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ABSTRACT

This bulletin issue contains five papers on the theme of adults with mental illness who are parents of very young children. "Parents, Mental Illness, and the Primary Health Care of Infants and Young Children" (John N. Constantino) offers the experience of a trainee in a combined residency in pediatrics and psychiatry, focusing on identification, risk assessment, and initial management of infants of mentally ill parents. "Maternal Depression as a Context for Child Rearing" (Sherryl H. Goodman and others) examines characteristics of maternal depression, the potential parenting impairments brought about by depression, characteristics of infants and young children of depressed mothers, and interventions. "Treating the Relationships Affected by Postpartum Depression: A Group Therapy Model" (Roseanne Clark and others) describes a therapeutic approach to addressing the needs of the mother with postpartum depression as well as her infant, their relationship, and the family. "Previewing: An Intervention Strategy for Psychiatrically Ill Parents of Infants and Toddlers" (Paul V. Trad) discusses an intervention protocol which helps parents to make predictions about their child's future and about changes in the parent-infant relationship that will occur when new skills are mastered. "Providing Integrated Treatment for Parent/Infant Dyads at Risk because of Parental Emotional and Mental Illness" (Barbara D. Munk) describes a comprehensive, community-based model for parents with mental illness, called the Parent/Infant Therapeutic Program. (JDD)

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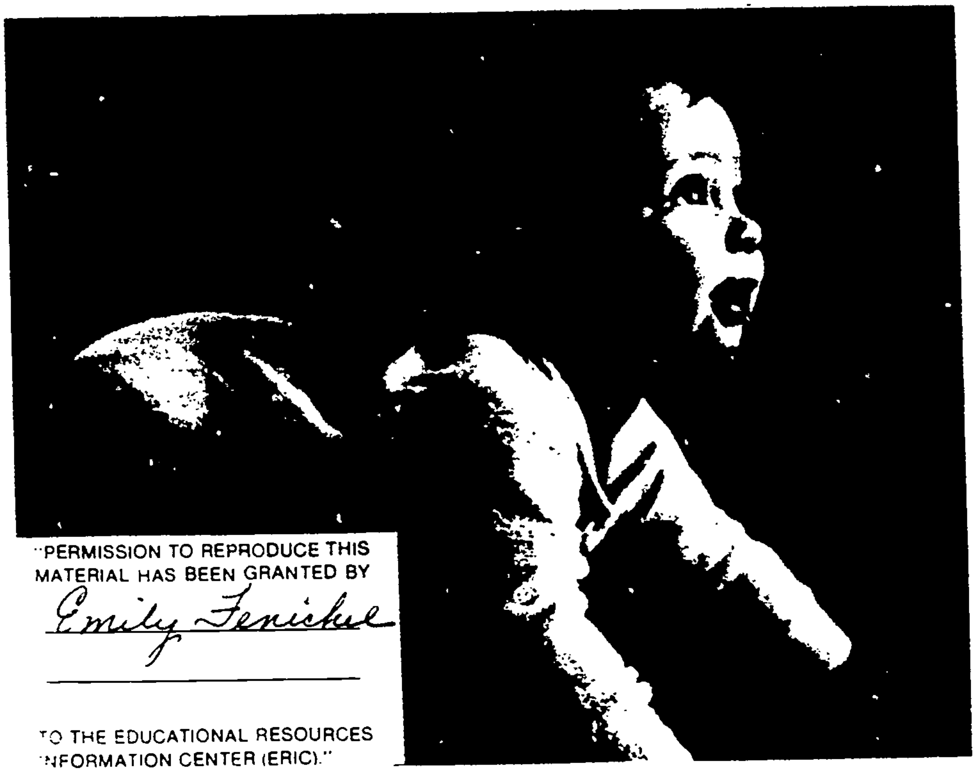
Parents, Mental Illness, and the Primary Health Care of Infants and Young Children



HOWARD ZEHR

John N. Constantino MD. Senior resident in pediatrics, general psychiatry, and child psychiatry, The Triple Board Program, Albert Einstein College of Medicine, Bronx, New York

In a way, providers of primary pediatric health care are in an ideal position to initiate interventions for children of parents with mental illness. They have access to children from the time they are born, they follow families for many years, and in the current system, they are a child's only formal contact with the larger health and human service system until the time of school entry. Several monumental barriers stand in the way of their fulfilling this role. The first is a lack of sufficient time to address psychosocial issues in the children they care for. This is, in part, a result of the fact that in the current health care system, cognitive services in primary care are poorly reimbursed. If a pediatric clinician has to see 30 or 40 patients a day, there isn't much time to sit with a family for an hour to explore psychosocial issues. Consequently, it is not very often done. If a clinician recognizes a glaring psychosocial problem, he or she may refer a family for mental health services, but without an adequate understanding of the problem or an intimate rapport with the family, a mental health referral is often viewed as an indictment and is rarely pursued by the family.

