war conditions, he was brimming with knowledge, but not so much with the sort of handy arrogance that consultants often employ. As a pediatrician and psychoanalyst, he seemed a perfect choice to help the staff know what to do with these kids. In actual fact, he didn't really know, and it's a grand testimony to his wisdom that he didn't pretend. Instead, he *looked.*

The staff complained that he wasn't giving them what they wanted. He wasn't telling them what to *do* with kids that were hurt and lost and who challenged them every single day. Sometimes he just sat with the kids and played with his pipe. Sometimes he just watched the goings-on. Sometimes he asked the staff about everyday life in this place that was designed to give special care to lost and traumatized children who had been evacuated from England's cities—particularly after the Blitz that began in September, 1940—but who couldn't adapt to a regular "foster" placement.

Ever so slowly—and with much guidance from the hostel social worker, Clare Britton, who would later become Mrs. Winnicott—the idea emerged in everyone's minds that the most important part of the treatment plan would be in everyday interactions with the children that were marked by stability and empathy (tho' no sentimentality; Winnicott would not

hear of it). Years later, Clare would finally give this a name. She called it "holding" (Winnicott, C., 1955, p. 151-52), and she defined it this way:

> ***We* become*, so to speak, a reliable environment, which is what they so much need: reliable in time and place—and we take great trouble to be where we have said we would be at the right time…***
>
> ***We can "hold" the idea of him in our relationship so that when he sees us, he can find that bit of himself again which he has given us. This is conveyed by the way in which we remember details and know exactly where we left him in the last interview.***
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> ***I have deliberately used the world "hold" in what I have been saying, because, while it obviously includes "acceptance" of the client and what he gives us, it also includes what we do with what we accept* (Winnicott, C., 1955, pp. 151-52).**

Meanwhile, in another suburb of war-torn London, a similar population of very young, displaced children found themselves in the company of equally determined but unprepared caregivers and consultants, whose number happened to include Anna Freud and Dorothy Burlingham. They were about to discover another iteration of "holding".

The three Hampstead Nurseries where they worked were supported by American philanthropy, through the Foster Parents Plan for War Children, Inc., a connection that created channels for our learning early on in the USA about what Freud and Burlingham were seeing, and what interventions they were trying. These children were also separated from their parents, and were struggling to adapt to unfamiliar environments with stranger-caregivers with whom they were both trying to make—and to resist—intimate connections. As the children clamored for more individual attention, the nursery staff worked to discourage such "favoritism". The children, disappointed at their inability to find a "substitute mother" among their caregivers, began to appear listless and to refuse food. Lags in development began to appear.

This must have been both troubling and embarrassing for Sigmund Freud's youngest daughter. Perhaps out of desperation, an experiment was launched. The children would be divided into small family groups with four children and one primary caregiver in each. Anna Freud later wrote:

> ***The result of this arrangement was astonishing in its force and immediacy. The need for individual attachment for the feelings which had been lying dormant, came out in a rush…But the reactions in the beginning were far from being exclusively happy ones. Since all these children had already undergone a painful separation from their own mother…To have a mother means, to them equally, the possibility of losing a mother; the love for the mother being thus closely accompanied by the hate and resentment produced by her supposed desertion. Consequently, the violent attachment to the mother substitutes…was anything but peaceful…They clung to them full of possessiveness and anxiety when they were present, anxiously watched every one of their movements towards the door of the nursery and would burst into tears whenever***

> ***they were left….For a while we really thought that our grand innovation had been a great mistake*** **(Freud, A. and Burlingham, pp. 158-159).**

No one quite knew whether this condition of chaos was better or worse than the condition of lethargy that preceded the initiation of the little experiment. But momentary chaos was not the end of the story. Within a couple of weeks, "…with the realization that their new mother substitute really belonged to them, reappeared as often as she disappeared, and had no intention to desert them altogether, the state of frenzy subsided…" (Freud, A. and Burlingham, pp. 159-160). The children began to eat. Developmental regressions disappeared.

The children had been *held*—a state that had little to do with being touched, and everything to do with being with an available other who was sturdy enough to create an environment of safety and stability and certainty.

None of this qualified as a specific strategy, or even as a new theory of intervention with very young children.

