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Multimodal Parent-Infant Psychotherapy

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Lascia parlare il tuo cuore, interroga i volti, non ascoltare le lingue . . .

Let your heart talk, interrogate the faces, do not listen to their tongues . . .
Umberto Eco, *Il nomme della rosa [The Name of the Rose]*

In this chapter, we describe a model of therapeutic intervention with infants and families that incorporates diverse modes of understanding and various therapeutic approaches. This way of intervening seems most applicable to the needs of families with many concurrent problems. Dealing with these situations in the infant mental health clinic requires maximum flexibility, sensitivity to the unique needs of patients, and an ability to comprehend the various problems in order of importance and severity.

This model relies on a process of intervention that involves the parents and the infant as primary partners with the clinician in understanding the problem and in attempting its resolution. The therapist changes roles and techniques depending on the initial problem and how the situation evolves. The presenting problem may be simple in itself but may become complex and difficult given the family context. Or it may be only one of many problems the family faces, including other stressors and adverse social and economic circumstances (see Figure 6–1).

Parent-infant psychotherapy can be described as the interaction of the family and infant system with the system of the therapist or therapeutic team. Optimally, the transactions between these two systems are mutually

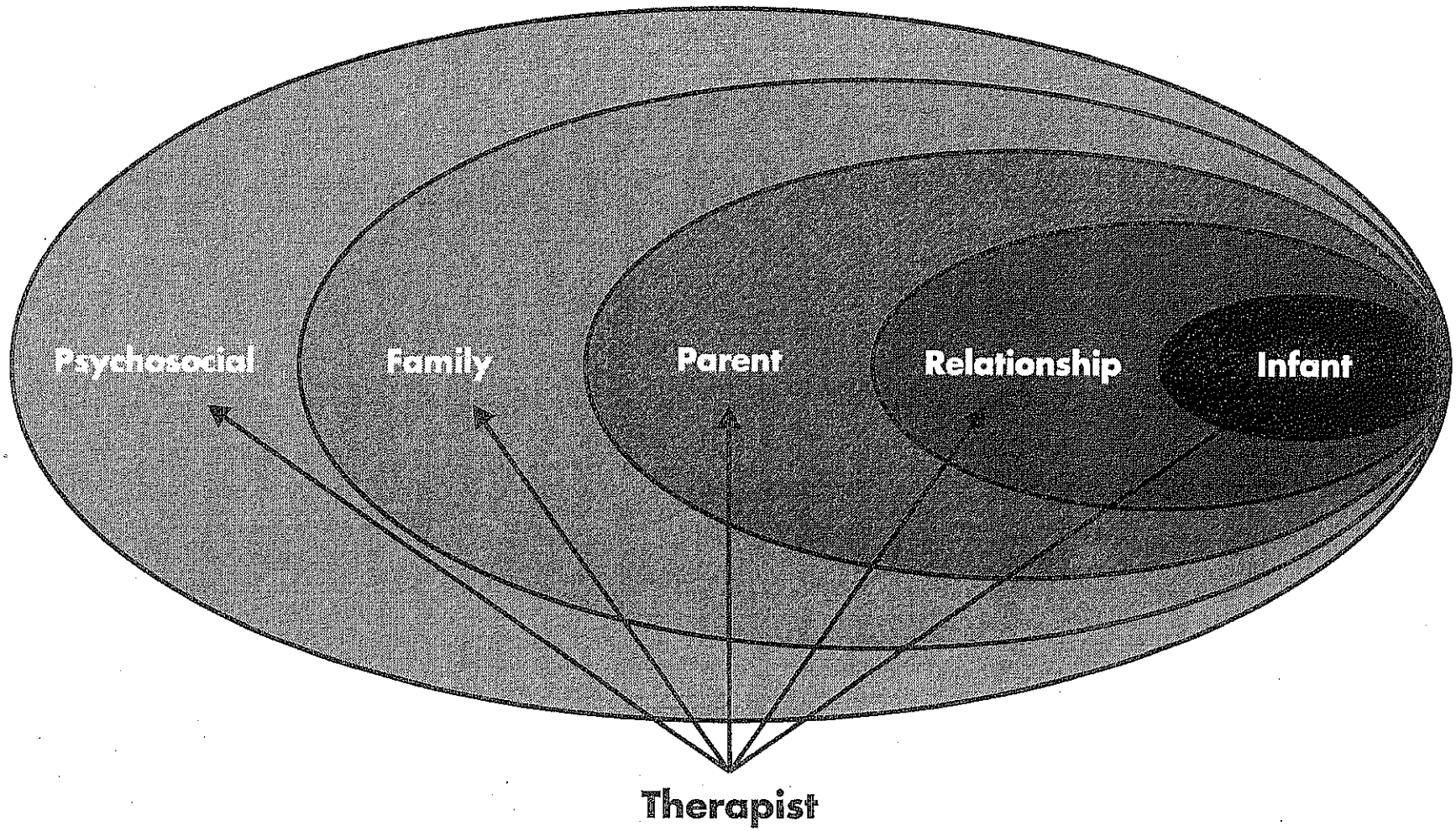

Figure 6–1. Multimodal interventions.

The multimodal approach to therapy can help clinicians recognize and prioritize problems so that interventions can be more appropriately tailored.

informative, satisfying, and constructive and result in a positive outcome—or at least the problem situation improves. In these exchanges, the therapist is ready to modify interventions, depending on changes and shifts within the family-infant system. However, if the therapeutic interaction does not lead to a mutually adaptive response to the family's unique set of problems, therapy may prove unsuccessful.

Our therapeutic proposal demands the therapist be highly flexible and able to use a variety of techniques. Using only one method to address all problems is not likely to fit the realities of a particular family, child, or parent-child relationship. When therapists are trained to use different interventions, they can apply various strategies to specific clinical challenges, taking into account factors such as the family's motivation to change, the infant's particular problem, and realistic constraints of the situation (e.g., traveling distance to see the therapist, financial limitations). Some recommended techniques are useful when the family has limited motivation or resources for prolonged treatment or when there is a need for rapid change.

In addition, different "theoretical lenses" (e.g., family systems therapy, developmental psychopathology, behavior therapy, psychoanalysis) can be used at various moments in the therapeutic transaction to gain a better understanding of the nature of the problems. These perspectives will inform and guide the interventions. The available literature on parent-infant psychotherapy tends to emphasize a psychodynamic perspective and interventions that provide a broad framework for understanding infant mental health problems (Cramer 1995; Lebovici 1983; Lieberman 1992; Stern 1995; Stoleru and Morales-Huet 1989). This framework guides most other interventions. There is comparatively little information available on less interpretive but more immediate and practical techniques.

There is little empirical evidence for the effectiveness of psychotherapeutic interventions, including those during infancy, except for studies on the models of brief parent-infant psychotherapy at the Geneva school (Cramer 1995; Cramer and Palacio-Espasa 1993) and the interactive guidance model described by McDonough (1995). To address the question of effectiveness, we are currently conducting a follow-up study of our multimodal approach.

In this chapter, we describe the impact of using diverse theoretical perspectives in our technical interventions with infants and families. It will become apparent that many techniques commonly used in family therapy are incorporated into these different maneuvers. We also address some indications and contraindications of the models and illustrate several points with brief clinical vignettes from an infant mental health clinic in a community setting.

