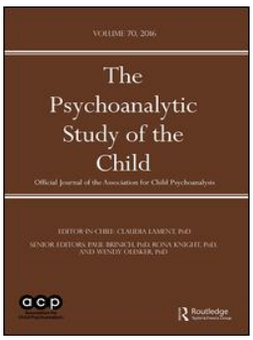

The Psychoanalytic Study of the Child

ISSN: 0079-7308 (Print) 2474-3356 (Online) Journal homepage: http://www.tandfonline.com/loi/upsc20

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To cite this article: Arietta Slade, Lois Sadler, Cheryl De Dios-Kenn, Denise Webb, Janice Currier-Ezepchick & Linda Mayes (2005) Minding the Baby, The Psychoanalytic Study of the Child, 60:1, 74-100, DOI: 10.1080/00797308.2005.11800747

To link to this article: https://doi.org/10.1080/00797308.2005.11800747

Published online: 28 Nov 2016.

Minding the Baby

A Reflective Parenting Program

ARIETTA SLADE, PH.D.,
LOIS SADLER, PH.D., R.N.,
CHERYL DE DIOS-KENN, L.C.S.W.,
DENISE WEBB, M.S.N., P.N.P,
JANICE CURRIER-EZEPCHICK, L.C.S.W.,
and LINDA MAYES, M.D.

Minding the Baby, an interdisciplinary, relationship based home visiting program, was initiated to help young, at-risk new mothers keep their babies (and themselves) "in mind" in a variety of ways. The intervention—delivered by a team that includes a nurse practitioner and clinical social worker—uses a mentalization based approach;

Arietta Slade, City University of New York, Yale Child Study Center; Lois Sadler, Yale University School of Medicine; Cheryl de Dios-Kenn, Yale Child Study Center; Denise Webb, Yale Child Study Center; Janice Currier-Ezepchick, Connecticut Department of Children and Families; and Linda Mayes, Yale Child Study Center.

This work was supported by a generous grant from the Irving B. Harris Foundation, and grew out of a collaborative effort between the Yale Child Study Center, the Yale School of Nursing, and the Fair Haven Community Health Center. Other members of the research team who have been essential to our progress are Michelle Patterson, Betsy Houser, Megan Lyons, and Alex Meier-Tomkins. We would also like to thank Jean Adnopoz, the Director of Family Support Services at the Yale Child Study Center, as well as Sean Truman, both of whom were instrumental in getting the program off the ground. Finally, we wish to thank the administration and staff at Fair Haven Community Health Center, particularly Katrina Clark, Kate Mitcheom, Karen Klein, and Laurel Shader, who along with many other members of the pediatric and obstetric services gave Minding the Baby a home.

The Psychoanalytic Study of the Child 60, ed. Robert A. King, Peter B. Neubauer, Samuel Abrams, and A. Scott Dowling (Yale University Press, copyright © 2005 by Robert A. King, Peter B. Neubauer, Samuel Abrams, and A. Scott Dowling).

that is, we work with mothers and babies in a variety of ways to develop mothers' reflective capacities. This approach—which is an adaptation of both nurse home visiting and infant-parent psychotherapy models—seems particularly well suited to highly traumatized mothers and their families, as it is aimed at addressing the particular relationship disruptions that stem from mothers' early trauma and derailed attachment history. We discuss the history of psychoanalytically oriented and attachment based mother-infant intervention, the theoretical assumptions of mentalization theory, and provide an overview of the Minding the Baby program. The treatments of two teenage mothers and their infants are described.

> Sometimes my daughter is just really nice and generous, and she likes giving me hugs and stuff . . . sometimes, just for nothing, she'll walk up to me and hug me so tight in my neck and it feels so good . . . 'cause I never had that when I was little . . .
>
> She probably doesn't understand why she's getting me mad. 'Cause she's so tiny she probably doesn't understand. But, that's kind of what I think about, you know, you can't compare your capacity to hers, 'cause she's still so small, she doesn't understand what she's doing wrong.
>
> I usually try to hide my anger. I try not to let anyone see those feelings. I did that for a long time before Denise and Cheryl came along. That's when I started opening up and talking to them. Because I had so much built in I couldn't hold it anymore.
>
> —Iliana, 19, mother of Lucia, age 13 months

> I look at this tape of me and Noni, and she's so little . . . I can't believe she's so big now . . . It's so hard to watch this . . . I see now that maybe her crying was to tell me she'd had enough . . . here I can see her face sad trying to tell me what I didn't know, that she may have been hungry or sleepy. The whole time she cried, I had no idea what she wanted.
>
> —Mia, age 19, mother of Noni, age 14 months

THESE YOUNG MOTHERS ARE STRUGGLING TO FIND WORDS FOR THE INner life—their baby's and their own; tentatively, poignantly, they glimpse the other, and themselves. They look for ways to describe what is inside, what can be known, what can be held in mind, and what can be contained. They hold the past next to the present, the

self next to the other. And as they discover their babies, they are discovering themselves for the first time.

Mia and Iliana joined Minding the Baby—a relationship based mother-infant intervention program—in their third trimester of pregnancy. Both had been in different ways abandoned and betrayed by their own mothers when they were but babies themselves. They had lived their whole lives against the backdrop of trauma, within their own families and within the culture of their violent, impoverished, and chaotic communities. Knowing others and their minds had been fraught with terror, disappointment, and rage. And now they were faced with the enormous challenge of holding their own children in mind, children who had been born at a time when they were still children themselves.

The crucial human capacity to understand the mind of the other, to make meaning of behavior—one's own and others—*in light of underlying mental states and intentions,* is essential to the development of social relationships, and most particularly intimate relationships (Fonagy, Gergely, Jurist, & Target, 2002). Fonagy and his colleagues have referred to this interpersonal and intrapersonal capacity as the reflective function, and they suggest that it is essential to affect modulation and regulation; experiences that can be known and understood, held in mind without defensive distortion, can be integrated and contained.

The capacity to mentalize, or envision mental states in the self and other, emerges out of early interpersonal experience, particularly the experience of being known and understood by one's caregivers. The child discovers himself in the eyes and mind of his caregivers, and derives a sense of security and wholeness from that understanding (Fonagy et al., 2002; Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon, & Target, 1995; Fonagy & Target, 1998). The child's discovery of himself depends largely upon the caregiver's capacity to hold, tolerate, and re-present the range of his diverse and contradictory mental states. Thus, a parent's reflective awareness is inherently regulating and containing for the child. Importantly, though, it is also regulating and containing for his caregiver. Parenting is a fraught and complex enterprise, and without developed capacities for reflective functioning, parents are vastly more prone to impulsivity, disorganization, and dysregulation in relation to their child (Slade, 2002, in press, 2005).