But it did seem to point to the possibility that "being there" could be *the* most important part of treatment with lost children. It was consistent with Winnicott's unrelenting assertion—very much in opposition to the perspectives of his psychoanalytic colleagues of the day—that what we do *around* the child may be even more important than what we do *to* the child. This was a perspective that continued throughout his career, "…as he searched for ways to apply psychoanalytic theory to difficult situations where psychoanalysis [itself] would involve 'wasting our time and someone else's money'" (Kanter, 1990, p. 25). Imagine the furor.

In the early 50's—long before she met her first blind child, and even longer before the term "infant mental health" first crossed her lips—Selma Fraiberg was melding social work and child psychoanalysis into a set of principles about how to *be* with young children who were suffering. She began with the basics of engagement, asserting that any therapist or caseworker must know that young children "…hate being questioned" (Fraiberg, 1952, p. 377) and that the first priority of any child in a therapy room was his determining his own safety. If Jimmy picked up a broken toy fire truck and indignantly demanded to know who broke it, Fraiberg's focus on Jimmy's internal life allowed her to know that he wasn't really interested in an answer to his question at all. He wanted to know what happened to the child who broke it. He wanted to know if he was going to be held, or punished, or simply misunderstood in this room.

And so Selma Fraiberg would respond: "Oh, one of the kids broke it, accidentally, but I didn't get mad" (Fraiberg, 1952, p. 377). Not quite sure about what her answer meant for his future with her, he would ask if she would be mad if he did it on purpose.

Again, she went straight to his interior life: "I wouldn't like it, but I don't get mad at children" (Fraiberg, 1952, p. 377).

Her answer meant that Jimmy just might feel held. The central question of the stability and reliability and safety of his environment was addressed, which might mean that the young

analyst would be given a chance. Jimmy might even answer a question. It wasn't psychoanalysis, *per se,* but it was informed by psychoanalysis. As Fraiberg would later lament: "I do not think one can 'analyze' a love-starved child's need for love any more than one can 'analyze' a starving man's need for food" (Fraiberg, 1962).

So we shouldn't have been surprised—tho' we were, as we would be at almost every juncture of her scientific and clinical life—when Fraiberg waltzed into the home of a blind child for the first time with this same brand of modesty and curiosity, focusing on what was really needed, rather than on what she happened to feel equipped to give, at the moment. Indeed, Fraiberg acknowledged that, while she noticed that the clinical picture with these children closely resembled autism in the sighted—something she knew about—she actually had no idea what was needed, nor what she had to give. She melted our hearts with her testimony to this state of blissful readiness to learn: "We were in no way prepared for the impact of these blind children on our eyes" (Fraiberg, 1970, p. 102). Seeing the disconnectedness of the sightless children from the world outside their bodies, she was at first convinced that the children had suffered brain damage. "I think I would have rather believed anything than to consider that something in human experience could produce these automatons" (Fraiberg, 1970, p. 102).

She saw "…personalities frozen on the level of mouth-centeredness and non-differentiation. There was no 'I' or 'you'…no sense of a body self and 'something out there'" (Fraiberg, 1970, p. 103). The result? "All of this was of a piece with the most distinguishing characteristic of these children—the absence of human connections...[M]other was barely distinguished from other persons; her comings and goings went unnoticed. There were no cries to summon her, no sounds of greeting when she appeared, no signs of distress when she left" (Fraiberg, 1977, p. 10).

The hands of these children were also blind. They did not reach out for objects in order to attain them. It would only be logical, then, that the children did not move toward objects—both inanimate and human—which meant, for many, that they did not walk, or even crawl.

Now what does any of this have to do with *holding*, and with Fraiberg's discovery that it was central to intervention with blind children, and with their mothers?

Listen to her muse about nine-month-old Toni, blind from birth:

> ***Vision keeps the baby "in touch" with his mother and with the world of things, giving continuity to experience. The sighted child at nine months does not have to be continually held by his mother or talked to by her in order to "be in touch" with her.***
>
> ***But when Toni could not touch her mother or hear her mother's voice, she was robbed of her mother and robbed of a large measure of the sensory experience that linked her to the world outside of her [own] body* (Fraiberg, 1970, p. 112).**

Toni could neither *hold* her mother nor *be held* by her, unless someone could teach Toni how to discover objects in the world out there, and retain those objects in her mind. Until that happened, Toni would neither *feel held*—which is to say: protected, known, in reliable

partnership with—nor would she be able to reward her mother by moving towards her, showing preference for her, nuzzling into her.