Even if this could somehow be circumvented, another barrier is that management of psychosocial problems has not traditionally been a high priority in the training of professionals in pediatric health care, and there are widespread biases—some not very well informed—that lead to mismanagement of such problems. Pediatric practitioners have all experienced frustration in trying to deal with fragmented and complex social service systems, and have often come to skeptical conclusions about the value of mental health

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interventions because of bad experiences with well-intentioned attempts at intervention. They tend to minimize the risk status of children with psychosocial problems—particularly when they are physically "perfectly healthy"—because they are trained to view children as characteristically healthy and resilient. At the other extreme, when parents who are stressed or overwhelmed exhibit neglectful or inadequate parenting practices, there is an impulse that arises from a pediatrician's natural role of child advocate to expose those inadequacies, sometimes to the point of shaming parents into taking more proper care of their children. Without recognizing whether or not a mental illness underlies the "inadequacy," there is sometimes an assumption or a hope that a parental deficit is a simple matter that can be easily fixed by the appropriate lecture (to the parent) or by some other educational endeavor—which, in fact, may do little more than increase the anxiety level of the parent, and thus do more harm than good (Cadman et al., 1987). Adequate training on how to handle these delicate situations can be of great benefit both to the pediatric practitioner and to the children under his or her care.

> *It is important for trainees to be allowed **time** to explore complex psychosocial issues in the families of the children they manage as primary clinicians.*

There are many ways of incorporating education on psychosocial aspects of care into training programs for pediatric health professionals. Although pediatric training programs are traditionally geared toward experience with large numbers of patients, more is not always better, and it is important for trainees to be allowed *time* to explore complex psychosocial issues in the families of the children they manage as primary clinicians. Without sufficient time to understand psychosocial problems, or the time and means to gain experience in coordinating their management, such problems become a study in frustration to be avoided at all cost. It is not surprising, for example, that trainees in inner city programs get "burnt out," when they are forced to view the ravages of social disadvantage in 15-minute pediatric visits, during which time it is all they can do to make sure that the immunizations are up to date and that the child is safe and grossly physically healthy. This translates into generations of clinicians who have not experienced any rewards in dealing with psychosocial problems, and do not want to have much to do with them in their future work.

The remarks that follow are derived from five years of clinical and academic experience as a trainee in a new combined residency in pediatrics and psychiatry that *has* allowed time for such interdisciplinary activity (see side bar); there is a particular emphasis in this article on issues relevant to "front line" identification, risk assessment, and initial management of infants of mentally ill parents.

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The concept of mental illness

It is first important to call attention to the idea that any approach to infants of mentally ill parents depends greatly on how one views mental illness itself. There are as many different ways of thinking about what constitutes mental illness as there are for defining adequate parenting, and not everybody agrees about who is mentally ill and who is not. The term "mental illness" lumps together what is certainly a very heterogeneous group of disorders (from schizophrenia to pathological gambling), and it is always important to have a sense of what makes each specific parental mental disorder unique in its impact on children. Indeed, it may be that the most important effects of any given disorder on a child's development have to do with highly specific genetic and environmental influences that are not shared by other mental illnesses, in which case it makes little sense to consider them together as a group. For example, whereas young children of psychotic parents may be most affected by confused meanings in their parents' words and behavior, children of severely depressed parents may be more affected by an absence of positive emotional responses to their achievements. The more we understand about *how* a given parental mental disorder uniquely affects children, the more we will be able to target specific educational and insight-oriented interventions toward the families involved.