Trauma interferes in a number of profound ways with the development of reflective capacities (Fonagy et al., 1995, 2002). Parents who have been traumatized find their children's needs and fears over-

whelming and profoundly evocative, and as a result often find it difficult to read the most basic cues without distortion or misattribution (Fraiberg, 1981; Lieberman, 1997). At a most basic level, the defensive processes enlisted in the face of trauma fragment the development of stable, coherent representations of the self and other. What we see in the words of the mothers quoted above are tentative efforts to form such representations, and allow themselves moments of knowing the self and the other. Mia's evaluation of her own failure to understand what her 4 month old infant was feeling provides a clear example of how difficult this can be.

Minding the Baby, a relationship based home visiting program developed out of an interdisciplinary collaboration between the Yale Child Study Center and the Yale University School of Nursing, was initiated in 2002 to help young, at-risk new mothers keep their babies (and themselves) in mind in a variety of ways. We began with the assumption that—in addition to being relationship based and interdisciplinary—our program would focus on the development of mothers' mentalizing capacities. Based on Fonagy and his colleagues' work of the last decade (see Fonagy et al., 2002, for a review), we knew that—by virtue of early relationship histories that were universally characterized by attachment disruption and trauma—the reflective capacities of these women would be compromised. Furthermore, we believed that addressing the deficits and defenses that had led to such disrupted functioning would be vital to the development of healthy mother-child relationships. Obviously, while parenting is not the only factor contributing to the regularity and evenness of infant development (temperament and biology being but two of the myriad endogenous and exogenous factors that can affect development), we believed that enhancing parental reflective functioning would help mothers facilitate their children's development in crucial ways.

This approach is in line with what Fonagy and his colleagues have termed "mentalization based therapies" (Bateman & Fonagy, 2004); this term refers to treatments that directly address and target the development of reflective functioning or mentalizing capacities. In essence, these approaches—which Fonagy and Bateman have most extensively developed for work with borderline patients—are designed to very explicitly help patients make sense of mental states. It is this model that has informed the development of Minding the Baby.

We also began with the assumption that when working with infants, containment and regulation take place not just at a mental level, but

at a physical level as well. The knowledge of mental states, thought so crucial to responsive caregiving, is preceded and indeed founded upon an understanding of physical states. As Freud pointed out, "The ego is first and foremost a bodily ego" (1923, p. 6). Winnicott (1965) made a similar point:

> In healthy development at this stage the infant retains the capacity for re-experiencing unintegrated states, but this depends on the continuation of reliable maternal care or on the build-up in the infant of memories of maternal care beginning gradually to be perceived as such . . . The infant becomes a person, an individual in his own right. Associated with this attainment is the infant's psychosomatic existence, which begins to take on a personal pattern; I have referred to this as the psyche indwelling in the soma . . . the infant comes to have an inside and an outside, and a body-scheme. In this way meaning comes to the function of intake and output; moreover, it gradually becomes meaningful to postulate a personal or inner psychic reality for the infant. (p. 45)

In other words, the child comes to know his body through the hands of his mother. As we can see from Mia's reflections on her inability to acknowledge her baby's most essential needs for sleep or food, even the recognition of physical states can be compromised in traumatized mothers whose own bodies have in a variety of ways often been a source of trauma. Thus, we wanted to help our mothers come to feel safe and confident in knowing their babies' bodies as well as their minds, to feel that they could contain and regulate their babies' physical states, and then slowly, with time, come to know their babies' mental states.

In the sections below, we will begin by briefly describing the essential principles and methods of Minding the Baby, as the program has evolved from its original inception three years ago. We will then present two cases in an effort to exemplify the approach intrinsic to our reflective parenting program.

Mother-Infant Intervention: A Brief Overview

Thanks to the remarkable and groundbreaking work of Selma Fraiberg, clinicians have been working in a psychoanalytic way with mothers and babies for more than 30 years (Heinicke, Fineman, Ponce, & Guthrie, 1999; Heinicke, Fineman, Ruth, Recchia, Guthrie, & Rodning, 1999; Lieberman, Silverman, & Pawl, 1999; Lieberman, Weston, & Pawl, 1991; Seligman, 1994; Stern, 1995). Infant-parent psychotherapy is today a highly valued and legitimate mode of psy-

choanalytically based treatment, and the infant mental health movement—reflected in the emergence of organizations such Zero to Three, The National Center for Infants, Toddlers, and Families, and the World Association of Infant Mental Health—is well established both in the United States and abroad. And, as attested to by all of the papers in this section, neither the fact of the child's age, nor the fact that the *dyad* presents for treatment are considered in any way impediments to analytic intervention. Indeed, the age of the child and the mother's active participation in the work are seen as crucial to progress and early structural change (Fraiberg, 1981). And, in contrast to traditional notions of psychoanalytic work, infant-parent psychotherapists routinely work in situations of risk and trauma, where little about the environment can be contained or easily modulated. Circumstances once considered "unconventional" (Seligman, 1994) are now considered normative, albeit challenging, opportunities for analytically oriented work.

Essential to the infant-parent psychotherapy model is the notion that in a disrupted mother-baby relationship there is some basic distortion of the mother's capacity to represent the baby in a coherent and positive way. Fraiberg introduced an idea that now underlies virtually all infant-parent work, namely that in troubled dyads the mother's representation of the baby has been distorted by unmetabolized and unintegrated affects stemming from her own early and usually traumatic relationship experiences. The goal of infant-parent psychotherapy is to disentangle these affects from the relationship with the baby. And, as in all psychoanalytic treatments, it is the relationship with the therapist that leads to shifts in the mother's representational world, and the ultimate "freeing" of the baby from the mother's traumatic projections. The parent-therapist relationship in an infant-parent psychotherapy is—from a traditional psychoanalytic perspective—somewhat unusual, primarily because of the concrete supports and guidance that are offered by the clinician within this setting. At the same time, the notion of transference is crucial to understanding how this relationship unfolds, and in anticipating the pitfalls inherent in the mother's coming to trust and rely upon the clinician. Ultimately, and optimally, the therapist provides a crucial and transforming alternative to the mother's previous relationships with caregivers; the experience of being heard and valued by the clinician frees her and the baby as well.