MULTIMODAL INTERVENTIONS

Not all families respond the same way to certain models of therapy. For instance, some parents with an infant who cries "almost all day" may come to the clinic asking for immediate advice on what they can do to help their child. They may feel quite disappointed if the clinician does not give them suggestions for how to help their baby cry less. Therapists who notice the parents' desperation may focus their inquiry, even from the first session, on what could make the infant cry so much and then recommend ways to alleviate this severe challenge (e.g., carrying the child more, reducing auditory stimulation, using a pacifier). Once the most troublesome symptom is alleviated somewhat or ameliorated altogether, the focus could shift to discovering other factors contributing to the baby's difficulty. Then the therapist may learn about an array of issues, such as the parents' feelings of anger and rejection toward the child or severe stressors they are experiencing. To help the baby, these problems must ultimately be addressed. Alternatively, the process may terminate once the parents notice their infant does not cry so much after they implement the therapist's initial recommendations.

In contrast, another family with a baby who cries excessively may not welcome the clinician's advice. Parents who have major difficulties with self-esteem or trust toward others, and whose own families have accused them of not taking good care of their baby, may feel resentful if the therapist initially suggests any concrete interventions. In such a situation, the therapist may find more useful a reflective model that emphasizes aspects of empathy toward the parents primarily and toward the infant secondarily. The therapist should try to establish a trusting relationship with the parents so that they do not feel suspicious of treatment recommendations. Conceivably, after these initial therapeutic moves, the parents may become receptive to techniques they can use to calm or comfort the baby and preempt further crying episodes.

A multidisciplinary team (including, e.g., family therapist, occupational therapist, language therapist, physician, developmental psychologist, and psychiatrist) can most readily design multimodal strategies. (Or one clinician may simply consult with colleagues from other disciplines.) When there is a team, clinicians with different backgrounds contribute their unique expertise to the understanding of the clinical problems. (In some cases, the use of a one-way mirror or videotaped sessions may be helpful. Of course, these methods require informed consent from the parents.)

Through case discussion, members of each discipline participate in designing a solution while also learning from each other and expanding

their own therapeutic repertoire. This approach can be illustrated with the following case.

David

Ms. G, an 18-year-old mother, brought David, her 11-month-old son, to the clinic with the complaint that the baby was extremely aggressive and frequently threw temper tantrums at the slightest frustration. According to her, David is rarely content for any length of time and seems very unhappy. When angry, the baby hits and also tries to bite her. Indeed, he has bitten her many times. Ms. G shows several small bruises on her arms. David also hits others who take care of him, including his maternal grandmother and aunts.

At this point, the clinician can explore in several directions, depending on his or her theoretical point of view and professional background. A family therapist may be interested in the systemic framework and meaning of these complaints and in the infant's and mother's behavior.

Ms. G says while she is working, her mother looks after David. She regrets having to rely on her mother but chalks it up to multiple stressors in her life. She not only works in a fast-food restaurant but also attends college. She takes care of the baby the rest of the time. Later, when asked about her relationship with her mother, she mentions they have had many physical fights in the past. She would even bite her mother during those fights. Some recent confrontations were set off when her mother found out Ms. G was pregnant and kicked her out of the house.

The therapist could then examine the transgenerational aspects of the situation and try to explore with Ms. G how the aggression (biting) seems to traverse at least three generations. The therapy might proceed by focusing on that point of view. The therapist could also explore the multiple stressors Ms. G faces: poverty, the care of her baby while attending school, conflicts with her mother, and problems with access to the health care system.

In contrast, a clinician with a more child-focused, developmental point of view might focus on how the child has developed these problem behaviors. During the session, the therapist might explore and observe how the child plays, moves around, and speaks; how the child's emotions fluctuate; and how the child eats, sleeps, and reacts during transitions. The therapist could try to get an idea of the baby's cognitive status, sensitivities, and emotions.

The therapist learns David has a long history of crying for extended periods and is highly sensitive and fussy. If things do not go his way, he immediately loses control and cries or attacks those around him. In the

session, the therapist observes David accidentally bump his head on a table. He then becomes angry, walks toward his mother several feet away, hits her, and tries to bite her, as if she were the one who caused his pain and he wanted to punish her. The therapist then suggests David is struggling because he does not know how to express his anger in a more adaptive way. The therapist recommends several interventions. One intervention is to diminish the intensity and array of stimuli in his milieu; another is to ease the transitions during his daily routine. The therapist also suggests Ms. G empathize with her son's pain by expressing her own concern when the baby is upset. Later on, in front of Ms. G, the therapist "teaches" David not to hit or bite and shows him with a doll what happens when someone bites another person. The therapist illustrates biting a doll and "marks" (Gergely and Watson 1996) the doll's ensuing pain by exaggerating the emotional expression associated with the pain. He then suggests an alternative and demonstrates it by asking David to touch the doll gently so as not to hurt it. David appears surprised. The clinician asks David (and his mother, who will also model for her son) to give the doll a kiss instead of biting it. David does so, and the therapist applauds. He advises Ms. G to practice this new emotion at home. He also recommends she name the negative feelings David displays when he appears so frustrated as being "mad," empathize with David, and soothe him, instead of chastising him and giving him a time-out.

This intervention is a more cognitive-behavioral approach to the same clinical situation and was the first level of intervention with this family. A clinician with more psychiatric orientation might be interested in the fact that Ms. G's mother suffers from bipolar disorder. The clinician would then attempt to explore symptoms of mood disturbance in Ms. G and the infant.

Ms. G says she is sad and angry most of the time because her hopes of going to medical school were shattered by the baby's arrival. If Ms. G endorses more symptoms of major depression, the first suggestion might be for her to engage in a trial of antidepressant medication. She mentions she is very irritable and tired and has little energy for dealing with the infant. She often feels like not getting out of bed in the morning and is pessimistic about her future.

A more psychodynamically oriented professional might explore the number of consciously mixed feelings that Ms. G expresses about David and his birth. Ms. G says she tried to have an abortion when she learned she was pregnant. When she went to a clinic, she was told it was "too late." She realized she would have to continue the pregnancy but had decided to give up the baby for adoption. When Ms. G's mother found out about this plan, she became enraged and pressured Ms. G to "keep the baby," saying it was a disgrace to the family that she could even think of giving the baby up for adoption. She offered to help Ms. G care for David.

The psychoanalytically oriented therapist may conclude Ms. G has not made space (Hoffmann 1995) for David in her life and her mind. The baby feels like an intrusion or even a punishment; he has spoiled her plans and now she must pay the consequences for her mistake. The therapist may begin the clinical work by talking about Ms. G's feeling that the child came at the wrong time in her life and that she did not really want him. This realization may help Ms. G start thinking about making room for her son in her life.

A child therapist may be more inclined to speak for the baby and thereby promote the development of empathy in Ms. G for her son. Observing the child in action with his episodes of aggression and biting, the clinician could reflect on the question of how David might feel when he is trying to bite his mother and how he may have chaotic feelings when he is throwing a tantrum. The therapist may also discuss how the infant could express his intense feelings differently. This possibility of change in the baby's expression of feelings may help Ms. G understand the intentionality in the child's actions and teach her to predict and perhaps preempt future explosions. These realizations could at least help her to contain David and accept his feelings, without reprimanding him and giving him a time-out.

These are only a few suggested points of view to use in approaching this situation. We suggest a clinician or therapeutic team could hold several of these models in mind and consider the clinical scene through different lenses. Then one or two strategies could be used to approach the problem. The decision of which strategies to use also depends on the therapist's intuition and his or her perception of the infant and family; it also depends on what the family wants and which therapeutic goals the family can achieve. The therapist and the family would then negotiate a therapeutic contract, understanding that both parties should be open to adjusting their focus according to the progress made in therapy.

