Extension of the Q&A with Martha Heineman Pieper, Ph.D., in Seminar Series 3

The first topic I want to talk about is consciousness. We need to distinguish between mind and brain. Brain is the province of medicine, physics, neuropsychology, etc. Studying the brain has never told us much that's important about our self-experience, which is what goes on in the mind. Mind or consciousness is an **emergent** quality of the brain; that is, it is a property of brain but not reducible to it. The maturation of the brain potentiates the development of consciousness but does not explain self-experience. In order to understand child development, psychopathology, and treatment, we need to focus on mind because it is a primary source of motive experience and therefore is a cause of the experience of subjective personal existence.

The most fundamental necessity for human life is actually a meaning – a meaning that signifies being loveable, loved, and causing that love. This meaning is generated within intrapsychic consciousness, which is the level of consciousness that we have discovered. Intrapsychic consciousness has as its focus the inner well-being that comes from the accomplished meaning of being loveable, loved and causing that love. This intrapsychic meaning is necessary for life to continue. Every baby is born with an intrapsychic ideal or precept, the content of which is being loved, lovable, and causing the caregiver to love them. We know this because when that ideal is not met with perceptual experience, that is a sufficient relationship with a caregiver, the baby will die. We saw that in the Spitz film on marasmus[1], which showed that when babies got complete care in every way other than having a relationship with a meaningful person,

[1] "Grief, A Peril in Infancy" (Spitz and Wolf, The Research Project, 1947)

they simply wasted away and died because they lacked the meaning of causing the love of a meaningful caregiver.

We see this in animals too. Willliam Wimsatt cited the significant experiment with caterpillars in which the precept or ideal of light is so powerful that if you put caterpillars in a test tube with light at one end and food at the other they will stay with the light to continue to match that ideal with experience. Equally compelling are cowbirds, which lay their eggs in other birds' nests. Obviously if a baby cowbird imprinted on the nest parents as most birds do, the species would die out. Instead, the content of their inborn ideal or precept contains characteristics specific to cowbirds (i.e., particular songs and plumage), and because that ideal is not met by the characteristics of the nesting parents, baby cowbirds do not imprint on them. Rather, after a month they reject their birth parents and nestlings and fly around until they meet a cowbird flock where their inborn ideal is matched with the percepts (songs and plumage) of other cowbirds. They then join the flock and continue to mature as cowbirds. This is conclusive evidence of the existence and influence of inborn ideals that must be matched by experience if a baby is to mature.[2] There are many more ways to show that the gratification of the need for experience that matches an inborn ideal is crucial for life to continue, but there is no time for that today.

In humans the intrapsychic precept is a dominant ideal every baby brings into the world, the content of which is being loved, lovable, and causing the love of the caregiver. I can't emphasize enough that while the content of the intrapsychic precept or ideal

[2] Preston, Elizabeth, "How a Parasitic Bird With No Parents Learns What Species It Is," *New York Times,* July 3, 2025.

changes as the baby develops, the **meaning** of the precept stays the same. In the first phase of development, the precept or ideal is what we call veridical, which means true, because every experience the baby has reflects actual caregiving experience. At birth, the content of the intrapsychic ideal is so diffuse that so long as the caregiving they receive is reasonably accurate, all experiences with the caregiver empirically signify intentional caregiving. As I will describe, after the first phase, the intrapsychic ideal or precept is non-veridical or inaccurate for a while in that it does not signify an empirical experience of actual caregiving behavior on the part of the caregiver. I should emphasize here that while the content of the intrapsychic ideal becomes non-veridical, that is, does not reflect actual caregiving behavior on the part of the caregiver, in paradigmatic development the caregiver's behavior toward the baby is accurate, that is, veridical and attuned to the baby's needs. The fact that the intrapsychic precept becomes non-veridical is adaptive in that the baby will accept inaccurate caregiving as matching (gratifying) the functional intrapsychic precept. As a result, regardless of the accuracy of the caregiving they receive, the baby will respond to the caregiver positively and lovingly, making the caregiver's efforts rewarding and fulfilling.