Fraiberg's work was to have an enormous impact *outside* of psychoanalysis as well. Beginning with the publication of her seminal papers, home visiting—although widely practiced in Great Britain and

other Western countries since World War II, and in the tenements of New York in the early 1900s by public health nurses (Wald, 1915)—has become one of the most common approaches to improving psychological and developmental outcomes in high-risk mothers and babies across most of the United States. Certainly David Olds and his colleagues' Nurse Home Visitation program is the most effective and valid of the many home visiting programs described in the literature (Kitzman, Olds, Henderson, et al., 1997; Kitzman, Olds, Sidora, et al., 2000; Olds, 2002; Olds, Hill, Robinson, Song, & Little, 2000). In Olds' model, experienced public health nurses conduct frequent home visits to first-time high-risk mothers and their infants beginning in the end of the second trimester of pregnancy and proceeding to the child's second birthday. Like Fraiberg and her colleagues, Olds emphasized that the development of a therapeutic relationship with the home visitor is key to a number of positive mother and child outcomes. Olds chose to use nurses rather than mental health professionals for a variety of reasons, the most central being his belief that they are perceived by families as highly informed and helpful, and are free of the stigma of mental health service providers. When Olds first began his work, nurse home visitors did not receive any training specific to mental health concerns; however, as the program has evolved over the past twenty years, and the mental health needs of families have emerged with great clarity, nurses have received increasingly specific training regarding what might be called "psychoanalytic concerns," namely how to think about and work with the sequelae of severe trauma and relationship disruptions (Robinson, Emde, & Korfmacher, 1997; Boris, Nagle, Larrieu, Zeanah, & Zeanah, 2002).

While the infant-parent psychotherapy and NHV approaches differ in emphasis, they are nevertheless rooted in the fundamental notion that changing the quality of the mother-child relationship *through a transforming relationship with a clinician* is key to improving outcomes for child and mother. In addition, both approaches provide a range of ego supports for the mother, so as to improve the chances that—by completing her education, delaying further childbearing, and gaining secure employment—she will be in the best position to surmount the multiple stresses associated with urban poverty, and she will be able to serve as a secure base and facilitating environment for her child. What the NHV program *adds* to the psychoanalytic model of parent-infant work, however, is the emphasis on the body and on physical care; despite the fact that the issues of the body played a central role in classical psychoanalytic theory, this is an

aspect of development and of the mother-child relationship that has not been effectively integrated into psychoanalytically based infant-parent work. It is abundantly clear from the past two decades' research that early trauma is profoundly disruptive to the developing individual's sense of physical integrity and wholeness (Herman, 1992). Mind and body become inextricably intertwined, and the pathology of biology, arousal, and self-care cannot easily be distinguished from disruptions at an internal, psychological level. For that reason, we believed that it was essential to integrate the nursing model with the infant-parent psychotherapy model into a singular, unified model. We did this by creating a home visiting team that included both a pediatric nurse practitioner and clinical social worker.

The enhancement of reflective functioning was a central goal of both the nursing and mental health aspects of the program. Thus, we used a variety of techniques—drawn from both nursing and infant-parent psychotherapy approaches—to deepen a mother's understanding and awareness of her baby's mind, her baby's body, her own mind and body, and the exquisite and complex interrelationship amongst all of these bodies and minds (Slade, 2002; Slade, Sadler, & Mayes, in press).

Minding the Baby

The best way to describe Minding the Baby is through example, which we will provide in the form of case material in the sections below. These cases[1] will be used to describe some of the particular techniques we use to enhance reflective functioning within our model. Before turning to the cases, however, we will describe the program and its methods in a general way.

Minding the Baby is based in an urban community health center that provides health care for an underserved population of families, most of whom live at or below the poverty line, and are of diverse cultural and ethnic heritages, including African American, Caribbean American, Puerto Rican, Mexican, and El Salvadoran. This link to community health care services is crucial, because programs that are not adequately linked to services provided by local health providers and other community agencies risk becoming isolated and less effective. In addition, Minding the Baby services are provided by master's level clinicians; we see this level of advanced training as crucial in preparing clinicians to be able to assess and manage the complex

1. We have created composite cases for reasons of confidentiality.

clinical issues involved in working with highly disadvantaged and traumatized populations.

First time mothers are recruited from prenatal care groups offered at the health center. The Minding the Baby team is made up of a pediatric nurse practitioner and a clinical social worker; both are involved in the recruitment and initial evaluation process, and both see mothers on a regular basis. Typically they alternate visits, beginning in the last trimester of pregnancy. Families are seen weekly until the baby's first birthday, at which point visits are tapered to every other week through the child's second birthday.[2] In some cases, the mother may be visited by both clinicians in one week, or by one visitor consecutively when there are physical or mental health crises. In various times of crisis, visits may last hours, and—when the home is too chaotic or disrupted—take place in locations as diverse as the neighborhood library or a fast food restaurant. Prior to beginning the intervention, the clinicians receive extensive training in reflective functioning; this includes exposure to relevant background materials in psychoanalysis and attachment theory, a comprehensive review of Fonagy's work, and in vivo training in recognizing and identifying different levels and types of reflective functioning. This training is offered jointly, so that the nursing and mental health approaches are always unified when considering the mother and baby. Since many of the families served by the program include adolescent mothers, the clinical team also receives extensive training and supervision regarding the particular developmental and behavioral characteristics of teen parents (Sadler, Anderson, & Sabatelli, 2001; Sadler & Cowlin, 2003). Because thorough evaluation is crucial to testing the efficacy of Minding the Baby, mothers and babies are assessed at regular intervals over the course of their participation in the program using a range of standard psychological, psychiatric, health, and developmental measures (see Slade et al.). Data from these assessments allow us to evaluate change in a systematic way.

While space restrictions prohibit our elaborating the content and process of home visits, (these are more fully described in Slade et al. 2005, and in Slade, Sadler, Mayes, Currier-Ezepchick, de Dios-Kenn, Webb, Klein, Mitcheom, & Shader, 2004), we will briefly describe what we see as the essential features of a reflective parenting program (see too Goyette-Ewing, Slade, Knoebber, Gilliam, Truman, & Mayes,

2. This schedule of visits is determined largely by funding and personnel constraints, although extra visits are routinely offered in times of crisis or intensified demand.