In a recent article that appeared in the *Infant Mental Health Journal* (on serving the mental health needs of families of children under age three) Jennings et al. (1991) asserted the following:

> *In recent years, the need for infant mental health programs has become widely accepted. Unfortunately, the usual approach to infant mental health can result in fragmented services to families. A major problem is a shortage of clinicians who feel knowledgeable and comfortable with both infants and with mentally ill parents. A second problem is the lack of program models that provide comprehensive, integrated mental health services to families with infants or very young children.*

The Triple Board Program, a new combined residency track in pediatrics, general psychiatry, and child psychiatry, was designed, in part, to teach pediatricians-in-training the needed skills to manage patients who require multidisciplinary care at the interface of pediatrics and psychiatry. One of many unique aspects of this program is that residents are given the training and the time to explore complex psychosocial issues in the families of the children they manage as pediatricians. Infants and children of mentally ill parents are commonly identified in general pediatric clinics and can be followed in a specialized "triple board clinic" where they are allotted ample time for thorough psychosocial assessment and follow-up. In attendance are supervising faculty from the departments of pediatrics, developmental pediatrics, and psychiatry. Multidisciplinary approaches to training may be one way of turning out clinicians who are equipped to work closely with infants of mentally ill parents.

Editor's note:

The contributors to this issue of *Zero to Three* help us to understand three kinds of experience—that of adults with mental illness who are parents of very young children; that of the infants and toddlers of these parents; and that of professionals who are dedicated to understanding, supporting, protecting, and, when possible healing, these parents, these children, and their relationships.

The articles in this issue do not make easy reading. They do not promise us a rose garden or even a tidy, cost-contained, short term treatment protocol. These reviews and reports from the front line do, however, have much to teach us about how theory and clinical experience inform and enrich each other; about the training, time, and money needed to treat a **relationship**; and, once again, about the complexity and power of earliest relationships.

Having said that, the fact that an entire issue of this publication is devoted to infants of 'mentally ill parents' seems to suggest that there are common threads in the wide array of parental mental disorders that exist, and that there may be something about the inclusion of a human condition into the category ***mental illness*** which identifies a potentially deleterious influence on the child of an affected parent. In support of this, data on basic similarities in the rearing environments of ***resilient*** children from widely divergent psychiatric risk categories point toward the idea that many parental mental disorders may share some kind of final common pathway through which they exert (or get blocked from exerting) a negative impact on children. If this is so, the question of what it *means* to be mentally ill becomes more than a semantic one; the answer may offer important clues to understanding how to help children with mentally ill parents.

A definition for mental illness which was taught to me on the first day of my psychiatry training applies here: mental illness can be defined as the relative inability (assuming physical health and a reasonable living environment) to experience fulfillment (or happiness) in self, in work, and in love. This definition, though broad and perhaps controversial, captures one element of parental mental illness that may have a profound impact on a developing child: a relative difficulty in maintaining fulfillment in investing effort or love into that child. This does not by any means imply that mentally ill parents do not love their children. It means simply that the emotional incapacitation which defines mental illness exists at the level of feeling fulfilled and at peace in fundamental areas of human life, one of which is in an individual's love relationships. As far as children of mentally ill parents are concerned, this view of mental illness points out a generic potential for a parental mental disorder to translate itself into a complicated kind of emotional unavailability or neglect, since parents who are less able to fully experience (or feel satisfied with) the emotional rewards of raising a child are going to have a more difficult time of keeping up with its demands.

The unique elements of each particular parental disorder may then feed into this larger consequence of mental illness in complicated ways. A depressed mother may be acutely aware of her baby's developmental needs, but may not have the energy to maintain an active and stimulating interaction with him or her. A psychotic father may recognize his children's need for structure but may not be able to maintain consistent limits in dealing with their behavior. A personality disordered parent may be very invested in a child, but may have difficulty distinguishing his or her own needs from those of the child. A parent with an anxiety disorder may be too internally focused to be emotionally available to his or her children. Through complicated chains of events, all of these situations can result ultimately in frustration, in intense dissatisfaction with the role of being a parent, and in a consequent disruption of the emotional connection between a parent and child. Such a disruption is by no means unique to parents with mental disorders; all parents have moments of fragility, emotional unavailability, self-absorption, and empathic failure. For parents with mental illness, however, such states may be more prolonged, may be misinterpreted as personal assaults, or may feed into chronic feelings of inadequacy: there are opportunities for vicious cycles to begin early in life and to prey upon a parent's already compromised sense of self. This is illustrated in the following pediatric case history.