Different Perspectives and Techniques for Various Therapeutic Goals

Factors in Therapeutic Goal Setting

At the beginning of clinical work with a family and child, several factors, as listed below, must be understood in order to arrive at a realistic therapeutic agreement or "contract":

- The infant's problems as well as his or her strengths and attributes
- The family's perception of the child's problems and what they wish to change

- The therapist's recommendations about what the problems are and what could be done to change them
- Real-life factors, cultural factors, limitations, and factors that operate in favor of and against therapy and change

Infant's Problems, Strengths, and Attributes

A patient profile can be made as a result of a hands-on assessment of the baby. Each line of development should be assessed in its own right: language, motor skills and coordination, sensory integration abilities, reciprocity and relatedness, emotional status, expressiveness and emotional regulation, play, attention span, and so forth. With this profile in hand, the clinician would know both the child's relative strengths and the child's most challenging areas.

Family's Perceptions and Wishes

The therapist clarifies what the family sees as the problem; what their theories are about its nature, cause, and maintaining factors; what they think should change; and their motivation for change and investment in change. The therapist also determines the family's systemic resources for making such change possible.

Therapist's Recommendations

By integrating the observation and assessment of the infant, the family as a whole, and the caregiver-infant relationship, the clinician develops a priority list of what needs to change and what should be addressed first. This list would constitute the therapist's "wishes," not necessarily what would be worked on.

Real-Life Factors and Limitations

The real-life factors and limitations would include the ability to come to sessions, work demands, economic difficulties, and family stressors (e.g., a mother with chronic fatigue syndrome, a father with diabetes). The therapist could also take into consideration what the family perceives as dysfunction and the parents' preferred remedy for the situation.

The Therapeutic Contract

The therapeutic contract should be the result of a mutual exchange, a negotiation, so to speak; it should not be decided by only the family or the therapist. Ideally, it would be a cooperative approach to the problem and would include the priorities for addressing it. The contract should

be fairly explicit, but at times it can be left implicit. In many of the most difficult families, a contract can be most useful for focusing initially on the problems presented by the infant, that is, the problems that initially bring the family to the clinic. The clinician deals explicitly with these areas while also starting a therapeutic process on other aspects, such as the parent-infant relationship, the spousal relationship, or, if present, the parents' malignant projections toward their child.

Two extreme points of view illustrate the benefits of a negotiated therapeutic contract. At one extreme, therapy is dictated by "the expert" (the therapist). After exploring the situation, the therapist arrives at a conclusion about the problem and its solution. He or she then gives a "prescription" of what the family should do. This approach used to be the traditional medical model. At the other extreme, some family therapy involves having the therapist work only on what the family perceives as the problem. Logically, once that problem is resolved, therapy is terminated. Even at the other extreme, however, the parents must agree at least on a working definition of the problem and what should be attempted to solve it.

Both these extremes (and even more balanced approaches in between) sometimes forget the infant also has a contribution to make to the therapeutic contract. For example, the nature of the child's difficulties, development, temperament, and unique characteristics should inform the family's perception and the therapist's recommendations.

We suggest that in most situations it is optimal to seek an intermediate point between the two extremes. Neither the vertically designated prescription from the expert nor the unmodified and unquestioned view of the family and its definition of the problem is the best therapeutic approach. From our point of view, the clinician can make valuable contributions to the definition of the problem and its possible solution, which should not be ignored or set aside. The family also plays a major role in deciding what the problem is and what the therapy should be. Parents, however, vary in their knowledge of child development, child psychopathology, and other aspects of human relationships. Thus, their view of the problem may be either quite accurate or quite inaccurate. The knowledgeable therapist can help the family redefine the problem and inform them of possible interventions. Many parents welcome "expert" opinions and are eager to implement suggestions. In short, the family and the therapist should seek to arrive at a mutually agreed-upon area where clinical work can take place, that is, where the therapist, family, and infant can collaborate to reach a common goal.

DIFFERENT INTERVENTIONS AND TECHNIQUES

Apparently simple and practical interventions, such as giving advice or offering practical help to parents, do have a psychodynamic meaning that may or may not be discussed openly in the therapeutic relationship. All the interventions we describe here have a psychodynamic impact, but this aspect is usually not emphasized in the context of multimodal interventions (Figure 6–2).

Practical Help

Parents of young children, by the very nature of the demands of this stage of life, experience significant stress during pregnancy, delivery (or cesarean section), the neonatal period, and later on. Many of these stressful situations are usual, but families may go through additional adverse circumstances. Stress factors have not only a cumulative but also a multiplying effect, putting the family and infant at more risk. People are able to tolerate only a certain amount of stress, after which their homeostasis and ability to cope are likely to collapse.

When the therapist sets practical help in motion, at least one stressor may be eliminated. In some cases, the alleviation of some stress can make the difference between a positive and a negative course. Relieving some immediate concern may also enable a parent to face the challenges presented by the baby, be more emotionally available or patient, or even enjoy the child more.

In their model of infant-parent psychotherapy, Lieberman and Pawl (1993) described the use of practical help. This often preliminary step promotes the development of trust between the parents and the therapist and moves them closer to the ultimate goal of a corrective attachment experience.

Here we refer simply to the implementation of practical actions to alleviate the stress felt by parents. This provision of services may indeed be perceived as helpful by parents who are on the verge of succumbing to overwhelming psychosocial circumstances or are socially isolated, as is the case with many inner-city families.

Ms. B

During a house visit with a social worker (Mr. Jack Moseley, whose spontaneous help to the family was most useful), one of the authors consulted with Ms. B, a 20-year-old single mother of two children. One child was 2 years old, and the other was 9 months old. Ms. B's inner-city apartment was very old and quite dark. It consisted mostly of one big room with a stove in the middle.