When experience with (percepts of) the caregiver match the intrapsychic ideal, we call this *perceptual identity*. Intrapsychic perceptual identity means that the ideal of being loved, lovable, and causing the love of the caregiver is met with experience that is congruent. As the baby develops and becomes more cognitively aware, the intrapsychic precept or ideal changes, but the meaning says the same. If you take only one thing away from my talk today it is that the content of the intrapsychic precept changes because of the baby's increasing developmental sophistication, but the meaning never

changes. The meaning is always that the baby is lovable, loved, and causing the love of the caregiver. This meaning or perceptual identity between the intrapsychic ideal and experience is necessary for life to continue. This is true even in psychopathology.

At the end of the veridical gratification phase, the baby's awareness of their surroundings differentiates until their most intense pleasure comes from the smiling face of the caregiver. This differentiated smile marks the beginning of the phase of stranger anxiety. Previously, if the object that caused the baby to smile moved away, the baby would be distracted and find something else to focus on. As a result of the baby's maturation, which allows their smile to differentiate because they recognize and respond most intensely to the caregiver's face, the **content** of the intrapsychic precept, the ideal that signifies intrapsychic gratification – being loved, lovable, causing the love of the caregiver – changes to being the face of the caregiver. Because the caregiver's face has taken on the special meaning of intrapsychic pleasure, when another, strange face appears, the baby has a developmental, that is, normal, loss because the percept or experience of the strange face does not match the changed intrapsychic precept which is now the caregiver's face. The mourning of this loss occurs when the caregiver returns and presents their face, which of course is the percept that matches the new precept and supplies perceptual identity, that is the meaning of being loved, loveable and causing the love of the caregiver.

The precept of the caregiver's smiling face is non-veridical as are all of the different intrapsychic precepts until the end of the regulatory intrapsychic self stage. As I described, non-veridical means not accurate in that it is not an empirical representation of the caregiver's actual caregiving responses. The caregiver, of course, continues to

give the baby accurate caregiving, but the precept or intrapsychic ideal has changed and the percept or experience that matches that ideal changes as well. Again, I emphasize that when the changed intrapsychic precept is gratified, i.e., met with a matching percept of the caregiver's smiling face, the *meaning* of intrapsychic pleasure is the same – being loved, loveable and causing the caregiver's love. While the content of the precept is non-veridical, the *meaning* of the perceptual identity process is always the same. The reason that the smiling face of the caregiver, which is the necessary percept at this phase, is non-veridical is that the baby cannot assess the quality of the smile. Ideally the caregiver's smile is genuine and veridical, that is, accurately loving and responsive, but the ideal or precept of the smile is non-veridical in that it could be matched by a percept of a distracted smile or, even, a grimace. The baby will not be able to assess the veridicality or accuracy of the caregiver's responses until the regulatory intrapsychic self stage when the baby becomes able to recognize the stability of the caregiver's caregiving motives. At that point the intrapsychic ideal or precept will also be veridical again.

One question that is often asked is what does veridical intrapsychic caregiving mean? The caregiver does not have to have read *Intrapsychic Humanism* or *Smart Love* to give veridical, that is, accurate care. They just have to be tuned into the baby and have the space and motivation to provide the experience or percepts that match the phase-appropriate intrapsychic precept. So, for example, when the caregiver sees that the baby experiences a loss when they see a stranger's face, the caregiver will know to substitute their own face if possible. Their face, of course, is the percept that matches the content of the new precept.

As the baby's brain matures, the baby's developing cognition enables them to become more and more aware of their surroundings. This increasing awareness is what drives the developmental process in the first years of life. The baby becomes aware that even when they can't see the face of the caregiver, they can see the caregiver in their field of vision and feel cared for just by that experience. As a result, the content of the intrapsychic precept changes from the face of the caregiver to the presence of the caregiver. This marks the end of the phase of stranger anxiety and the beginning of the phase of separation anxiety. Separation anxiety is the next developmental loss. A developmental loss occurs when experience with the caregiver (a percept) does not match the current intrapsychic precept. At this point, when the newly functional intrapsychic precept of the caregiver's presence isn't matched by the appropriate experience or percept (the caregiver's actual presence) – the caregiver leaves the room – the baby may express the upset of separation anxiety. Caregivers who are tuned into the baby will make the correct intrapsychic caregiving response and come back. If you talk to parents of children in this phase, they often say that when they go to the bathroom they can't close the door because their child gets upset. This problem is, of course, time-limited because caregiver's presence being the content of the functional intrapsychic precept is time-limited. The change in the intrapsychic precept to the presence of the caregiver rather than the smile of the caregiver is clearly adaptive in that it offers the baby much more scope for exploration and curiosity.