2003; Grienenberger, Popek, Stein, Solow, Morrow, Levine, Alexander, Ibarra, Wilson, Thompson, & Lehman, 2004; Slade, 2002). Our ultimate goal is to help mothers acknowledge that the baby has a body and a mind of his own, and to learn—as a function of this awareness—to tolerate and regulate the child's internal states. The work almost always begins in the therapeutic relationship, with the clinician holding the mother in mind so that she can begin to know herself, only then slowly coming to know the child. We have found that it is our clinicians' willingness to witness the mother's world, to witness her emotions and her body, to hold these in a safe way in the here and now, that makes the mother feel heard and ready to know the baby in all his complexity. This process—and its various permutations—is manifest in the cases below.

Fonagy and his colleagues have described reflective functioning or mentalization as occurring along a continuum, from an absence or denial of mental states, to a simple capacity to recognize basic feelings and thoughts, to the emergence of true reflective awareness, namely the capacity to understand behavior in terms of mental states, and to understand both the nature and dynamic interplay of mental states (Fonagy, Target, Steele, & Steele, 1998; Slade, Grienenberger, Bernbach, Levy, & Locker, 2004). Minding the Baby tries to help mothers develop this capacity, with each of the clinicians doing so in distinct, but complementary ways. The nurse provides ongoing help in relation to physical health and caregiving, while the social worker provides infant and parent mental health services and social service support. At the same time, however, their roles overlap in a number of ways, with both providing developmental guidance, crisis intervention, parenting support, and a range of concrete supports such as rides to work, emergency food, medical supplies, and the like. As has been described again and again in the infant-parent psychotherapy literature, the very real needs of high-risk families require that they be helped at many levels at the same time; this demands constant flexibility and collaboration on the part of the treatment team (Lieberman, 2003; Seligman, 1994).

As is true of all analytically based work, the development of a therapeutic relationship is at the heart of all parent-infant interventions. However, establishing productive alliances with abandoned and traumatized women and their families is not easy. These alliances are regularly disrupted by powerful and elemental transferential reactions on the part of mothers who have been betrayed and hurt by those who cared for them. The home visitors are repeatedly inundated with demands and crises (eviction, food shortage, domestic violence)

that require immediate action. So often clinicians struggle with rescue fantasies as well as feelings of futility and helplessness; often they are intensely dysregulated by reports of violence to mothers and babies alike. The clinical team's ability to keep the "infant in mind" is often challenged by the chaos, maternal pathology, and levels of extreme deprivation experienced by the family. Consistency—the bedrock of any therapeutic work—is difficult to achieve even at the level of maintaining regularly scheduled visits. Add to all these complexities the fact that the multidisciplinary team—while sharing common beliefs and values—does not always share a common language. Although the construct of reflective functioning provides common ground for discussion, as do the guiding principles of our model, there are nevertheless crucial differences in approach that must be managed against the backdrop of families prone to splitting and disorganization.

The supervisory relationship—which sets the tone and parallels developing therapeutic relationships—becomes critical to managing these multiple levels of complexity. In Minding the Baby, the pediatric nursing specialist and clinical social worker are supervised jointly; we see this approach as crucial to exploring the myriad diversions that threaten the clinical work. As a team, supervision is used to set priorities, identify barriers, and explore alternative routes to enhance reflective capacities while addressing the concrete and physical needs of the family. Without supervision that is both clinically focused and personally validating, the team's own reflective capacities are challenged and even diminished.

In the following sections, we will describe our work with Mia, Iliana, and their babies. In some ways, theirs are similar stories: both had babies as teenagers, and both of their childhoods were characterized by loss, trauma, and abandonment. At the same time, their stories are different in important ways: they began the program with different strengths and resources, and with very different openness to internal experience. They differed in the degree to which they had developed capacities for reflective functioning, in levels of ego and self organization, and they struggled with different kinds and depths of vulnerabilities; equally important, they had different levels of support within their families and communities. Unsurprisingly, their progress in a number of areas can be charted quite differently; most important for our purposes in this paper are differences in the development of mentalizing capacities in these two women. Both have made—relative to their status at the beginning of the program—enormous progress. And yet both stories convey how complex and

vulnerable progress is for women living with such enormous external and internal burdens. Both stories also convey how such complexity invariably requires multiple and flexible levels of care, care that we feel is best provided by the integrated, multidisciplinary model offered by Minding the Baby.

MIA

We first met Mia at age seventeen when she was seven and a half months pregnant. Mia and her boyfriend Jay—who was eight years her senior—were living with his family in a situation that was both chaotic and overwhelming. Mia had been forced to move out of her home when her mother discovered Mia was pregnant. Mia had been the great hope of her family; she had done extremely well in high school, and was hoping to be the first member of her extended family's generation to go to college. But Mia's hopes for the future had been dashed by the conception of her unplanned baby. She dropped out just months before her graduation from high school. The baby solidified Mia's already estranged status from her single mother, who had disapproved of her boyfriend, whom she saw as certain to derail her hopes and dreams for her daughter; as she put it: "You're just another teen mother statistic." Mia recalled, "This never was supposed to happen. I'm breaking everyone's hearts." What Mia's solemn pregnancy story evoked but omitted in her whispery voice was that perhaps her heart, too, was broken.

When we met Mia, we found a young woman struggling to disavow the reality of the baby and of her internal world on many levels. She was doing everything she could NOT to think about her baby, and was awkward, distracted, and almost dissociated when asked about the baby. "Oh . . . That." While there were small glimmers of anticipation of a new relationship—"I talk to my belly," Mia could scarcely invest in this possibility. "I just hope I still have it by the time it's five." (Her own mother had lost custody of her when she was five.) At the same time, Mia showed a number of indices of what we might call latent capacities for reflective functioning. While these were scarcely manifest in relation to her thinking about the baby, she was able to reflect upon her initial denial of her pregnancy, and in so doing to suggest a shift in her capacity to hold her complex emotions in mind: "I was in denial even up to my fifth month. I couldn't sleep, saying, 'I know I'm not pregnant.' . . . I didn't know what to do." More striking was her ability to describe her own complex fears and worries about becoming a mother, and—in particular—her feelings of being lost

and overwhelmed. The depth and quality of her language, and her capacity to vividly describe her pain led us to feel that as little as she was able to imagine the baby, and keep any kind of a representation of a relationship in mind as she prepared for motherhood, she was able to give voice to her own anxieties and sense of confusion. This proved to be a resource that was of great value to her once the baby was born.