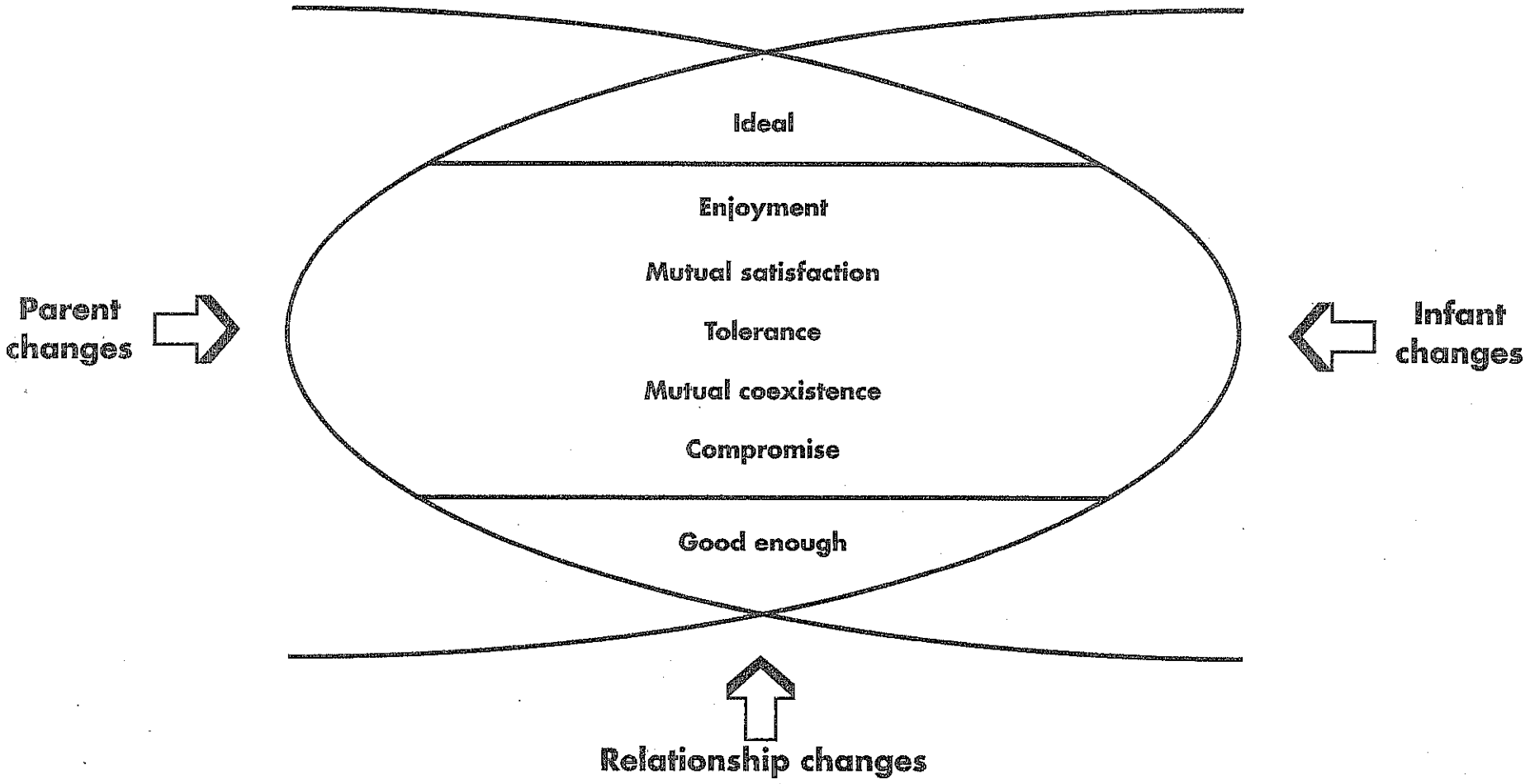

Figure 6–2. Focus of multimodal interventions.

The focus of multimodal interventions can be on the parent or the child, or on their interactions, so they can be helped to work toward developing a better relationship.

The consultation concerned the 9-month-old baby, who was not eating well and, consequently, not gaining weight. Ms. B appeared very hesitant and burdened, looking much older than her 20 years. Because the baby was not thriving, the pediatrician had called child protective services, suspecting the mother was neglecting the child. The social worker, on the other hand, thought Ms. B was quite devoted to her two children but felt overwhelmed and lacked the energy to try new strategies to feed her baby.

Ms. B said she did not know how to get her child to eat. He only wanted to drink milk and juices, which did not provide enough calories and protein to grow. The therapist suggested Ms. B give the baby puréed foods to play with and explore. He asked her whether she had a high chair for the infant. Ms. B said she did, but it was still in the box. Some relatives had given it to her as a gift several months before, but she had never opened the box and assembled the high chair. While the therapist was explaining to Ms. B about experimenting with food, the textures of different foods, and the critical periods for introducing consistent foods, the social worker unpacked the high chair and put it together. Ms. B then put her baby in it and placed some puréed food on the tray in front of him. The infant immediately proceeded to touch the food, pick it up, and put it in his mouth. In a follow-up visit several weeks later, the baby was found to be eating a variety of puréed and even "lumpy" foods. It appeared that assembling the high chair for Ms. B was the "jump-start" she needed to set in motion the process of working with her problem in feeding her child.

Practical help may be necessary, or a first step in therapy, for parents who have a sick baby and do not have a telephone, who have had their water disconnected, or who lack heating. At times, several social services can be drawn on with the intervention of the therapist, who is often more knowledgeable about such resources. The goal is to create a more favorable set of circumstances for the family and the infant.

Practical help should be offered with a clear goal in mind. The therapist should differentiate among adequate interventions; excessive, inappropriate, and unnecessary interventions; and those based on the therapist's sense of guilt. The therapist should also avoid interventions that the family may view as an intrusion or an indication that the therapist thinks the family is ineffective.

Information

Families in the United States and other developed countries are becoming increasingly nuclear, and many are quite isolated from a support network. As a result, parents often do not have any role models from whom to learn about child rearing, nor do they have anyone to ask about common infant problems. In the past, shared cultural values and practices made it

easier to know what to do and how to manage child rearing. Some parents may turn to books, but in many circumstances they just do the best they can, creating novel interventions that may be quite useful sometimes but detrimental to the child at other times. It is well known that one major risk factor for child maltreatment is social isolation, especially for single mothers (Olds et al. 1997).

The therapist may give parents information about a number of issues, including child development, common and transient alterations in infant behavior and organization, and the emotional needs of young children. There are multiple situations in which the therapist can reassure the baby's caregivers with simple developmental information or help them with recommendations that experienced parents might find commonplace and unremarkable. For novice, isolated parents, such information may make a significant difference in their ability to care for their babies.

Although much of this knowledge can be gained from videotapes and pamphlets, the parents most in need tend not to avail themselves of such knowledge through those channels. They may also be more likely to welcome specific information suitable for their particular child—that takes into account the uniqueness of their situation—rather than material meant for a wide audience. To illustrate this principle, the following list gives examples of information that may be helpful to parents:

- The competencies of newborns and infants, including their ability to see and hear, their need for touching and holding, and the ways parents can promote a reciprocal relationship between themselves and their child (Maldonado-Durán 1996).
- Preparation of baby formula and monitoring of infant nutrition. For example, parents may dilute the formula too much or not notice situations in which the child does not gain weight because he or she drinks juices, which satiate the appetite but have relatively poor nutritional value.
- The transient nature of many infant behaviors. For example, children need to be held, but the need usually will not persist with that intensity after walking starts. Each stage represents different needs. The same is true with struggles over autonomy during the tenth month of life. Exploratory biting by the infant at 9 or 10 months of age can be misconstrued by others as attacks. Similarly, the child's insistence on dropping things on the floor to repeat an interesting spectacle can be interpreted as stubbornness.
- The importance of routines to help support the young child's efforts at self-regulation.

- The need for cognitive stimulation of the infant's developing brain and the importance of language, speech, and play. The stimulation for the baby may include face-to-face contact to support the development of reciprocity.
- The development and changes in the baby's emotional life, for example, the emergence of separation anxiety and consequent clinginess. Talking about the emotions of young children may foster in the parents an attitude favorable toward "mind-reading" the child, which is a crucial element of sensitive parenting (Fonagy 1998).
- Normal patterns in the development of eating abilities, sleep routines, crying, motor functioning, and sensory processing.
- Common health concerns and childproofing strategies for the home.
- Individual differences between children and the uniqueness of the individual child. For example, parents may need information about specific sensitivities, temperament, and the different "types" of children (Greenspan 1991). Parents may have preconceived expectations about how the child should be, while being less aware of healthy variations.
- Cultural variations in child-rearing practices, particularly for migrant parents or those from different cultures. For example, if the parents do not have a cultural perspective, they may practice co-sleeping with their baby or prolong breast-feeding and find themselves questioning their intuition about what to do (Moro 1994). In industrialized cultures, parents from nonindustrialized cultures often are perceived as not fostering their child's independence, yet being independent is not an important cultural value for these parents.

This information may alleviate many of the parents' concerns and help them solve problems and answer questions about what to do when faced with the unique demands or challenges of their child. The therapist, however, may encounter contraindications to providing such information. Some parents may feel annoyed or even insulted by the clinician's "lectures," notwithstanding the quality of the information or the obvious need for it. Except in situations in which the primary needs and safety of the baby are at stake, the therapist should respect the parents' defenses. Caregivers with conflicts originating from dealing with their own authoritarian parents may not be responsive to further information. The therapist also has to exercise "mind-reading" skills to ascertain how the initial pieces of information are received. It may be more strategically sound to offer no information until a trusting relationship is established, which may take a long time for some families.