Next, at about a year, the content of the intrapsychic precept changes again. I emphasize that the meaning is always the same. As a result of the baby's cognitive maturation, the baby has the capacity for a stable eidetic memory of the caregiver. An

eidetic memory denotes mental images that have unusual vividness and detail, as if actually visible. As a result, the content of the intrapsychic precept changes from the presence of the caregiver to the image of the caregiver. The eidetic memory of the caregiver is stable enough that it can serve as a percept or experience that matches the new precept of the image of the caregiver. The eidetic memory of the caregiver can now serve as a source of gratifying percepts to create perceptual identity with the new content of the precept or ideal. This development marks the end of the pre-eidetic stage and ushers in a new stage, the regulatory intrapsychic self stage. In the beginning of this stage the eidetic memory of the caregiver reflects the presence of the caregiver. Recently research has shown that at about a year, which is when we've always said eidetic internalization occurs, babies actually are able to hold memories for longer. So there is actual clinical research that supports what we describe as going on inside the infant’s mind in terms of the capacity for retaining and using memories.

There are two phases in the regulatory intrapsychic self stage – undifferentiated and differentiated. Initially in the undifferentiated phase of the regulatory intrapsychic self stage, the content of the intrapsychic precept or ideal is the image of the presence of the caregiver. This is stable enough to provide perceptual identity or intrapsychic gratification for short times when the caregiver is not present, and also when the caregiver is present. As time goes on, and the baby becomes increasingly perceptive and aware, the baby realizes that they feel increased pleasure when the caregiver is playing with them. The baby begins to realize that the pleasure of playing with the caregiver is much more enjoyable than, say, playing with blocks in the caregiver’s presence. At this point the eidetic memory of the caregiver differentiates into two

different sets of meanings – presence and caregiving. They have both been contained in the memory all along, but the baby now recognizes them as different and can use either aspect of the memory of the caregiver to gratify the intrapsychic ideal. I emphasize that this isn't some magical process but is entirely the result of the baby's increasing sophistication and maturation and ability to make differential perceptions.

This form of perceptual identity between the memory of the caregiver and the intrapsychic precept or ideal we call transference. Why? Because the percept or gratifying experience derives from the eidetic memory of the caregiver which is being stimulated by actual experience with the caregiver. The memory is a replica of the caregiver rather than the actual caregiver at the moment, and that meaning is what is being transferred to gratify the intrapsychic precept, which continues to have the content of the image of the caregiver. To repeat, the precept or intrapsychic ideal is the image of the caregiver, and it's being matched by the eidetic memory that's being stimulated by the actual caregiver playing with the baby or being in the same room with the baby.

When the caregiver stops offering the baby caregiving and turns to personal motives, the baby expresses transference caregetting anxiety, which is the third developmental loss after stranger anxiety and separation anxiety. It occurs when the baby is relying on caregiving percepts that are filtered through the memory of the caregiver. In other words, the baby has come to prefer caregiver percepts to presence caregiver percepts as matching (gratifying) the intrapsychic precept of the image of the caregiver. The baby responds to the loss of the caregiver percepts that occurs when the caregiver begins to pursue personal moves with some sort of upset and protest that we call transference caregetting anxiety. If the caregiver cannot give up the personal motive at the moment

or becomes irritated or otherwise disapproves of the child for wanting attention, the child will regress back to the use of presence caregiver percepts since the caregiver is still present.

Unfortunately, because this phase has never been recognized as a developmental achievement, caregivers often mistakenly conclude that the baby has become too needy or dependent, and they can be rejecting of the request for continued caregiving and encourage the baby to go off by themselves and play. An important aspect of what we, as caregivers, can do for families is to help them understand that caregetting anxiety is actually a developmental achievement that is the result of the baby's maturation. Why wouldn't the baby prefer to have caregiving pleasure with a caregiver than just be in their presence? We can transform caregivers' thinking from concluding there is something wrong with their baby when they are expressing caregetting anxiety to understanding that their baby has reached an important developmental milestone and that they can feel proud of their baby for wanting more of their attention.