J.G. is a physically healthy 6-year-old boy who has been followed in our clinic system since birth; I have known him since he was about 2 years old. In reviewing his chart, the end of the initial note from his first well-baby visit reads: "Mother seems depressed—discussed social work intervention with her—doesn't seem to want help." Over the next two years, mother brought him to the clinic for all of his scheduled visits for well-child care, and the issue of depression never came up again, at least in the notes. When I first met the family (which included the boy, a 14-year-old half-sibling, and their mother), mother was quiet and tense, very firm and business-like in the way she fed, dressed, diapered him, and set limits on his behavior. She was very attentive and involved with what he was doing, almost to the point of tuning me out. There were no complaints from his mother until a visit at 2½ years, when she mentioned that he tended not to talk or put his wants into words. His comprehension was excellent, and mother said that "when he wants to, he can talk just fine." According to my scribbled notes, there was "a behavioral feel" to his reticence; formal hearing testing revealed no abnormality. When he returned three months later, the first thing that struck me was that this time his mother appeared very detached from him. Although she remained business-like, she seemed to avoid eye contact with him as much as possible, and she had numerous complaints about the boy. She said that when he got angry at home, he would grab her by the collar and scream at her, telling her to shut up. At night, he would scream in his sleep that animals were biting at his toes. He was also aggressive toward other children, and mother asserted her conclusion that he had inherited his aggressive behavior from his father, who was an abusive man who routinely destroyed household objects and furniture in fits of rage. (Mother separated from the boy's father before he was born, and the boy had no contact with him until age 3).

So it seemed that this mother, who had previously been very invested in the child, was now rejecting him as something defective and reminiscent of his "evil" father. Although she was urged to regard his behavior as a communication of intense feelings and needs, she was unable to view it in any other way than to see it as an inborn defect. I talked to her about the available option of enrolling the boy in a therapeutic nursery and made it clear to her that the problem was serious and that the child deserved the benefit of a trial of early intervention. She rejected the referral and told me that maybe he would grow out of it. She returned six months later when the boy refused to take oral penicillin for a strep throat. "Give him a shot, because he won't take his medicine," she said. She declined to elaborate further and was in a hurry to leave the clinic, because she was angry that she was made to wait her turn, when all that the child needed was "a quick injection."

On the next visit, mother reported to me that she had begun working 3-4 days per week "to maintain my sanity." She described how the boy was bossing her around and constantly demanding that she remove her shoes so that she wouldn't leave the house. She would respond by shouting, "Who do you think you are?" and made it a point to wear shoes in the house (even when she wasn't planning on going out) in order to teach him a lesson. He himself refused to wear any clothing whatsoever in the house, and became enraged each day when mother left for work (at which time he was left with an uncle or his half-sibling). On a recent trip to a relative's home, he had thrown a 2-year-old girl on the ground and began kicking her in the ribs. He often initiated fights with other children, and continued to scream in his sleep. As the mother complained about his behavior to me, the boy sat next to her, listening intensely, smiling from time to time when his mother looked at him. He refused to talk about any of it until he was offered a toy, after which he was willing to answer questions only with yes or no answers. A senior psychiatrist on our faculty interviewed the boy and his mother and entertained a differential diagnosis of conduct disorder, post-traumatic stress disorder, and possible psychotic disorder—there was a strong suspicion that

the boy had been exposed to hostile or abusive behavior, but this was never confirmed or proven. The mother was urged to enroll the child in our therapeutic nursery but she again declined the offer, insisting that she was providing him with as good an environment as he could possibly have; she could not see how such an intervention would make any difference.

Nine months later he returned to clinic, brought in by his uncle—mother was now working full time (child stayed at the home of a sitter) and couldn't take time off to bring him in. I gave the uncle my home phone number for mother to call me at home in the evening if she wanted to discuss her son's progress. To this day, she calls frequently but almost never discusses his behavior—she asks for medical advice over the phone, requests special appointment times, gets very annoyed if I am unable to return her call the same day that she leaves a message, and tends to talk a lot about successes in her work as an interior decorator. When I ask about his behavior, she usually replies, "He's still the same," and changes the subject. When clinic visits are arranged specifically to address behavioral problems, she has other family members bring the boy to clinic.

Just before his 4th birthday, his mother enrolled him in a pre-school day care center, where he was found to exhibit hyperactivity and oppositional behavior. During a pediatric visit at age 4½, he repeatedly made quiet but extremely menacing gestures to his mother during the course of the interview. By age 5, his behavior at school had improved dramatically but he continued to be very difficult to manage at home. He was mainstreamed into regular kindergarten, where he became once again defiant and hyperactive, and played only with a few other disruptive male peers in the class. At home he needed constant supervision, without which he would engage in such activities as punching holes through window screens or unravelling toilet paper in the bathroom. On one occasion, he told his father that his mother's new boyfriend beat him up (which apparently did not happen) in order to procure for himself more time with his father. He is now 6 years old, is intermittently enuretic, and continues to be highly oppositional.