Both of our home visitors worked hard during the third trimester to help the mother "make room" for the baby (Mayes & Cohen, 2001): preparing the room, planning for childcare, thinking through labor and delivery. Mia had little conception of the child's concrete, physical needs, and when encouraged, for instance, to wash a baby doll in preparation for caring for her own child, she giggled uncomfortably and abandoned the activity, embarrassed. Signs of depression—which were to become far more pronounced after she gave birth—were evident.

Mia gave birth to a healthy girl, Noni. While she had begun to make amends with her own mother toward the end of her pregnancy, she was still living with her boyfriend's family. The home was dirty and crowded with multiple relatives. The adults in the home were intrusive and often inappropriate; Mia had to guard her and the baby's food carefully. TVs blared and there was the din of the distant conversation. The progress that she had begun to make in pregnancy—reconciling a bit with her mother, beginning to give voice to her fears—began to slip away, as Jay became disinterested in being with the new mother and baby.

Her baby appeared well-cared for but Mia did not touch her readily, and Noni remained alone in her crib. Mia muttered, "Shut up," under her breath when Noni cried. Her movements were perfunctory and task-based. She admitted to crying daily, bathing less, and not bothering to get dressed unless she had to go out. Mia was often pale, her eyes puffy from crying. She spoke with eyes downcast, disgusted with her isolation and feeling of uselessness. Within one month post-partum, the team felt that her depression had reached a critical level (likely as a function of biological as well as other factors). As is very typical of the mothers we are working with, Mia was averse to seeking psychiatric treatment, leaving us with little choice but to address her severe depression in a way that respected her pace, needs, and expressed wishes, but at the same time kept clearly in focus the very real possible risks to the baby. We decided that the social worker should see Mia weekly, so as to provide the level of mental

health services appropriate to the level of the psychiatric emergency. At the same time, we did not decrease nursing visits, which she was starting to use in a limited way. The last thing we wanted to do was give her less of anything, and we felt that the nursing visits' focus on developmental guidance and parenting support—keeping the baby alive for her in the here and now—was a crucial balance to the work of uncovering and discovering the pain of her past.

With this shift, Mia began to find words for her despair, and she began to tell her story. While we had learned pieces of the story during the evaluation period and the first months of the intervention, it was only now, with the baby real, and Mia's fragile denial and determination shattered under the weight of reality, that she began to tell us about herself in a more detailed and—finally coherent—way. Mia, an only child, was born to a heroin addicted mother who was herself a teenage mother. Mia's father died of a drug overdose when she was two; Mia was with her mother when she found him. When she was five, following years of neglect, she was removed from her mother's care and placed in foster care for two years. Remarkably, her mother managed to get clean and bring Mia back to live with her. Despite her own drug problems, Mia's mother was a strong, determined woman of enormous intelligence and perseverance who in her own way communicated a fierce loyalty and love for Mia. In many ways, Mia's mother's dreams had propelled her forward; at the same time, however, Mia sabotaged and bridled at these dreams (the pregnancy being a very clear example), and longed for the uncomplicated love she had never had.

Over the course of the next few months, Mia began to forge a relationship with the social worker, giving voice to her feelings, and allowing herself to remember and describe moments and fears long forgotten. Week after week came the small but significant indications that the capacity to identify and reflect upon her internal states had begun to take root. She could not talk about the baby, but she could talk about her childhood experiences; slowly she found words for the terror that was associated with these remembrances, and for her own needs for comfort and support. These were feelings she had all but deleted from her awareness. First came the memories, and the feelings, and then came the effort to make meaning. She began to create a narrative, a story line that she could reflect upon, making meaning of the present in light of the past. The social worker worried that delving into such memories would be too painful and overwhelming for Mia, and she watched vigilantly for signs of traumatic stress. She

did not push, but instead remained gently present, watching for Mia's glazing over, the sign that she had remembered and described all that she could.

At four months of age, Noni was an attractive and communicative baby, who in many ways managed to ignite Mia's maternal capacities. On occasion, she could elicit maternal traits in Mia such as affection, playfulness, and pride. Mia's competence and efforts to attend to the routine care, if not the emotional care, of the infant, were highlighted and validated. "There's no one else that can comfort her like you. Look how she's gazing right at you as if to say 'thanks.'" This kind of comment, repeated multiple times over multiple home visits, fed Mia on many levels, and acknowledged her importance to the baby in ways that she herself could not yet recognize. Despite being unable to recognize her baby's experience, she was, however, able to express complex feelings about her: "I don't regret the baby, but I wish I didn't have her so young."

At the same time that Mia could care for Noni competently and sometimes lovingly, she could also be quite aggressive and harsh with her. She had at this point no capacity to recognize or tolerate fear or distress in her baby (having not yet been able to articulate her own fears and need for comfort), especially fear and distress that she herself generated. Mia's game of choice was to startle her infant, which she would do in a variety of ways. She would loom into the baby's face quickly, smiling in a threatening way as she approached menacingly, or she would shove a shrill squeaking toy intrusively in her face. Mia delighted in this game, oblivious to Noni's startled grimace and frozen expression. Noni would attempt a false, scared smile, as if she needed to placate Mia and keep her at bay. Repeatedly, Mia raised the threshold for tension, but did little to soothe the frightened baby, re-enacting her own helplessness as a child. This scary experience was repeated again and again, with the other adults' finding similar pleasure in startling and overwhelming Noni.

Equally disturbing was the fact that not only did Mia fail to recognize Noni's fear, but that she viewed Noni's response as false and manipulative. Whenever Noni would become distressed—not only with the startle game, but at times when she took a tumble or hurt herself—Mia would respond indignantly with some version of the following: "Faker! Big fake-crier! You don't fool anyone." Thus, Noni's self-experience was both disavowed and distorted within the context of her mother's response; it is these kinds of early relational experiences that Fonagy and his colleagues (2002) so richly describe as fundamental to a child's developing an abiding feeling of alien-

ation and emptiness. Even in these early months we could see Noni dissociated and frightened in interaction with her mother.