If caregiving is not veridical, and by nonveridical caregiving we just mean that the caregiver is not on the baby's wavelength exactly and doesn't understand that the baby needs the caregiver to endorse the baby's wish not to lose the pleasure of direct positive interaction, the baby will not progress to the next and final phase of intrapsychic development, the differentiated phase. There can be many reasons why the caregiver cannot give veridical care, including environmental deprivation, a health crisis, or the caregiver's misunderstanding of what the baby wants and needs. The point is not to blame the caregiver, but if, for whatever reason, the caregiver is not able to provide the experience, or percept, that actually matches the caregiving precept of the image of the

caregiver, the child will regress back to a reliance on the memory of the caregiver's presence for intrapsychic gratification. In other words, veridical or accurate caregiving means that the caregiver responds with the experience or percept that matches the precept that is operative at the time. If the caregiver has the space to respond to the child, it is not difficult to know what the child needs. If the child is responding with anxiety, for example, when they see a strange face, it's not difficult to figure out what it is that the baby really needs at that moment, namely to see the caregiver's face.

So at the end of the undifferentiated phase of the regulatory intrapsychic self stage, the baby becomes able to distinguish and prefer caregiving percepts (experience) from the pleasure that comes from simply being in the presence of the caregiver. If the caregiving is nonveridical, intrapsychic development will stop here and the baby will not move on to the differentiated phase of the regulatory intrapsychic self stage. The baby will continue to rely on experience that is filtered through the eidetic memory of the caregiver to gratify the intrapsychic precept, which continues to have the content of the image of the caregiver

In terms of clinical applications, there are many varieties of non-veridical caregiving experience that clients may have had as babies in the undifferentiated phase of the regulatory intrapsychic self stage. A baby's wish for caregiving pleasure and the caregetting anxiety they expressed when their caregiver pursued personal rather than caregiving motives could have been met with irritation, pacification, disapproval, actual anger, etc. As babies, clients may have to some extent abandoned the wish for caregiving pleasure and regressed back to relying on percepts of the caregiver's presence. So, when the therapist takes a vacation, for example, these clients can

become very depressed or dysfunctional. They may become angry and alienated when the therapist is not present. We often see the continued reliance on presence caregiver percepts with children who don't want to leave the waiting room or their parents.

There are many clinical manifestations of what happens when babies do not progress beyond the undifferentiated regulatory intrapsychic self stage, that is, they continue to rely on the eidetic memory of the caregiver for gratifying percepts rather than on actual experience with the caregiver. Clients who as babies were able to seek caregiving pleasure even though their caregiver could not stably provide it may seek caregiving but then react with ambivalence or suspicion about the therapist's caregiving. For example, children may hide after they share something important. They'll go and get under a table because at some level they are afraid of the therapist's reaction to their desire for caregiving. A little boy of four or five was very open in his first psychotherapy session, but then at the end of the session, he said, "I'm sorry. I talked so much." This is an example of experiencing the motive for caregiving as dangerous unstable, and unreliable.

I once had a four-year-old client who would be walking around in the therapy room and suddenly would fall over with no warning to see if I would catch them. And it was random. I had to watch this child all the time because they would suddenly just fall. Of course, it was their way of testing my caregiving. They were asking, are you paying attention? Are you a stable caregiver? But the positive aspect of this was that they were open to the possibility that they could get reliable caregiving.

Let's return to a paradigmatic developmental process in which the caregiver is able to respond veridically, that is, accurately, to the baby's caregetting anxiety. Remember that

the process is driven by the baby's increasing perceptiveness and ability to distinguish forms of relationship pleasure. That is, the baby themself transforms the content of the intrapsychic precept – not the other way around. The baby comes to realize that the actual, empirical experience with the caregiver is more pleasurable than the more indirect pleasure in which the caregiving percept that creates perceptual identity with the intrapsychic ideal is filtered through the eidetic memory of the caregiver. So the baby is inspired to want more and more intrapsychic gratification through direct experience with the caregiver, with the result that content of the intrapsychic precept changes from caregetting and presence images of the caregiver to actual caregetting experience with the caregiver. And this is a huge, huge change. In the first, undifferentiated phase, when the caregiver suddenly stops active caregiving to pursue personal motives the baby experiences what we have called transference caregetting anxiety. The caregiver's pursuit of personal motives causes the loss of gratification of the caregiving aspect of the image of the caregiver. The baby mourns that loss by regressing back to the presence aspect of the precept of the caregiver. So, in the undifferentiated phase if the caregiver is playing a game with the baby and gets a phone call, the baby may experience transference caregetting anxiety and protest, but then if the caregiver has to continue to pursue personal motives, the baby is going to fall back on the gratification of just being in the presence of the caregiver.