So Fraiberg set about the tedious task of introducing Toni to objects she could not see, and then seducing her into touching and smelling them, and then into searching for them and rejoicing in finding them, when Fraiberg placed them just out of reach. Fraiberg held Toni's environment up for her, inviting her to discover it. In the process she was also holding Toni, in a way even her mother had not known to do.

Perhaps it couldn't have been anticipated that Toni's mom—and many other mothers of blind babies—would *themselves* require *holding*. These moms were not *seen* by their babies, and that constituted a rarely-articulated loss for these moms. Someone needed to hear these mother's stories, to assure them that their losses were substantive, and to reassure them that their babies needed them, still. They needed to be introduced to their own babies, and to notice that their babies were now looking for them.

Psychotherapy in the kitchen was born. At its heart was a simultaneous clinical *holding* of both mother and baby.

Some of the blind babies, like Peter, had begun to engage in behaviors that seemed overtly rejecting, if not aggressive. Peter bit and clawed at his mother's face and neck. Had the observer not been Selma Fraiberg—ever curious, slow to diagnose, eager to see the whole picture—Peter might have been seen as deviant. The chorus of people who believed moms of blind children in that era should institutionalize their babies might have gained one more singer.

But this psychoanalytically-trained scientist/observer was a master of *holding,* while never using the word: holding the data in suspension, holding the infant-parent dynamic in her mind while imagining all the possible explanations, holding back on the urge to interpret too soon.

This piece of data particularly caught her attention, and complicated some of the too-easy and premature diagnoses that might have come to mind: when she took Peter into her own arms, meaning to give mother a break from his assaults, Peter "…seized me and clawed me," Fraiberg said (Fraiberg, 1977, p. 33). She responded to these painful assaults by moving away, maintaining contact only with her voice. Peter would then appear lost, his affect would flatten, and he would begin swaying and rocking. Mother and Fraiberg watched the strange sequence together, allowing mother to wonder, for the first time, if she had been mistaken about Peter hating only *her*.

The oral-incorporative function of the mouth in a blind child—and the possible transfer of this function to the hand—was not a new concept to Fraiberg. But she had never before turned this understanding into an interpretation-in-the-moment. Guided by her psychoanalytic understanding of the child's hunger for a reliable object, and her imagination about what it might be like trying to retain an object that could not be seen—and, therefore, not held in the mind—she said to Peter, as he was biting and clawing at her,

"You don't have to be afraid. I won't go away." Peter, she said, released his "death grip" at once (Fraiberg, 1977, p. 33).

It was a startling moment. Peter's mother found herself suddenly looking anew at a behavior "…she had always interpreted as aggressive and now began to understand as a kind of inarticulate terror" (Fraiberg, 1977, p. 33).

Later in the session, when Peter exhibited the awful and familiar clawing and biting behavior directly with his mom, the pioneering analyst—surely unaware that she was about to open the door to a brand-new clinical and developmental field—spoke to Peter, once again: "You don't have to be afraid. Mother will not go away" (Fraiberg, 1977, p. 33). Peter stopped, again. Mom was flabbergasted, not only at the strange connection that had been made, but by how close to him she began to feel, after this simple interpretation. Behavior changed; attachment got a boost. It was "like magic," the mother said.

Mother and baby had both been *held*.

It would be some years before we began to conceptualize the act of holding as a worthy element of early intervention—as, in fact, a necessary context for everything else we do in infant-parent psychotherapy and casework. We saw each other do it, but we forgot to name it, which meant that we failed to give it value. The result was that we allowed ourselves to emphasize diagnosing, giving guidance, teaching parenting skills and engaging in other more easily-repeatable behaviors while missing the element that just might give it all meaning, and might provoke healing.