Julia

The importance of establishing a trusting relationship can be seen in the case of the D family. Julia was a 4-week-old infant at the time of the first consultation. A social worker referred the family because Ms. D repeatedly alluded to the surprising capacities of her daughter. Ms. D was certain the baby knew all of her mother's emotional states, could make decisions about her clothing, and had specific tastes about the decorations in her room. As time went on, the mother attributed more capacities to her daughter. At 2 months of age, Julia was seen as having clear preferences for television programs and clothing, and her parents were making arrangements to have her learn Spanish, German, French, Iroquois, and Potawatomie (the last two are Native American languages). Initially, the clinician attempted to provide information about the cognitive development of children—how it would be hard for an infant to make choices in clothing and TV programs. Such statements went mostly unheard by Julia's parents until their reasons for perceiving Julia as a super child could be addressed. The therapist discovered that Ms. D had lost a previous child from sudden infant death syndrome, and she was afraid that Julia would also die. She saw Julia almost as a reincarnation of the previous child, whose attributes compounded Julia's. Ms. D felt as if life had compensated her for her previous loss with an extremely gifted and special child. When the therapist addressed the mother's need to mourn the loss of her first baby, Ms. D's excessive attributions toward Julia diminished.

Emotional Support

When a baby is born, a parent is also "born" (Lebovici 1995). The adult who did not have children has to be born into a new identity as a parent (parentification)—a challenging and demanding task. The perinatal period is one of great vulnerability and usually requires much support from other adults who are emotionally close to the new parent. This period of adjustment seems true even of gorillas; when a gorilla baby is born, other females tend to support and help the new mother (Bard 1995).

The therapeutic stance of providing emotional support means, among other things, "being with" the parents and the infant. Sharing in their experiences, concerns, anxieties, and emotional pain, as well as in their happiness and hope, can be helpful and sustaining. Such an intervention may be more necessary or meaningful when parents cannot rely on relatives or close friends to participate with them, especially when difficulties develop. When a baby with a malformation or major disease is born, the distraught parents need an opportunity to discuss the situation, including their feelings, uncertainty, and pain; such contact may help them cope not only in the here and now but also in the future. Processing their experience and feelings may prevent difficulties down the road.

The therapist can encourage the parents to express their feelings, even negative ones toward the baby, and can help the parents to process them.

One aspect of emotional support is the therapist's function as a "container" for the feelings and experiences of parents and infant (Maldonado-Durán 1997). This support involves helping the parents cope with a difficult or potentially devastating situation involving great uncertainty and tension. At times, therapists underestimate their role as a listener and container. Many parents benefit from and find relief in "telling their story" to someone who is attentive and interested in hearing it. Often the therapist just has to be available; he or she does not have to say anything or interpret the meaning of the experience. The narration of the story and the reexperiencing of contained emotions associated with the story can have a strong therapeutic impact on adults who have gone through difficult or traumatic events.

Emotional support may also be necessary to mark, amplify, or simply acknowledge the feelings parents have around certain developmental achievements in their child. Particularly when parents are isolated and lack social support, the therapist may function as a "mirroring" figure for their efforts at parenting. Mirroring involves affirming the joy felt by the parents when the baby achieves developmental milestones, such as growing a tooth, saying "Mama" for the first time, or taking the first few steps. Parents enjoy these celebrations and sometimes actively engage the clinician by pointing out milestones, anniversaries, and accomplishments. Emotional support may be particularly helpful a) when the baby is born with some malformation or known dysmorphic syndrome, b) when the infant develops a major chronic medical illness, or c) when the newborn must be sent to a neonatal intensive care unit.

Many young parents, in particular, need to be reassured that they are doing a good job. Praising their devotion, skills, and attunement to the infant may help them continue to carry out these difficult tasks. All parents need gratification and social feedback. When the baby is less competent to reward the parents, the support of others can substitute to some extent.

Most parents are willing to speak about their feelings and share them with an interested person. This self-revelation is sometimes not possible, however, with more suspicious or emotionally injured adults, who may fear any sense of vulnerability or emotional closeness with someone else. The therapist should recognize the need for distance and defenses (e.g., denial, intellectualization, and rationalization) when parents are not in a position to explore other reactions. These defenses sometimes aid parental adjustment when parents must cope with their baby in difficult circumstances.

Advice From the Therapist

Winnicott used to say that the most difficult aspect of his work with patients was imparting advice (Newman 1995). Imparting advice is, indeed, a very difficult aspect of any therapist's work, but one that may be necessary. In some circumstances, it may be helpful for the therapist to assume the position of an "expert" on issues of child development, behavioral and emotional problems, and interpersonal relationships. The giving of advice seems very distant from the work of interpretation and reflection more typical of psychoanalytically oriented therapy. However, advice may be the most indicated clinical intervention in certain situations.

In some clinical cases, not giving advice can be counterproductive. Giving advice may help to engage the family in therapy and preserve their interest in seeking help or their hope for some benefit from it. Parents may even feel quite disappointed when a therapist does not offer suggestions about how to deal with their baby's problem. For instance, a therapist may be asked to consult with parents about a youngster who frequently hits or bites other children and is on the verge of being expelled from his third day-care center. Such parents may feel desperate to deal with a problem that represents many complications for them. They may feel frustrated if the therapist takes a stance of exploration and prolonged reflection about the problem without offering alternatives that the parents or the day-care staff can implement immediately. If no suggestions are made despite their requests, the family may decide that seeing a therapist is not helpful.

One function of the clinician may be to alleviate psychological pain, as in the case of the parent who feels helpless or incompetent. Another therapeutic task is to foster the hope that the situation will improve. After the parent implements some of the therapist's advice, a problem situation may become much easier to manage. Once the major tensions and the sense of urgency have abated, the parent may feel better able to reflect and examine fantasies.

Many situations call for advice, including those in which the parents need to be taught techniques to soothe and promote the infant's self-regulation. Optimally, this advice should be grounded in a careful examination of the child. Concrete suggestions also can be given about how to help a child settle to sleep or how to attempt to feed an infant with a minor disturbance (e.g., frequent vomiting, falling asleep at feeding time, pervasively diminished appetite).

Alex

Alex R, a 2-week-old infant, was referred for consultation by the lactation consultant from the hospital where he was born. His mother is a young

married woman who recently immigrated to the United States with the baby's father. A number of relatives live with the couple in their home and share in taking care of the baby. Ms. R's first pregnancy ended in a stillbirth.

Ms. R was quite apprehensive and worried because Alex "cries all the time," particularly at night. She was referred because she had lost her patience and had spanked the baby. In her mind, there was no reason for Alex to cry, but she could not console him. She regretted her outburst and wanted help to learn how to soothe her baby.

On examination, Alex appeared to be a very sensitive infant. He squirmed constantly and was quite restless and fussy. He quickly built up to active crying. Once he started crying, it was difficult to console him. Ms. R said this behavior was exactly what happened many times—day and night. The baby had very tremulous movements and was easily startled. He was hypersensitive to touch and did not accommodate being held in his mother's arms.

After examining the baby, the therapist recommended using a pacifier to give oral stimulation (i.e., nonnutritive sucking) to the baby as a soothing technique. It had been observed that the baby could better self-regulate while he was sucking. At first, Ms. R was surprised with this recommendation. She explained that her own parents did not like pacifiers, which were frowned on in their native country. But she said it would be fine to try using one. Then, infant massage was discussed and demonstrated, particularly the difference between superficial and deep touch. Finally, it was suggested she reduce surrounding stimuli (e.g., loud voices, television) for Alex.

In a follow-up interview, Ms. R reported she was enjoying her baby more than before. She appeared much more relaxed, and she felt the recommended techniques had proven effective. Her relief seemed helpful later on, when she was able to discuss her fears about losing Alex in light of the loss of her previous child.