However, in the differentiated phase the baby has come to realize that the best possible thing that can happen is to play with the caregiver directly, and that the reliance on the caregiver's presence is an inferior kind of pleasure. So, if the caregiver gets a phone call, instead of regressing to percepts of the caregiver's presence the baby will respond

with what we've called the Intrapsychic No. The Intrapsychic No is a communication that means, I'm feeling a loss of not interacting with you – please keep playing with me. The accurate caregiver will either be able to put aside their personal motive and resume caregiving or will communicate that they have to take the phone call, but the baby is right that it would be much more pleasurable to be able to continue their play. The message to the baby is that their request is legitimate and would be the caregiver's preference as well. The caregiver will not be irritated, try to distract the baby from their request, try to send the baby off to play by themselves, etc. Rather, the caregiver will wholeheartedly endorse the relationship intimacy that the baby is pursuing.

When over time the baby has experience after experience after experience of having the caregiver respond this way, the baby begins to be able to distinguish the caregiver's motives from the caregiver's behavior, that is, to distinguish the temporary loss of pleasure that the caregiver has to stop interacting with them and pursue personal motives from the ongoing pleasure that the caregiver endorses the child's wish for unbroken caregiving. This is a watershed in development, because in response to the loss of the caregiver's caregiving, the baby has learned to turn to the caregiver for increased intimacy rather than regressing away from it in the sense of relying on the caregiver's mere presence. This change in the baby also changes the content of the intrapsychic precept so that the ideal of being loveable, loved and causing the love of the caregiver is now an accurate reflection of the caregiver's stable immutable motives to give ideal care. I can't emphasize enough what a transformative event this is. The baby has gained the genuine certainty that the caregiver is responsive and wants what the baby wants, namely to be really, really involved and close. The caregiver recognizes

that their personal motives at this moment in their child's development are much less important than giving the child the caregiving they need and want. The content of the intrapsychic precept has now changed to the knowledge, the empirical certainty, that the caregiver's motive to be regulated by the baby's need for caregiving is stable and immutable and the baby can now provide the percepts that gratify or match that precept because the baby has experienced that this is true. *The content and the meaning of the intrapsychic ideal or precept are now identical.*

The result is what we have called the veridical regulatory intrapsychic agent self, which means that the child can provide their own intrapsychic motive gratification from their empirical experience of the stability of caregiver's motive to give intrapsychic care. While this is obviously a watershed moment in development, there's still what we call a developmental split, which means that there is still transference gratification that the child can sometimes fall back on, and that does continue. But increasingly, as we will see in the next chapter, the superiority of the pleasure that the child gets from the actual experience of the caregiver's stable motivation begins to supersede the transference gratification supplied by the eidetic memory of the caregiver, which becomes weaker and weaker.

Having given you a general overview of important terms and the trajectory of intrapsychic development from the pre-eidetic stage through the regulatory intrapsychic self stage, I will turn in the time remaining to a few of your questions that may not have been answered.

Question: Explain how the caregiving percept differentiates in the undifferentiated phase but it's still transference.

Answer: It's still transference because in the undifferentiated stage, all experience with the caregiver is still matched with the eidetic memory or image of the caregiver because that is the content of the intrapsychic precept or ideal. So in that respect, the transfer is from the child's experience of the caregiver to the image or memory of the caregiver that is the content of the intrapsychic precept. And in this image of the caregiver the child eventually distinguishes two sources of pleasure, caregiving and presence experience.

Question: Can you explain the difference between non-transference caregetting anxiety and transference caregetting anxiety?