The next task was clearly to help Mia recognize her baby's fear and distress, feelings that were at this juncture too threatening for Mia to see, even in her own history. We began by trying to elicit curiosity about the baby's intent, "Why is she fake-crying? What could she want by calling out to you?" Focusing on the baby's intentions helped Mia slowly attend to the cues or events that led up to the baby's distress. It also served as a chance to allow Mia to reflect upon her own experience of the crying. "How does it feel when you think Noni is trying to trick you into paying attention to her?" Her responses opened up a discussion about the "street's" code of emanating fearlessness, denying needs, and feeling excited by fear. After revisiting these themes many times over, Mia began to explore the times in which she felt afraid, alone and/or felt like no one was taking her needs seriously. Mia admitted that indeed her own obvious cries for help in dealing with the overwhelming demands of straddling adolescence and motherhood were not being heard.

As the intervention proceeded, we did not approach these deficits in Mia's mentalizing capacities directly, of course, but rather began by using the therapeutic relationship with the home visitors to give voice to her own experiences of fear and distress. These therapeutic relationships then became the platform from which she could view the baby's experience—her intentions and affects—with increasing accuracy and clarity, without needing to distort or misinterpret as a means of protecting her own fragile sense of self. Mia's willingness to hold the baby in mind was quite tenuous and fleeting at first, and had to be nurtured in a variety of ways at all times, because her tendency to slip out of reflective awareness was so strong. Slowly, she began to be able to step out of automatic reactions and timidly observe her child's feelings. Noni began to be able to express a more extended range of emotions toward her now more available mother. When the baby was thirteen months old, Mia moved back into her mother's home. She made the choice to move away from the father of the baby because she believed it was a better environment for a baby. When asked, "Why now?" she replied, "*She's much happier. In the other home, she'd hold her hands over her ears, it was too much for her* . . . I wanted to for her. It was an easy decision." Mia was making links between the baby's behavior (holding her hands over her ears) and internal dysregulation (too much for her), and she saw herself as instrumental in protecting the baby and providing her with a more regulating and containing environment.

When Noni was 14 months old, 17 months after Mia's entry into the program, the social worker reviewed a videotape that had been made of Noni and Mia interacting when Noni was 4 months old. Mia was obviously troubled in watching the tape, and noted readily how insensitive she had been to Noni's cues—"I had no idea what she wanted, I couldn't read her . . . I see now that her crying was to tell me she'd had enough . . . here I can see her face sad telling me what I didn't know, that she may have been hungry or sleepy . . . She's trying to tell me she's scared, and I'm just in her face, scaring her." While Mia tried throughout the sessions to minimize and deflect some of the guilt she felt in recognizing her failure to hold Noni in mind, she was nevertheless fully cognizant of the fact that she was ignoring *signs of distress that she was readily able to identify in retrospect*. This reaction signified crucial progress to the treatment team.

The central focus of the work of both home visitors was to make Noni and her internal world real to Mia, slowly and in a way she could tolerate. At the same time, it is important to highlight the fact that the work was taking place on many other levels as well. Mia was overwhelmed by her living situation, and we worked in a variety of ways to help her make Jay's family home safer for the baby. This meant she first had to recognize that the baby required safety and that she could participate in providing that. Filters were provided that protected the baby from the smoke in an environment where everyone smoked cigarettes. She needed help with travel to and from school, with birth control, with obtaining food for the baby, and with basic caretaking skills. We brought toys and baby books, and taught her how to play with the baby. She had several frightening blow ups with Jay (who had a history of violence), which required our help in sorting out. All reflective work took place against this backdrop of concrete support and education: help in stress reduction, vocational planning, safety procedures, medical care, and the like. Without these levels of support, the therapeutic work would have been utterly impossible.

Noni is now 20 months old, and Mia is living in her mother's clean and orderly home. Jay is still firmly in the picture; indeed, he is often present at home visits, and is proud of his understanding of development, as well as the mutual feelings of love and attachment that he and Noni obviously have for each other. Noni is clearly a loved child, cherished by the extended family on both sides. When seen in the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978), a laboratory based separation procedure that is used to assess infant attachment status, Noni was not classified as disorganized in relation to at-

tachment (Main & Solomon, 1986), but showed many signs of a secure attachment; this is a crucial marker of developmental and relational consolidation. Mia is still an adolescent, one who has suffered a range of traumas in her short life. And yet, over the course of home visits, we see the effects of these traumas diminishing in her day-to-day interactions with Noni. She finds pleasure in her, she plays with her, she inhibits her own instincts to frighten and overwhelm. She comforts her child and tolerates her distress. For the most part, Mia can hold Noni in mind.

Despite Mia's continuing struggles, when we contrast her behavior with Noni at 4 months with the responsive and "good enough" mother we see now, it seems evident that the slow effort to help Mia keep Noni in mind has been successful, and we can feel somewhat confident that there are protective factors in place for both Mia and Noni that will make a big difference in both of their developments. This in sharp contrast to Iliana, whose case we turn to next.

ILIANA

We met Iliana, 19 years old, at a group prenatal class in the second trimester of her pregnancy. She was accompanied by the father of her baby, a 20-year-old man with a previous history of substance abuse and incarceration. During the two-hour class Iliana remained attentive but maintained a skeptical distance from others in the group. Indeed, distance and anger were to characterize Iliana's central struggles, both as they were manifested internally and in relation to the team. In contrast to Mia, who from the beginning had some capacity to hold complex mental states in mind, Iliana was overtly more angry, more defended, and much less able to tolerate and describe her internal world. She had survived a childhood deeply marred by chaos, poverty, and violence. Her mother had left the family when Iliana was five. Her father, deeply involved in drugs and alcohol, erratic and sometimes violent, had been her sole caregiver. She was sexually abused by her grandfather. However, the abandonment by her mother—of whom she spoke with bitterness and rage—was a defining moment for Iliana, a scar that would not heal. Iliana's defense against pain was to threaten and push away anyone who got close to her. She was proud of her toughness, her readiness to fight and establish her dominance on the street. She readily described herself as the kind of person who would act before she thought, and was clearly pleased at her capacity to frighten and intimidate people. At the same time, though, impending motherhood had stimulated—as it so

often does—the wish to mother differently than she herself had been mothered. Iliana wondered aloud if she could learn to be the kind of mother the baby could count on. "I know I've got to change and not just walk away or not talk when I'm mad. It's not just me and what I want anymore." This snippet of mentalization, in which she linked her behavior to internal experience and recognized that her own intentions and desires were changing, was brief and fleeting. This was all we had to work with.