Advice can be a "behavioral prescription" to try to alleviate a problem at hand. In several areas of infant functioning or symptoms, parents may not intuitively know what to do. For example, many parents may be surprised to be told that their baby naturally reacts cautiously and anxiously to new stimuli and that, therefore, such stimuli should be presented gradually, giving the baby time to get acquainted with them. In other words, each baby is unique. The clinician, who may have a fund of knowledge and experience about strategies for helping a baby cope with a changing environment and stimuli, can suggest two or three techniques that have been useful with other infants. Similarly, in dealing with a number of sensory integration difficulties (DeGangi 1991), some parents show great inventiveness and imagination to help their baby cope, and they modify their caregiving practices accordingly. However, many parents feel baffled and frustrated when what they do is not helpful to their baby. The clinician's experience may be necessary as a resource to deal with those situations (Zeitlin and Williamson 1994).

A common situation that requires advice from an "expert" is how to deal with an infant who shows little response to surrounding stimuli or interactions with caregivers. The baby can be hyporeactive or self-absorbed. If the parents do not persist in trying to engage the child, the child may eventually have delays in language, motor development, and the ability to engage in circles of reciprocal communication. Parents may require suggestions for techniques to prolong interactions and "seduce" the child into longer interactions. Left to their own devices, parents sometimes give up and let the child withdraw for significant periods. Letting the child withdraw extensively without any attempt to engage him or her is undesirable because in the first 2 years of life there may be more plasticity in the brain for the development of more refined pathways.

Parents often welcome such advice. However, as with the previously described interventions, advice may be contraindicated when parents feel vulnerable, criticized, or even "attacked" by the clinician's expertise. It may also prematurely close an issue that needs to be explored. In many situations, however, advice can open the door to further work once the parents' sense of immediacy and helplessness with the infant's symptoms has abated.

Translation of Infant Signals From a Developmental Point of View

In this intervention, the clinician may "speak for the infant" (Carter et al. 1991). A therapist who is experienced in evaluating children's problems can assess the baby's "symptoms" and then communicate to the parent some of the infant's needs and unique features. It is preferable to frame these needs as preferences and challenges rather than as difficulties or deficits. Here the therapist is a translator or an intermediary in the space between caregiver and infant. This translation frames the child's behavior from a new point of view that helps the parent understand the child's messages or states. As a result, the parent's perception of the baby may change, enabling the parent to invent strategies, develop new patience and empathy, and find new motivation for helping the baby overcome roadblocks. This situation is often the case with the infant who struggles with autonomy and tries to do everything on his or her own, which is developmentally appropriate. When the therapist points out that it is healthy for a baby to struggle to achieve autonomy, the behavior that the parent may have perceived as defiance or stubbornness can be seen in a new light. Something similar can be said about temper tantrums at 2 years of age. At times, parents will experience the toddler's territoriality

and unwillingness to allow others to play with his or her toys as selfishness and greed. They may expect the toddler to understand the concept of "taking turns" or "sharing toys." However, they might revise their view after learning more about the normal development of prosocial behavior.

As described by Carter et al. (1991) and Fraiberg et al. (1989), the therapist can be a conduit for signals from the child to the parents, helping to promote sensitivity and empathy. The parents may have difficulties with their perception of the baby's communications, or they may even misattribute meaning. When the clinician notices that the parents' attribution involves distortions and actual misattribution of meaning, suggesting an alternative meaning may promote a more benign reading of the child.

A therapist who is well versed in infants' language can help parents understand the child's communication. For instance, in the first few months of life, turning the head to one side, yawning, or hiccuping may be signs of overstimulation and a need to take a break from interactions. This information may help parents adjust the amount of interaction with their baby. In addition, parents who learn to recognize states of quiet alertness in the newborn may be able to take advantage of them as a time for interacting better with their baby. It is also useful to recognize other states, such as somnolence and active alertness, in which such interaction is not possible. Smiling, trying to grasp the parent's face, and cooing vocalizations all may be noted by the therapist as the infant's attempts to say something positive to the caregiver. As the infant develops, such behaviors may be interpreted as reflective of the toddler's emotional life.

Pearl

Ms. M and her boyfriend were recently advised to have some conversations with a mental health clinician. Ms. M is 17 years old, and her boyfriend is 18. They brought in Pearl, their 10-day-old infant. Ms. M appeared highly stressed and uncertain about how to look after the baby. When Pearl started fussing and appeared uncomfortable, the therapist asked Ms. M why she thought the baby was upset. In a quite serious tone of voice, Ms. M responded that Pearl was just "being mean" and that she enjoyed bothering her mother. As the therapist and the parents explored this idea, other possibilities were suggested, such as the fact that, for example, the baby might feel sleepy or hungry. Ms. M proved sensitive to these alternative possibilities and began trying to remedy the possible causes of Pearl's discomfort. In this case, the misattribution of meaning was due more to a lack of awareness of the child's neediness and dependence than to a lack of empathy. Ms. M was sensitive to the child's discomfort once alternative interpretations were contemplated during the session.

Parents who have had difficult experiences in their own childhood may not find it easy to develop a repertoire of sensitive responses to their child. But with the assistance of another person, they may be able to learn the possibilities and nuances of their child's behavior. The therapist's knowledge of infant development and psychopathology can guide them not only in characterizing a problem but also in designing a strategy for its solution by means of a "developmental map" of what to suggest to parents.

Knowing about the normal development of feeding abilities, for example, can help a therapist design interventions for a child with a feeding disturbance. This process may involve deciding precisely where the child is having problems and then recommending the next developmental step the child can try to master, depending on when the disturbance began. For instance, the therapist may suggest that the child begin eating puréed foods rather than only liquids (Maldonado-Durán and Sauceda-Garcia 1998; Ramsay 1995).

A similar approach can be used to address diverse aspects of a child's development, including fostering the infant's ability to self-feed and explore new solid foods after he or she manages to tolerate semisolid textures and new flavors. This model also applies to an infant's difficulties with gross motor development, coordination, and fine motor skills. In addition, anxiety problems can be approached with this developmental frame of mind. The therapist can design interventions to help the child cope with each stage in the mastery of fears and anxieties, such as moving gradually from constant closeness to the mother to using transitional objects and playing games that involve separations and reunions. Another example of an intervention would be going from engaging in mutual attention and gaze to playing in a reciprocal way in simple interactive games (e.g., tossing a ball back and forth) to playing games involving a verbal exchange. This framework helps start treatment by meeting the child at the point at which he or she is developmentally and then going on to the next step, in what has been construed as a "Vygotskian" approach (Wertsch and Tulviste 1994).

Parents as Therapists

To deal with several problems, a behavioral modification approach may be indicated. The principles of behavior therapy include conducting a detailed analysis of parent-child interactions and examining the sequence of those interactions. The behavioral analysis helps obtain a picture of the transactions between parent and child and determine where an alter-

native sequence might be introduced. A common situation is that of the toddler with intense and frequent temper outbursts and difficulty calming down. A behavioral analysis could help the parent identify precipitating or at-risk moments, early signs of frustration, and ways to preempt those outbursts.

In the clinic, we frequently see parents who have a limited behavioral repertoire for denying their child what he or she wants. For instance, they may say, "No!" but then fail to provide any further engagement, alternatives, or interactions to help the child cope with the ensuing frustration. We suggest strategies for empathizing with the child and initiating other activities that may help prevent the temper tantrum.

Behavioral interventions often use measurements that involve keeping a record of some behaviors and then assessing progress. Merely asking parents to record their child's behavior can have a powerful impact on changing some behavioral sequences.

Implementing changes, particularly in negative interactions, encourages both the parent and the child. When a positive space for engagement is created along the lines of positive parenting (Howard 1991) and the child is rewarded (mostly emotionally) for adaptive or flexible behaviors, other aspects of the relationship may also improve.