What Holding Looks Like

You may notice that we've gotten this far without naming the behaviors associated with holding. Holding is, indeed, something we *do*, but it's not something we do according to a rule book. We don't even do it the same way each time. It's as finely-tuned as any other disciplined clinical or casework intervention. It's guided by the specific patient or service user, which means that everything depends on our attunement to that *particular* patient or service user. According to Winnicott, a useful prototype for holding is the mother-child relationship, in which the mother first becomes sensitized to the baby by feeling herself in her infant's place. This "…deep empathy with the baby's predicament" creates a "facilitating environment…in which her infant may be able to *be* and to *grow*," Winnicott said (Winnicott, D., reported in Abram, p. 261).

Holding asks us to *carry* the experience of the patient or service user gently in our hands, keeping confidences, defending the patient or service user against those who would disrespect her, lifting up his story as if it were our own. Holding means *speaking* of, and writing about, the patient or service user with both dignity and an eagerness to treasure information with which we've been entrusted. The pull to *hold* makes us behave oddly, at times, demonstrating devotion when it looks strange to do so. Parents refer to a similar thing that erupts in them, more or less separate from their ability to control it, as the

emergence of "Mother Bear". It seems to be a state in which nothing whatsoever exists except the child's pain, and the parent's determination to *be there.*

Any effort to nail down what holding *is* must include clarification about what it *is not.* For example, it is not the same as *caring*, which might easily be understood as an attitude or even as a personality trait, and might be claimed by most anyone, irrespective of actual behavior. Holding is also not about being *nice*, as a thing in itself; indeed, some acts of holding may appear to be anything *but* nice. Under certain circumstances, the demands of holding may make us appear brutal, may make us constrain, may be confrontive.

For example: I once listened as a teen mom described the living circumstances in the home she shared with her baby, her brothers, and her dad. Almost as an aside, she mentioned that there was no door on her bedroom, as her father had recently removed it. She did not appear to be pointing out a violation, which, of course, put me on alert: why would a young woman not even notice such an erosion of her privacy?

In a conversational style, she mentioned that she was hoping to see the father of her baby that evening. She added that her dad had agreed to her having a date, as long as "Well, you know…". I didn't know. This was my first home visit. Already a bit dumbstruck by the volume of things I didn't know about this adolescent mom and her baby, and the implications of all those things, I asked if she were saying that there were house rules about what she must first do before she went out on a date.

Her affect changed only slightly, but just enough for me to notice the replacement of the flatness and matter-of-factness on this little girl's face with something else. Something to which she was unaccustomed was happening, as she considered whether or not to tell me.

It wasn't exactly a "house rule," she said. It was just what daddy needed from her. He would be perfectly happy to allow her a date for only the token payment of her performing oral sex on him before she left. It was just how things were, and had been for years. When her mom died, she said, she sort of became the woman of the house. There was a strange and nearly-pitiful look of impotence and vague sadness on her face.

I found myself in the presence of a different person than the one I thought I had met when I first arrived: now I saw a kind of raggedy victim who was also a child-mother. There was precious little time to muse on this revelation. Her dad was coming off his shift at the plant in the next few minutes. As if suddenly aware of the implication of what she had just told me, she panicked. I musn't tell anyone! And I should be gone before he got home.

She so desperately needed to be held, but I was quite certain that none of the usual varieties of holding were right in this moment. I think she could tell I had no intention of complying with her understandable and terrified demand that I agree to silence. I was going to *hold* her, driven by a near-brutal determination to protect her, even against her will. I explained that I would very much like her to listen in on the phone call I was about to place to the

authorities. I pledged to stay with her when—any minute now—her dad came home, but how could I possibly justify putting her in this position? Arguably, what I was planning to do was almost as bad as the abuse. And, of all things, I was yet another man telling her how things were going to be. I applauded the fury that was rising up in her, but held firm to my commitment to *hold* her, safe from her father's next round of anticipated assaults.

It has to have been one of the hardest, and meanest, things I've ever done. She did listen in on the call, dad was late, and we did get her and her child out of the house. She was made safe, for the moment. I so wish I could testify that all was well after that, but we all know it wasn't. I can't even be sure that my version of holding was the right version, at that moment and on that day. Perhaps dad's rage would wipe out any hope for her safety. Perhaps dad would halt her frail testimony with threats and manipulation. Even if none of these outcomes obtained, she still faced coping with losing her dad, having already lost her mother, years before. And she still faced the monumental task of becoming a parent to her own infant child. My holding couldn't stop merely by getting her out of the house, and her dad out of her bed. I could have to figure out what the next act of holding must be.