Answer: Well, transference caregetting anxiety happens when the primary source of gratification still comes from the eidetic memory of the caregiver because that is the content of the intrapsychic precept. The caregiver is playing with the child and interrupts the caregiving to pursue a personal motive. The child feels a loss expressed as the upset of transference caregetting anxiety. However, if the caregiver cannot at that moment resume caregiving, the only way the child can respond is by regressing to the presence caregiver aspect of the precept in the internalized memory of the caregiver. So, for example the child is playing with the caregiver who turns away to cook dinner, and the child has a loss which they express as transference caregetting anxiety. The caregiver says, "I'm sorry. I've got to keep cooking, but you know I'll be with you as soon as I can." The child does not have any way to handle that at this point, except to regress back to use the presence of the caregiver to supply the percept that gratifies the precept of the caregiver's presence in the internalized memory of the caregiver. In veridical caregetting anxiety, the child in the same situation will respond not with regression but

with the Intrapsychic No, which means that they will in effect say to the caregiver, “Okay, you can’t play with me right now, but I really would like you to, and how do you feel about that?” The caregiver communicates with a smile, “Yes you are right, that would be much more fun than cooking dinner, and as soon as I can we can play again.” Eventually the stability of the caregiver’s caregiving motives becomes the gratifying intrapsychic percept, and the content of the intrapsychic precept has changed to reflect that. Now the caregiver’s caregiving motives rather than the caregiver’s caregiving behavior has become the intrapsychic ideal and the baby can supply the percept of the certainty of the caregiver’s caregiving motives to match that ideal and supply intrapsychic motive gratification on their own out of the empirical knowledge of the stability of the caregiver’s motives.

Question: Can you unpack this quote from the book: “The caregiver’s facilitative response to the child’s intrapsychic precept provides a reality testing for the child that confirms the child’s intrapsychic perception that her agent himself does have a loss-free capacity for effective agency with regard to the autonomous capacity to experience the reflection of agent self as agent self.”

Answer: What it really says is that when the regulatory intrapsychic self is established, it’s loss-free because it’s focused on the caregiver’s motives, not behavior. It’s not whether the caregiver can continually play with the child or never has a personal motive. That’s not the issue. The issue is the child’s knowledge of the stability of the caregiver’s caregiving motives and pleasure at being involved with the child and wanting to put their personal motives aside, whenever possible, for the pleasure of caregiving. Caregiving behavior is necessarily unstable in that the caregiver always has personal motives that

must be attended to. The child's empirical knowledge of the stability of the caregiver's preference for intrapsychic caregiving motives is solid and there forever.

Question: In paradigmatic development, a child roughly three years of age has a rock solid, veridical regulatory intrapsychic agent self that autonomously and reflectively can distinguish veridical from nonveridical intrapsychic relationship pleasure within the context of the caregiving relationship with the parent. What does that mean for the child in terms of the child's interpersonal experience with others, peers, teachers, and so on?

Answer: It's huge because the child is not depending for their intrapsychic motive gratification on anything external. For example, if their toy breaks or another child won't play with them, or if it's raining and they can't go out and play in in the playground, these losses will be registered but won't affect their intrapsychic (inner) well-being because they are supplying their own, intrapsychic well-being with the empirical knowledge of the caregiver's stable caregiving motives. And there are many other important consequences. For example, as happens in psychopathology, the child will not seek out conflict with others; they won't self-sabotage; they won't rage at themselves in response to losses. We'll go into all of this more when we get to the chapter on psychopathology, but the consequences for not just the child's inner well-being, but also how they are in the world are enormous.

Question: I understand that in this stage, the child comes to know and prefer empirical mutuality, closeness, and veridical involvement. They seek it from the parent, and when the parent responds and provides veridical care, it's a response to the child's motive for care, but also the caregiver's own motive and choice. So, the child both comes to know the caregiver's motives, the boundary between the child's mind, and that of the

caregiver's mind and motives, but also feels they are the one causing the caregiver to care for them. For some reason, the two seem incompatible. That is, you can't make someone do something, if that makes sense. Something about this causing caregiving has always felt confusing to me. Can you explain that?

Answer: Well, the answer is that while you can't make someone **do** something, you can inspire them to **want** to do something. And that's the key, right? The paradigmatic caregiver finds that giving intrapsychic care and responding to the child's need for the appropriate percept to gratify the content of the functional precept is more pleasurable than following their personal motives. So, it's not that the child is forcing the caregiver to do anything. It's that the caregiver is choosing to respond with intrapsychic caregiving out of the recognition that that will give them superior pleasure. And I think when parents may not have gotten accurate care in their own childhoods, it can be very hard for them to realize how much pleasure there is in the real intimacy that you can have with a child. That's one of the things that as clinicians we do try to communicate to parents when we counsel them – if you can put your personal motives aside, and if you can really respond to what your child needs at that moment, you're going to feel really, really good. There are many variations of parent responses of course. We see all the time that parents feel that the child has to jump through hoops, has to do what the parent wants. We try to shift the focus. What does a child need? How can you respond? Not what do you want from this child but what does the child need from you? So, it's a whole shift in perspective that goes on.