Behavioral and Cognitive Interventions

Behavioral and cognitive techniques vary, depending on the child's age, but often can be used with quite young children of about 10 months and older. One can use these interventions with the child while the caregivers are also in the consulting room. In this manner, the therapist "trains" or models to parents some of the therapeutic interventions. The parents can then operate as co-therapists at home, where some techniques can be implemented more frequently than is possible in the therapist's office.

These techniques can be employed to help infants with sleeping and feeding problems, those with very short attention spans, or those who are less responsive to reciprocal interactions or who exhibit hyperactivity. These methods can also help expand the behavioral repertoire of children who express frustration in mostly physically aggressive ways, such as biting, kicking, hitting, or pinching. In addition, these techniques can benefit children with intense anxiety about brief separations who become "paralyzed" when they are exposed to some feared stimulus.

These cognitive and behavioral interventions are more visual and representational, with limited use of language, particularly with younger infants. A behavioral sequence can be represented either with people or

with dolls, puppets, or stuffed animals (Lillard 1993). Using these objects in a way that the child can easily see, the therapist represents the challenging situation and suggests a direct message, for instance, by substituting one behavior for another. This teaches the child to substitute a new strategy for a maladaptive way of dealing with challenges.

The goal of these interventions is learning. The therapist (or the parent coached by the therapist) will help the child learn things that he or she has not mastered, such as self-control, response inhibition, delay in response, or attention to a scene for longer spans of time. Even a child with biological vulnerabilities can often benefit from learning new behaviors. For example, with an infant who often bites when he is angry, a disagreement or frustration could be depicted with two dolls, one representing the young child and the other an adult. In this theatrical display, the infant doll "hits" and "bites" while demonstrating anger at the adult doll. The play scene can be repeated with different interactions and outcomes and with different actors. If capable, the child could participate in the scene and in this way, in play, express or represent his own anger and reactions. Then an alternative scene might be suggested, for instance, in which the child does not bite, because biting hurts the other person, or does not hit and instead says, "I am mad at you." When the youngster substitutes an alternative, more adaptive behavior for biting in play, he is praised, and the more adaptive sequence is celebrated. Children can also be taught how to use soft touch to express tender feelings, elicit closeness, or receive reassurance from parents when they are afraid.

Children who are inattentive and distractible can be "trained," through repeated attempts and interesting sequences, to engage in longer periods of looking, playing, or interacting. The therapist will require skills to create funny, interesting, or engaging scenes that elicit the child's interest. For instance, the therapist may use somewhat exaggerated facial expressions or verbalizations, noises, or unexpected turns in the play sequences. The therapist may also be training the parents to do these things at home. This practice extends the parents' repertoire of strategies to engage their child. One uses different means to achieve this end, depending in part on the sensory preferences of the child: the representations may be more auditory (singing or making animated noises) or more visual, kinesthetic, proprioceptive, and so on. Whatever representation is used, the purpose is to capture the infant's imagination.

Through trial and error, the clinician can design an intervention suited to a particular child. For example, an infant may require that the caregiver or therapist play only in the corner of a room with one or two toys, lest the child become distracted and quickly disinterested. The clinician searches for a strategy that achieves the goal while the parent

observes what the child seems to prefer or what is successful in eliciting interest or engagement. They can then recognize early signs of overstimulation, frustration, or the child's need to disengage and do his or her "own thing." These observations may help the parents and the child in their everyday interactions at home.

The child may need behavioral support to cope with a challenging situation (DeGangi 1991; Zeitlin and Williamson 1994). Engaging and helping the child maintain a state of alertness or contentment may require deep pressure or massage to the trunk and limbs, vestibular stimulation, or oral activity (sucking or, in the older child, chewing). Older children (perhaps above 2½ years of age) can use some biofeedback techniques to help control anger and cope with overstimulation or anxiety. Abdominal breathing, muscle contraction and relaxation, and hand warming can all be taught in the context of playing a game. The infant with intense anxiety or traumatic stress responses can be helped to master difficult situations by gradually bringing him or her closer to feared objects. As a behavior changes slightly, it can be "chained" to another new coping behavior.

Promotion of Positive Parent-Child Relationships

For some parents, the prescription of play with their child can help them engage in a new, mutually gratifying space where the tension and strain of a relationship can be set aside. In this area, they can just have fun together and enjoy the moment. For the child, this relaxing play can create new memories of a positive exchange with the caregiver. In some cases, the therapist seems to give the parents permission to enjoy their child. At times, the clinician may have to subtly teach a parent by gradually including him or her in playful interactions with the young child. Without creating a sense of inadequacy in the parent, the therapist also needs the ability to play, using a sense of humor, laughter, and creativity. The therapist should convey that this interaction is not just a teaching moment but rather a true moment of relaxation and pleasure. At times, such reinforcement enables the parent to experience closeness and warmth toward the child and allows the creation of a no-conflict zone.

With the toddler, play can give a sense of effectiveness and of being in control. In the "floor time" technique (Greenspan 1991), the child takes the lead in play and the parent follows, so that the child can feel like an effective agent whose initiatives make a difference.

Psychodynamic Interventions

At times, psychodynamic approaches (more fully described in other chapters in this book) offer the only possibility for improvement or resolution of infant problems deeply entangled in relationship difficulties between parent and child. Addressing parental perceptions of the child and understanding and interpreting them (Vives-Rocabert and Lartigue 1995) can help release the child from ghosts of the past.

With many parents (particularly those with a history of previous losses, psychological trauma, problems with trust, and relationship difficulties), the more "naïve" interventions we have described are not effective or therapeutic. In these circumstances, the approaches described by Lieberman (1992), Lieberman and Pawl (1993), Cramer (1995), Cramer and Palacio-Espasa (1993), Lebovici (1983, 1995), and McDonough (1995) may be the only hope for helping an infant and parent.

Systemic Family Interventions

In clinical work with infants, it is useful to maintain a systemic point of view. The infant is seen as a member of a larger interactive system, encompassing not only the mother but also the father, siblings, and others in close relationship with the parents. These others have a profound impact, including transgenerational influences, on the mother-child relationship. Throughout this chapter, we have described interventions guided by these principles. Here we emphasize only two additional points: how to prioritize interventions and how to address other dysfunctional subsystems within the family.

The clinician often is faced with the question of what came first: the child's symptoms or the parent's way of dealing with the child. The systemic approach does not tackle the question from a linear point of view. Instead, it assumes simultaneous influences and multidirectionality. The intervention is directed to all members of the system at the same time, assuming that interventions with one member will have an impact on the whole.

Working With the Marriage

At times, the functioning of the marital relational system is crucial for understanding and addressing infant symptoms. When spouses have major differences in their approach to parenting, which may be part of broader marital disagreement, the differences can lead to confrontations on how

to handle various aspects of caring for the child: discipline, limit-setting, feeding, sleeping, and so on. On occasion, the infant's problem should initially be addressed from the point of view of the marital system.

Julian

Julian K, 15 months old, was brought to the clinic because of a sleeping difficulty. He woke up during the night, and the parents disagreed on how the problem should be handled. Ms. K has tried the "ignoring approach," which her husband supports, and found it unsuccessful; the baby still continues to cry for periods of more than an hour. She has decided to change her method and soothe the baby whenever he wakes up and cries. She wants advice from the therapist about how to help Julian sleep through the night.

Ms. K has discovered that if Julian sleeps in his parents' bed, he doesn't wake up. When the issue of where the baby should sleep (in his room or with his parents) is brought up, a major disagreement surfaces between Mr. and Ms. K. The marriage was the first for Ms. K and the second for Mr. K. Crying, Ms. K says she does not like to sleep in the marital bed because it is where her husband slept with his first wife. Ms. K wants to buy another bed, but her husband argues repeatedly that they cannot afford it. Ms. K immediately and angrily points out that her husband had just bought a Mercedes-Benz. He quickly responds that he bought the car only because it was necessary for his business as a realtor. This initial issue is only one in a long list of marital disagreements.