Perhaps we will need to hold anger. Indeed, since our job is to attune to, and hold, whatever is *there* in the patient or the service user, we need to be prepared for a variety of profoundly negative transferences, or even objective rage. It's not that we must volunteer to become punching bags for angry children, or for moms or dads in our care. But we do agree to temporarily stand—with sturdy non-reactivity—as a reliable hate object (Ferguson, et al, 2020a), while a patient or a service user behaves, figuratively, "….almost like an uncontained child, flailing arms and legs everywhere" (Ferguson, et al, 2020b, p. 13).

If we understand this, we don't see the father glaring ominously at us from the front porch, broom or stick in hand, as we arrive for a home visit, as a threat, but as a crying child, perhaps trying to tell us how terrified he is that we might be there to hurt his family. We *hold* those feelings, even before we know what they are. We don't react; we don't correct; we don't shame; and we don't turn away. We *hold.* Our empathy is aroused, our scientific curiosity enlivened, our ego set afire with determination to do what is utterly unnatural, at least in the non-therapeutic world. *Holding* creates a context for behaving oddly. Holding asks that we manifest devotion to the raging man on the stoop.

We may be required to hold the ancient culture of the family, their known and unknown history. Holding, after all, does ask us to *remember* what we've been told by the child or the parents, and to express our memory in specific acts of care. In the process, we deeply compliment the patient or service user by recalling details that are important not only to diagnosis and treatment, but that are *important to the person,* even if not recoverable in the moment.

For example, if we were faced with a suicidal Native Alaskan child, would we commit to remembering what we know—or should know—before we wade in? Would we take care to spot his great grandfather in the crowd of children torn from their parents by arrogant

white Christians, noticed in a family photo? Would we be able to conceptualize what un-nameable, centuries-old sorrow the child is now bearing? Because if we can't *hold* this child in this way, including holding the story of his culture, then we can't help this child.

A young Alaskan boy tries to hurl himself off a ledge, during a deep wilderness experience to which he was referred after persistent failures to reach him with standard mental health treatment. He has been tagged with Oppositional Defiant Disorder, and has been both beaten and sexually molested by his alcoholic father. He is episodically mute and he regularly engages in both violence against others and self-cutting. He is tackled in the middle of his suicidal jump by a gifted young psychologist whose questions are shaped by mindful awareness of the world from which this boy came, going back two hundred years—and a dedication to holding all of it. Clutching the boy tightly, this young therapist in the woods begins a strange *holding* inquiry—the kind that demonstrates a devotion to the soul of a child who can't even name why he feels so tortured: "What *happened* to you? What happened to your heart? What happened to your people?" (Trout, 2015, p. 6).

The conversations with this boy and his family in the days following his attempt to end an unnameable pain will not be about proper diagnosis, but about the countless losses in their culture, and the re-discovery of ancestral stories, hopes, and values. The clinician knows just enough about the culture, and this family, to guess that no one has talked about their sorrow in generations. His reactions to the boy, and to the suicide attempt, make clear that he is prepared to hold the whole story. Evidently, it's time for it to be told to a white person.

The Many Iterations of "Holding"

What do you suppose would happen if we paid special attention to supporting a mother's *holding* of her baby while he is still inside her? What might it mean for the mother-infant bond if communication could begin this early, creating a "facilitating environment" for the baby as mom grows acquainted with the baby's internal life? It turns out that a psychoanalyst in Hungary—whose work is being carried forward by a German colleague—worked out a facilitation to support just such prenatal communication. Followup with several thousand births showed rather astounding results in, for example, reduced c-section rates and depression, and soaring maternal self-efficacy (Schroth, 2010). But perhaps such results only suggest the beginning of the possibilities for mothers and fathers and babies discovering each other, holding each other, establishing ways of communicating with each other.