Question: Empirical mutual contact between the child's intrapsychic self and the caregiver's intrapsychic caregiving motives occurs twice during paradigmatic

development – during the veridical gratification phase of the pre-eidetic stage and then the differentiated phase of the regulatory intrapsychic self stage. Can you explain that and also the difference in the child's mind during the two stages?

Answer: It has to do with the content of the intrapsychic precept or ideal which is dependent on the developmental stage of the child. So, when the child is born, they're kind of in a fog. They have this innate intrapsychic precept of being loved and being the cause of caregiving love and they need experiences or percepts to match that and create intrapsychic motive gratification or perceptual identity. The intrapsychic motive is just simply another way of saying the need for experience to match the inborn precept. Most any positive experience with the caregiver will fulfill that and provide the content of being cared for. But it's very diffuse. Obviously, in the differentiated phase of the regulatory intrapsychic self stage, the gratifying percept is very specific, namely the first-hand experience that the caregiver has stable caregiving motives to put their personal motives aside and respond to the child. The content of the intrapsychic precept or ideal has become very specific and also veridical because it is an accurate reflection of the caregiver's caregiving motives.

Question: Then there's a treatment question. How can we best help clients internalize the knowledge that they can access our ongoing intrapsychic commitment to continue to care for them and gain their own ability to continue to feel cared for at the time of a treatment interruption when a part of the client assigns negative personal meaning to the therapist's absence. How can we apply knowledge of the specific developmental losses that occur in the regulatory intrapsychic self stage, transference caregetting

anxiety and non-transference caregetting anxiety to the work with our clients. How might this show up in adult clients?

Answer: Well, we see this all the time in treatment interruptions when clients feel depressed or manic or alienated. What we can do very gently is help them distinguish the real loss, that is, it's important to recognize there is a real loss if we take a vacation for two weeks – they have lost the caregiving percepts and the presence percepts for that two weeks. So, we help them recognize that there is a loss, but the second, gratuitous loss is the meaning they attach to that loss, which is, say, that we don't care about them but only about the other people we will be with, and there is a whole panoply of negative feelings that can be added in. That's what we can help them distinguish. So, over time, when we take vacations, hopefully we can help our clients distinguish the actual loss from the loss they're imposing based on their earlier experience.

There are many typical caregetting losses in response to an interruption. Clients may respond by rejecting your caregiving – when you come back, they skip a session. They talk about quitting. They're angry at you. You can help clients understand that while they had a loss, that loss does not have to engender negative meanings about the relationship.

When clients never progressed beyond the undifferentiated phase of the regulatory intrapsychic self stage, they may have a lot of trouble with caregiving in general, because they find it hard to believe in it. The reason they didn't get past the undifferentiated phase is that somehow the caregiving that they were getting was unstable. Either the caregiver just wasn't able to give accurate care, or wasn't around,

or they felt the client was being too needy, and they gave them some kind of negative feedback for wanting caregiving. So, you may give a client really good caregiving in a session and they reject it as non-caregiving, that is, they assert that you're not really taking care of them. One example would be the therapist who helped her client see that she was having an aversive reaction to taking care of herself. The client had started in an exercise program and then found all kinds of reasons not to go to it. The therapist tried to help the client see that this was an aversive reaction to thinking that she would start this exercise program and do something positive for herself. Next the client is associating to how critical her father was. The process meaning, of course, is that she felt the therapist was being critical rather than caregiving. You may often see this reaction in response to good caregiving. There was nothing wrong with what the therapist did, but the client was unable to enjoy it or accept it.

Question: Are there analogies to the Intrapsychic No in psychotherapy?

Answer: Absolutely there are. Let's say that there's a caregiving lapse when the therapist comes back from vacation. The client says, "Well, how was your vacation?" And the therapist goes into a whole description of everything that they did on vacation and how wonderful it was. So that's really a caregiving lapse and not really what the client wanted to hear about. A client who has been with the therapist a while or is very reflective might say, "That's not really what I want to hear about. I just asked you how it was and all you had to do was say, 'Fine.'" That's a version of the Intrapsychic No. If we hear that, and we know we've made a mistake, then we can be really positive and say, "It's great that you could say that. I'm so happy that you noticed that. You are absolutely right. I shouldn't have gone into all that." So, there's an experience where you can have

an Intrapsychic No in treatment. And it actually happens more often than you would think.