When Iliana revealed her pregnancy to her father and sisters she was told that she was "not fit to be a parent and was on her own." She had only known the father of the baby for several months and the pregnancy was unplanned. Their relationship was evidently troubled, although it was not until much later in the work that we knew just how troubled. She had little expectation of support from him ("maybe he'll buy diapers") and obviously felt let down and alone. Despite leaving high school during 10th grade, Iliana was—like Mia—clearly an intelligent and articulate young woman. Also like Mia, she longed for work that would give her a sense of purpose and meaning.

Unsurprisingly, it was very difficult to establish a therapeutic relationship with Iliana. Her armor—manifested in her attitude—was thick and tough. During the prenatal phase, she routinely failed to show up for appointments. She never called to cancel, but when phoned to reschedule, she always appeared interested in setting up another meeting. We viewed this ambivalence in a positive light (at *least* she was ambivalent), and she continued to reschedule appointments, well aware that she would fail to keep more than half of them. We hoped that our continued presence signaled a willingness to meet and work with her as she became ready and more trusting of us. This was but the first sign of resistance that was to manifest itself continuously as treatment proceeded, and the first of many times that our clinicians would have to remind themselves that her resistance was based in fear rather than an outright rejection of intimacy.

Not surprisingly, the fear of closeness to others was reflected in her relationship to her baby during pregnancy. "I talk to it sometimes, but I don't know why," she remarked. In this circumstance it was hard to make baby "real" to the young mother-to-be, except as the reason she had to stop "hanging out at clubs." To stimulate her thoughts and feelings we looked at pictures of newborns and discussed common infant behavior that is often of concern for new parents. Looking at the life-sized photo of a brand new baby, Iliana was finally able to speak of her fears. "It's hard to picture the baby. I've never held a lit-

tle baby. They are so small they look like they can break. And when the baby cries—I might get mad or nervous and just walk away!" Embedded in these comments were signs of another set of difficulties that were to recur throughout all phases of the treatment, namely Iliana's profoundly disrupted sense of her body. The new and frightening bodily sensations and discomforts of pregnancy made her feel out of control and angry. She was terrified of labor, and particularly frightened of the feelings of powerlessness and vulnerability that it would engender; these feelings can be especially poignant in women who have been sexually abused and who find labor retraumatizing. As might be expected, Iliana's feelings about her own body were to later define her feelings about and insensitivity to her baby's body.

Giving birth was an empowering experience for Iliana. Anticipating the terror she would feel giving birth, the nurse practitioner developed a labor plan with Iliana that allowed her to make choices ahead of time about medication, restraint, and other aspects of the delivery (Simkins, 2002). The labor was difficult, but the labor plan—which was supported fully by the midwifery team—allowed Iliana to feel in control of her experience. She was extremely proud of herself, and her daughter was easy to feed and console. The new mother held the baby—a girl named Lucia—closely, gazing warmly into her eyes and imitating her facial expressions. We pointed out how she was able to make the baby feel safe by holding her close and how she was learning to read the infant's cues to comfort her. Iliana was enormously pleased that she could regulate the baby's states to reduce her crying episodes without becoming overwhelmed herself. Given Iliana's tough veneer, and her enormous resistance to treatment, we had not allowed ourselves to hope for such an auspicious beginning. But as so often happens, Iliana got an important developmental nudge from her easy little girl.

This positive beginning helped Iliana become more open to developing a relationship with the Minding the Baby team; however, unlike Mia—who was able to form a relationship that allowed her to move toward reflective understanding in relation to her baby—Iliana and her relationship to us was defined by her concrete needs and demands on the one hand and by her angry resistance on the other. On the one hand, there were moments when she could be tender toward her daughter. At these times, however, Iliana was also reminded of her own loss, of not having been nurtured and protected by her own mother. Iliana said she longed to "be a little girl all over again. Not to have the childhood I did have, but to have someone take care of me." As a consequence, she often could not tolerate the baby's need for

care and comfort, and experienced Lucia as demanding and needy. The baby's distress irritated her, and she would handle her abruptly and speak to her harshly. We observed her roughly awaken the baby to change her diaper or harshly tell the baby to "shut up" when she whimpered. She misattributed the baby's facial expressions of discomfort as anger with her.

It seemed quite evident that any sign of distress in the baby aroused her own feelings of sadness and helplessness and were thus intolerable. It was very hard to help her at these moments, most likely because our giving voice to the baby's feelings made them even more unbearable. She took our "talking for the baby" as criticism, and responded with surly adolescent mumbling. Any hint of "correction" on our part (try though we might to remain benign and nonjudgmental) would trigger Iliana's hostility and defensiveness. At such moments, she was extremely resistant to new ideas or ways of interacting with the baby. We had to work around her defenses.

Iliana's profoundly disrupted sense of her own body also interfered with her ability to see the baby's needs as reasonable and separate from her own. Many times we would come to the home to find her disheveled, her hair uncombed, wearing her torn nightclothes. There were signs of neglect. Lucia was basically healthy, fed, and clean, but Iliana routinely failed to follow through on caring for what should have been routine physical care for her child. Lucia had eczema, and on several occasions both mother and child had advanced cases of ringworm. With her eczema untreated, the baby often had a number of raised, scaly patches of skin and was irritable and uncomfortable, which she would scratch continuously. Ignoring the baby's distress, Iliana instead complained of her own numerous physical complaints, and reprimanded her daughter for scratching.

In thinking about how to help Iliana become more sensitive to her child's bodily needs, we remembered that her relationship with the midwife during her pregnancy allowed her to feel someone cared for and she respected her body for the first time in her life. We wanted to build on this new experience and find ways to demonstrate acceptance of the mother's body (and, therefore, her whole being) in a caring way during home visits. Addressing Iliana's needs first, the nurse practitioner spent time at each visit asking about her symptoms, using questions about her past and current activities, nutrition, and abuse, to help the young woman make tentative connections between her feelings, symptoms, and self-care. We found that the more the young mother's pain was acknowledged, "heard," by the clinicians, the more able she was to understand her daughter's needs and experience.