For example, how might such prenatal *holding* by mother become part of a unique and gentle intervention when the baby inside experiences the death of a twin, or the awful fight mom and dad just had, or the ambivalence in mom that precludes her making progress in delivery? What difference might such early *holding* make to birth parents and prenates as they prepare their unborn baby for adoption?

Try translating these ideas to a modern-day IEP or early childhood mental health consult. Not atypically, these meetings seem designed to allow the successful completion of government-required documents, not to seriously investigate and maybe even discover a child's story. Parents often leave feeling either shame about their child's behavior and the vague sense that most people are blaming them for it, or dismay about this public acknowledgement that their child has officially been declared deficient, maybe even bad.

As is so often the case, it behooves us to look to countries allegedly less developed and sophisticated than our own to learn important things about healthcare, casework and education. At the Family Centre in Lower Hutt, New Zealand—which serves the Maori, Pacific Island and Pakena people in the region—IEPs are often turned into story-discovering and storytelling sessions. The quest is for the sort of understanding that might actually lead to the child doing better.

When a child acts out there, the community—including, of course, the child and the parents and the teachers, but also neighbors and aunts and grandpas—may be invited to look into the matter. They are *all* considered essential. The format includes pitifully little time for reciting test results, and more time for conversation and storytelling. The tribal chief might begin by remembering the day the child was born, just as the great storms were receding. A friend of the family might say to the child, in front of the group: "…we walked together when your Father was sick, we would walk every night together...You were only a boy and I knew it would be hard for you later" (Kalef, p. 144). And then the child's mother might say, "When your *Matua* (Father) first left, I was heavy with my own pain. I felt I had lost my identity and I know I left you and your sister too much. When I saw you with the older boys, I shamed myself for what I was letting happen. You are my brilliant boy, and I am sorry my sadness took away from the time I needed to be there for you; for us" (Kalef, p. 145). This is a holding environment.

The meeting adjourns with the community alerted to the problem they all share, and the child feeling the arms of holding around him. Theirs is a shared story, and the commitment to making things better is a shared commitment. The walls often built between parents and the educational system at IEP meetings in the US are not seen. The shame often experienced at such meetings in the US is not seen. The plan—perhaps unspoken and certainly not written down for submission to the government—is clear. The focus is on *holding*. It's almost as if Winnicott, himself, is there.

Foster and adoptive parents know all about holding, since it is, not infrequently, the only thing they can do in the face of a raging child, or a child who has just eaten most of the contents of the freezer in the middle of the night, or a child who seems intent on establishing that no one matters to him. I watched a foster mother once give a preeminent place to *holding* a child who seemed intent on rejecting all overture. But mom knew that, and accepted that, because she had carefully imagined the heart of her little girl as a first order of business, figuring out what form her devotion should take with a particular child. From this mom I learned that holding is not a catch-all, that it's not tactical, that it is shaped by a fine knowing of *this one child*. By definition holding is finely-honed, because it's based on a relationship, and on deep mentalization of the other. It only counts if the

child feels the power of it because it targets her particular soul, if it arises out of someone's profoundly intimate awareness of the nature of her wound. It works if it arises out of "mindsight" (Siegel, p. 35)—a capacity to *see* the internal world of self and others.

I can't explain why this particular foster mother, certainly with not a speck of psychoanalytic training, could look inside a hurt child she had only known for a few days and discern just what to do. No theatrics. Nothing fancy. Just a sweet, straight-to-the-core-of-things response that staggers anyone watching it—and anyone receiving it—with the accuracy of its aim, the grandness of its simplicity.

Chelsea's first mom had, just a few weeks earlier, murdered Chelsea's baby brother in front of her. Chelsea was three. Mom blamed Chelsea, when the authorities arrived. Chelsea spent the night in a crisis nursery, then went into foster care, never seeing her mother again.

She stopped talking, of course. She resisted all human touch, and would not make eye contact. No one could tell for certain if she was mourning the loss of her mother, or grieving for her baby brother, or if she were in shock over what she saw, or some awful combination of these. But she pulled herself into a ball, and was going to let *no one* in: not the nice police social worker, not the nice volunteers at the crisis nursery, not her foster mother or father, and certainly not *me.*

None of this seemed to surprise this strangely *knowing* foster mom. As far as she was concerned, it was entirely reasonable that a little girl would act this way after what she had just gone through. Somehow, she found a way to not take personally Chelsea's resistance to her ministrations.