The point here is that Ms. K apparently welcomed the baby's sleeping difficulty because it often compelled her to go to sleep beside his baby bed, which helped her express her own resentment about the marital bed. When this matter was addressed directly, the parents were able to agree on a number of issues about the baby's routine and about their involvement in parenting. In a few weeks, the child's sleeping problem disappeared.

Focusing on Strengths

Family therapists are interested not only in what the symptoms of dysfunction are but also in what aspects are functioning well. In therapy, the clinician often has to draw on the strengths of the child, the parents, and the family. At times, parents lose perspective about their basic strengths (e.g., the feelings they have for each other, their mutual commitment, their cohesiveness and love for each other) and get caught up in day-to-day conflicts. To help the parents regain perspective and to instill hope, the therapist may actively point out these strengths, which can become the point of departure for positive changes.

The technique of reframing can sometimes help change the parents' perspective about their baby. A child perceived as hyperactive and inattentive can also be perceived as very intelligent, curious, and actively engaged in exploring the world. These semantic maneuvers also allow a shift in the parents' point of view. "Defiance" in a child has positive elements (e.g., persistence, autonomy, and desire to develop one's own project) that parents can learn to appreciate. Thinking about these aspects of defiance may help parents allow their child more space to pursue personal projects. It may also help them engage in fewer face-to-face confrontations as they begin to appreciate their child's drive to succeed individually. In addition, differences of opinion on parenting, instead of necessarily leading to conflict, may give parents an opportunity to expand their views and consider alternatives.

Thinking of a family system as a whole helps the therapist be aware of where the interventions are focused. They could be focused on the child, on the parents, or on the parent-child relationship: Modifications in any one of these areas may bring about changes in other areas. Often the therapist must focus initially on the child because that is what the parents want. The child may have to be helped to take the "first step" in changing so that the parents can then also change their view of the child. At other times, parents are willing to change their own approach; their willingness, in turn, helps the child modify his or her responses or behavior. The perinatal period often seems uniquely suited to making changes and developing flexibility as members of the new family get to know each other in their new roles (Figure 6–3).

Psychiatric Interventions: Recognition of a Mental Disorder

With awareness of psychopathology, the clinician can at times notice behaviors and symptoms in parents that may lead the clinician to suspect a mental disorder in a family member. For the general population, the risk of having one condition is approximately 15% or somewhat higher. Particularly when the condition is not severe, it may go unrecognized by the family and the clinician. The main disorders to consider with new mothers are mood problems, depression (postpartum variety has been estimated at a 10%–15% prevalence in women in this period of life), posttraumatic stress disorder, or another major anxiety problem, such as panic disorder or a dissociative condition. Even attention-deficit disorder in a parent can lead to major difficulties in caregiving for a baby.

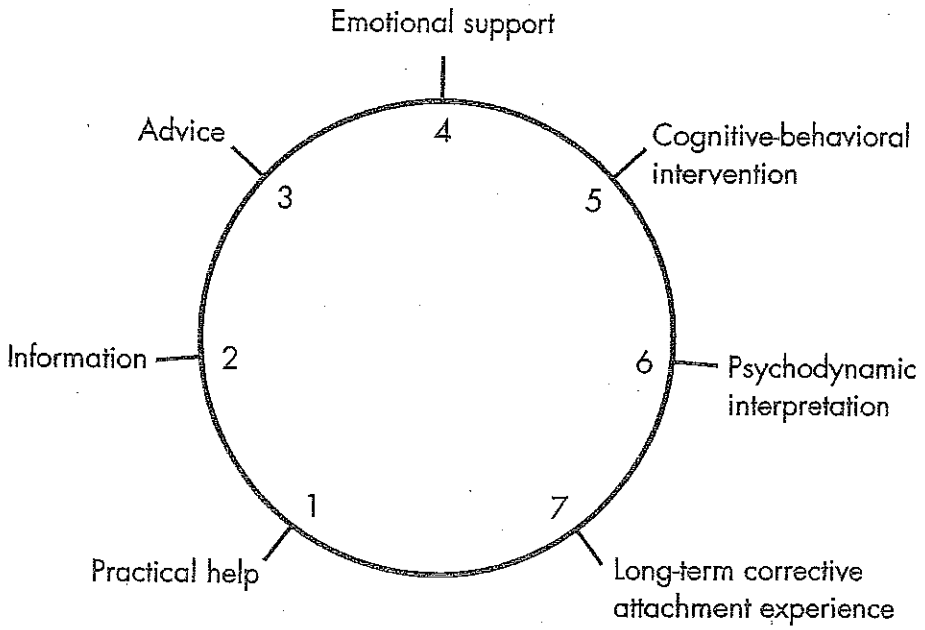

Figure 6–3. Continuum of interventions.

The continuum of multimodal interventions contains a range of practical approaches with psychodynamic overtones. They may be used either one by one or concurrently, as well as with one or more relationship problems.

Mary

Ms. A, a 16-year-old single mother, was referred for a consultation because her 4-month-old daughter, Mary, was highly irritable. As we observed parent-child interactions, the young mother clearly seemed to be doing her best. However, she often came to sessions without a bottle and diapers or would forget to give the child the medication for "colic" that had been prescribed by her pediatrician. Ms. A was herself in the custody of child protective services because of concern that she would neglect her baby. The clinicians suspected that Ms. A might have attention-deficit disorder and asked both Ms. A and her mother about her previous history. Ms. A's "being scattered" had been a major problem for a long time, not only during the perinatal period. When she was informed of the clinicians' impression, she seemed to feel relieved. Among other suggestions made to help her organize was a therapeutic trial of psychostimulant medication. She agreed. Ms. A was then able to think more clearly about future events, such as the fact that the baby might need a clean diaper or require feeding. She was also able to pay attention to several variables at one time, whereas before she had been able to focus on only one at a time. In addition, she could remember her child's needs, which before had seemed too overwhelming to handle.

Sometimes an adequate appraisal of the situation from the psychiatric point of view may mean the difference between success and failure in helping the infant. Problematic situations may include situations in which a young mother or father uses street drugs as a way to "treat" psy-

chiatric symptoms. Also, a parent with marked irritability and mood lability may suffer from an undiagnosed mood disorder; treating this disorder might markedly improve a situation.

Anxiety disorders (e.g., severe social phobia, panic, generalized anxiety disorder, and posttraumatic conditions) can have a severe effect not only on the parent-child relationship but also on the family as a whole. A parent may live in constant fear that the baby will die and experience multiple somatic symptoms (e.g., lump in throat, palpitations, constant tension, sweating, diarrhea, shortness of breath) or may have unpredictable episodes of panic. When these symptoms are alleviated, parenting and family life become easier. The gamut of severe psychopathology can occur in the perinatal period as well, and the clinician can help by recognizing the problem and treating it or referring the patient.

At times, postpartum psychosis is very obvious, but often it is not. Only careful inquiry can uncover it. For example, a young woman recently said that she felt constantly nervous around her baby. When specific questions were asked, she alluded to the fact that she would hear her baby cry when, in reality, the baby was sleep. She would also visualize the infant covered in blood and hurt. She felt so frightened by these experiences that she had not told anyone. Adequate pharmacological treatment alleviated these symptoms of postpartum psychosis.

We suggest that the therapist who can reflect on several points of view when faced with a clinical situation can better take all of them into account. This diversity may lead to a more comprehensive understanding of the situation from several points of view. Then, based on what seem to be the clinical priorities, the therapist should decide on some formulations to present to the family and on what therapeutic interventions seem the most suitable for the problem, the child, the parent-child relationship, and the caregivers.

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