Unlike Mia, who from the start could—at least in a limited way—engage in the struggle to understand her history, her relationships, and her emotional experience, we had to approach Iliana through her body, and through her concrete needs. She could not work at a metaphoric or abstract level. When we tried to talk to her about her feelings about her life experience, she would become enormously sleepy and actually appear to doze off. Mentalization could only take place at a very concrete, protosymbolic level (Werner & Kaplan, 1963). But as we did this, she began to involve us more directly in helping her. It turned out that Lucia's father had been abusing Iliana throughout the pregnancy, and he was now continuing to physically threaten her. This was the other side of Iliana's toughness: the paralyzed victim. Once she disclosed his abuse to us, she was able to use us to help her obtain an order of protection, and to support her desire to protect her baby. At this time she became more overtly dependent upon the home visitors, and in particular needed a great deal of social service help to obtain a place to live as well as a variety of social service benefits. Her extreme neediness was experienced by the home visitors as a continuing volley of demands, within the context of which they had to continuously work to keep the baby in mind for Iliana. These demands only increased when we decreased the number of regular home visits when Lucia turned one (a standard transition in the Minding the Baby protocol). She responded with overt indifference and appeared to pull sharply away, but she began to call us nearly daily with minor and major crises. Iliana the tough and defended young woman who needed no one could not get enough of us.

Over time Iliana has slowly become more aware of her baby's experience. When Lucia was 15 months old, Iliana, her new boyfriend, and the baby moved into a tiny apartment of their own. Iliana complained that the toddler was "always in the way. Always trying to do what I am doing. It makes me crazy!" The nurse practitioner brought over a small plastic tub and a few containers for the little girl to play in, and asked the mother to follow the baby's lead while she herself washed the dishes. Imitating her child's actions, Iliana suddenly "saw" what the child was doing. In imitating her daughter's splashes and play with soap bubbles, she laughed and exclaimed, "Oh! This is fun!" She had a sense of the child's internal experience at that moment and recognized that the sharing of the experience brought them closer together. She was able to express this feeling to her child by having a short conversation about what they were doing. This realization has sometimes spilled over into other parts of their life together. Recently Iliana laughingly described her daughter as "being

her own little self." Iliana had been outside watering the flowers in the garden, and—anticipating her child's desire to be included—had dressed her in a swimsuit. She had understood and accepted her baby's desire to be nearby and involved with her, as well as to explore her expanding world. The child's jubilant response served to reinforce and build on her mother's new capacities.

These moments of seeing the baby and taking pleasure in her have been accompanied by other shifts as well. Iliana now uses her community health center for routine medical care instead of going to the ER. She has a relationship with her primary care providers, facilitated by the nurse practitioner, who has served as a bridge between clinic and mother in an ongoing way. For Iliana, who has in the past tried to control her body and that of her baby's as a means of regulating her fragile sense of self, the willingness to allow others to care for her and her body is crucial.

As is captured in Iliana's own words at the opening of this paper, we also began to see signs of limited reflective functioning across a number of domains. While significantly less widespread and deeply held than Mia's capacity to understand and hold her baby in mind, there were signs that she had begun to understand that there was a baby to be known. She tentatively acknowledged that she had begun to allow the home visitors to get to know her, and to witness her experience. She has acknowledged the power of her mother's abandonment and her own unrequited longings for love and simple care. She began to talk about her child's needs and understanding as being different from her own. Thus, even though these reflective capacities can easily disappear in an instant when she becomes angry or threatened, it is nevertheless becoming more natural to her to think about the baby in this way.

At the same time, it is important to acknowledge that there are profound limitations to Iliana's reflective capacities, even after nearly two years of treatment. Unlike Mia, Iliana has not been able to develop and rely upon a narrative—a story of herself—that helps her to contain and make sense of her complex emotional experience. The understanding she does have often fragments under the intensity of her feelings. These kinds of phenomena have been described by Fonagy (2000) as typical of individuals who have suffered extensive trauma and who would be diagnosed with a borderline personality disorder. This is certainly a meaningful way to describe Iliana. She can still be openly neglectful of Lucia, and very harsh with her, although now she yells instead of slaps. Nevertheless, we worry that we will have to get child protective services involved, as there continue

to be multiple signs that Lucia is often in danger, either from Iliana's neglect or for Iliana herself. We understand the limitations of Iliana's availability to treatment as a function of multiple factors, most prominent being past and ongoing trauma and the lack of a stable, loving caregiver. In addition, Iliana had endured continuous disruptions in her sense of bodily integrity and wholeness; often, these assaults had been at the hands of those who were responsible for caring for her.

Discussion

As she approaches her child's second birthday, Mia has begun to hold her child in mind. Iliana's abilities to do this are far more compromised and fragmented, although she too has discovered reservoirs of pleasure in and identification with her child that are crucial and even miraculous. Developmentally, these young women began Minding the Baby with significantly different capacities for reflective functioning and mentalization, with Mia—while quite defended—the more ready of the two to think in a complex way about her interior life, and about the dynamic relationship between her feelings and actions. While certainly no stranger to trauma, Mia had managed to escape the physical trauma and abandonment that had devastated Iliana, and had found crucial comfort and safety in her relationship with her mother, who in her own narcissistic fashion kept her daughter in mind. From the standpoint of reflective functioning, Iliana began the program without any evidence of such capacities, and Mia began with at least rudimentary openness to acknowledging mental states, and occasionally holding their interconnectedness in mind.

Our multidisciplinary model allowed us to approach these differences in a flexible way, to balance the nursing and infant-parent psychotherapy approaches in response to different kinds of supports these mothers needed at different times. Mia was more ready to make use of a more traditionally therapeutic relationship with the home visitors; the first real shift in her treatment came in beginning to tell her own story to the social worker. She required relatively little help with physical care, but instead relied upon the nurse practitioner's expertise in parenting and child development. Iliana, on the other hand, needed a great deal of practical help from the nurse practitioner, and only when she had established an almost physical dependency upon this concrete level of mothering from the team was she able to begin to take in any developmental guidance or parenting support. She used the social worker to help her obtain social

services, again needing this kind of very concrete help to support any reflective capacity whatsoever.

We think that the progress made by the mothers and babies in our program has come—finally—from our home visitors' capacity to hold their bodies and feelings in mind, to witness their pain and their anger without dysregulation and retribution, and to keep the baby alive for the mother in the face of relentless chaos and uncertainty. As we hope we have been able to convey in our description of a mentalization based, multidisciplinary mother-infant intervention program, this is complex work indeed.

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