It was my first home visit. Chelsea, of course, would not look at me or talk to me or even leave her spot on the staircase to enter the room where we were meeting. Mom thought Chelsea might do a little better outside, which is where I was afforded a chance to see the most surprising interaction—this most remarkable act of *holding.* It was almost like a play, produced and directed entirely by Chelsea. (Can you imagine the import of that, all by itself: that Chelsea could feel in *charge* of something?)

Chelsea climbed aboard a trike, and headed directly for the street. I expected mom to run after her, if only to show off to me that she was able to protect Chelsea at all costs. But this was not a showing-off foster mom; this was a foster mom with laser focus on the wounded heart of the little girl who had been in her care only a few days. She calmly followed Chelsea to the street, and began to chant: "Oh no, my dear. In this house little girls are not allowed to be hurt, or to hurt themselves. In this house, little girls get protected by their mommies." And then she guided this precious, tortured child back to the yard.

Twenty feet away, I fought back the tears. I had just watched *holding.* No interpretations, no anxious scolding, just an intuitive mom doing a deep dive on behalf of a tortured little girl whose hearing of any other message except this one would surely have been blocked.

I'll forever hold this mom in a place of honor, not only for her amazing mindsight, but for whatever drove her to *seek to know* the heart of this child before anything else. Chelsea was

lost, so profoundly down-regulated that mutism and isolation seemed her only choices for keeping herself together. Not only did her foster mom *see* her, but she began to open the doors to co-regulation (Siegel, 1999), by being willing to "speak" to Chelsea's right brain, where most activity lived for this child of trauma (Schore, 2001). Better than any traditional clinical or parenting intervention, I'm guessing it will be this experience of co-regulation in her first foster home that will give Chelsea a shot at avoiding a lifetime of trauma-sourced depression.

It turns out that holding is exactly the right intervention for parents, too, sometimes—especially in a crisis.

It takes discipline and a clear focus on the soul of the other (rather than our own well-being, at the moment, or our fidelity to a formulaic intervention plan) to pull together what holding might look like, with a particular mom or dad, in a particular crisis moment. I learned of this example from colleagues in healthcare, while I was trying to teach them—can you imagine the audacity?—attunement.

> ***A young woman gave birth to a baby with severe congenital problems incompatible with life. The hospital staff were aware that they would soon need to remove lifesaving equipment. The parents were both gang members and responded with threats and anger when they were told the bad news about their baby's condition, including the news that the aggressive treatments being employed at the moment were actually… futile...***
>
> ***In many medical settings, the parents threats would have aroused an intervention involving security, social work, risk management and hospital administration. Everyone agreed that it was "inappropriate" for the family to threaten the care team. Somehow, the nursing staff also knew that this was hardly the point, so they stopped reacting; they stopped being afraid.***
>
> ***Several nurses volunteered to become the "primary team" for this baby and her family, foregoing scheduled days off to provide continuity of care. They simply didn't want the parents to be "dropped"; they wanted them to be held. The nurses found out that the father was an artist of sorts and they arranged for him to design a scrapbook about his baby's birth and her short, heartbreaking life. While he was at it, he created artistic items for the parents of the other children in the unit. The nurses knew that the family had few resources, so they pooled their own money to buy the baby a baptismal gown, and supported the family's wish to have the baby baptized in the unit--all while on advanced life-saving equipment.***
>
> ***Upon the arrival of the dreaded day, the baby was taken off life support and given to her parents and extended family, where she expired in the arms of her loved ones.*** **(Koloroutis and Trout, pp. 225-226).**

A whole family was held by a "family" of nurses. The outcome astonished everyone.

While it may no longer be fashionable to speak of therapeutic and casework interventions that are non-tactical, not easily subject to measurement (and, therefore, not "evidence-based"), and that are driven by the nuances of what we bother to learn from a relationship with our patients and service users, I conclude that these are the most reliable interventions of all. They are based on a different quality of assessment, and a radically different attitude toward what needs to be done—indeed, toward what is fundamentally efficacious.

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