Question: What was it that motivated you to develop a new theory of child development?

Answer: Dissatisfaction with all other theories. They appeared to us inaccurate, not grounded in children's actual behavior, didn't explain recognized stages, and never gave a good explanation of psychopathology. If you take a look at the Intrapsychic Humanism Society 20th Anniversary talk on my website, http://marthaheinemanpieperphd.com, I go into the genesis of Intrapsychic Humanism thoroughly, and I think you might find it interesting.

Question: How did you arrive at the understanding that children can have a stable inner well-being at this early stage in their development?

Answer: Well, because it's not verbal, it's intrapsychic; that is, it is the development and stable internalization of an ideal or precept that all babies bring into the world of being loveable, loved, and causing the caregiver's love. We can see when this ideal is matched with accurate caregiving, that is, with experience, how absolutely resilient and how stable babies become and how they are not dependent on externals for well-being. These children look amazing. When caregivers are able to be in touch with their child's needs they will recognize their child's developmental losses and developmental anxiety. They will respond to stranger anxiety, to separation anxiety, to caregetting anxiety. You can see it's a progression. It's very empirical and not metaphysical.

Question: Many clinicians comment that Intrapsychic Humanism is a lot like Attachment Theory because it emphasizes the relationship between the parent and child as the center of optimal emotional development. How would you respond to these comparisons to highlight the uniqueness of intrapsychic caregiving?

Answer: It's great that Attachment Theory emphasizes innate motives for emotional connection with the caregiver. It's really an important observation, not a theory of child development, psychopathology and treatment. That's the problem. It has very limited explanatory power. It does not explain the process of all the different stages – stranger anxiety, separation anxiety, the regulatory intrapsychic self stage, which no one has recognized before now, or the romantic stage and all the things that can go right or wrong. So it's a nice observation, but it's not a comprehensive, integrated theory of child development, psychopathology, and treatment.

Question: Why is it that children's Intrapsychic No is so often misunderstood? I think we talked about this and working with parents. How can we best help them?

Answer: Let's talk about the notion of independence. There's a complete misunderstanding that independence has to do with being comfortable going away from your parents, and that's really not what independence is about. In the regulatory intrapsychic self stage, independence is being able to supply your own intrapsychic motive gratification – to supply the percept of the caregiver's commitment to intrapsychic caregiving to match the content of the final intrapsychic precept. But parents are stuck on this old definition of independence. Unfortunately, when they see caregetting anxiety, they often conclude the child is too needy, too dependent, and they

try to push them toward this ill-conceived understanding of independence. So, again, something we can really do for parents is to help them understand caregetting anxiety as a developmental achievement.

Dr. Walker: We are about out of time but we can take a question only about what we've talked about today.

*Question: C*an children have a different percept for different caregivers? I have a client whose daughter is okay with Mom just being present, but with the father she needs to be held.

Answer: Well, at this phase, the gratifying percept should be the same for all important caregivers. There's obviously some kind of emotional problem there. Paradigmatically, the child doesn't really begin to differentiate important caregivers until the next phase, the romantic phase. And my hunch is in a case like that the two parents are responding differently to the child and the child's picking that up.

Question: Can you talk a little bit about how intrapsychic treatment can help clients resolve these phases or move through the developmental pieces that they didn't quite get from their caregivers? Is that the only way, or can parents who learn about this theory later help their kids achieve this?

Answer: Well, the establishment of the regulatory intrapsychic self is something that happens between one and two years of age. It is a relationship experience that is pre-verbal. However, parents can make a huge difference at any age when they learn what their children really need from them. They can help them become more functional, more adaptive, take better care of themselves, relate better to other people. If parents

understand this theory and start to apply it at any point, they can make a huge positive difference, and that's really the message that we try to give parents. Moreover, in intrapsychic treatment we know how to show clients the kind of stable intrapsychic caregiving that will allow them to have the intrapsychic stability they didn't get as babies. That does only happen in treatment. But, yes, parents can make an enormous difference in the quality of their children's life by applying these principles.