This case had a disastrous outcome. Although it is important to recognize that early intervention doesn't always work, this is a case in which it was never allowed to happen. This mother's "depression" was not addressed or understood until the boy was acting out at age 2½. Had the mother's problems been explored at the time when she originally appeared depressed, it might have been possible to predict which aspects of her child's future development would be problematic for her. Anticipatory guidance is more powerful and humane than retrospective fault-finding, and parents are more likely to be alert to situations that have been predicted by someone who understands them and cares about their well-being than to those that they fall into without knowing it.

BARBARA YOUNG

Aside from emphasizing the consequences of failing to engage a family in therapeutic interventions, this case illustrates several other aspects of the care of children of mentally ill parents. The first is that mothers who appear "depressed" on an initial postpartum interview may in fact have any one of a number of disorders (or no disorder at all) that might result in that particular presentation on that particular day: this has implications not only for clinical work, but for interpretations of research on "infants of depressed mothers" as well. A depressed mother with major affective disorder is very different from a "depressed mother" with schizophrenia or borderline personality disorder. Over the months and years following the initial presentation, their clinical appearance and the nature of their relationships with their children can be strikingly different. Although J.G.'s mother never agreed to a formal psychiatric evaluation, she exhibited very significant narcissistic personality traits—narcissistic personality disorder is one of many mental disorders that predispose patients to depressive episodes. After the difficult post-partum period, and during the first 2½ years of his life, J.G.'s mother was very invested in him, albeit in what appeared to be somewhat rigid and intrusive ways that persuaded him to conform to many of her needs and wishes. It was when he began to develop his own autonomy that she began to see him as defective and inadequate, perhaps as the only way of dealing with the undeniable fact that he was growing into his own personhood. His subsequent reticence and problematic behavior were interpreted by her as accusations that she was a bad mother, the thought of which was so intolerable to her that she refused to believe that his behavior was alterable, and blamed it entirely on the boy's paternal genetic heritage. As his behavior deteriorated further, he became the very symbol of her own defective self-image (the core of narcissistic personality disorder) from which she distanced herself in whatever way she could, both emotionally, and by going to work full time and leaving him with other caretakers.

The second point is that once a destructive parent-child relationship gets going, it can be very difficult to intervene. Even when the pathology is readily apparent, parents can be very reluctant to accept a referral for mental health services. When the perceived message is "you have a problem," the injury to self-esteem can be so painful to a parent that it is better to deny the problem altogether than to risk exposure of their inadequacy and a treatment that may not help. Finally, this case illustrates how important it is for pediatricians and other maternal/child caregivers to recognize both the peculiarities of specific mental disorders and the more universal features of mental illness in families with young children. It can be especially difficult for parents with narcissistic personality structure to tolerate the separation/individuation phase of their child's development. It may be possible to prepare parents for this long before it occurs, in a way that is non-threatening and useful to them. In this case, once the mother began to reject the boy and identify him as defective, it may have been too late to help her with this. The more universal feature of mental illness that this case illustrates is that once a parent becomes disconnected from the child, and thereby dissatisfied or unfulfilled in the role of parent, an emotional distance gets created that opens opportunities for neglect of the child's developmental needs.

Assessment of risk

The above case described the anecdotal course of one child of a parent with a personality disorder. What do we know of the general risk for populations of children of mentally ill parents? Outcome studies of children with mentally ill parents, though few in number, have found a strong association between parental psychiatric illness and child psychiatric disorders, and have identified some of the important variables relevant to assessing risk status in children of parents with specific mental disorders. In Rutter's (1966) study of 137 children of parents with mental disorders, parental disorder was most likely to be followed by behavioral disturbances in children when the parent exhibited "long-standing abnormality of personality" rather than brief and infrequent mental decompensations. Parental illness usually preceeded the development of the child's disorder, rather than the other way around, which suggests that difficult children probably should not be held responsible for inducing mental disturbances in their parents. Fisher et al. (1987) studied 77 children of parents who were hospitalized for mental disorders; the subgroup of children who were functioning *well* tended to reside in families that maintained warm and active interrelationships among members. In another study by Rutter and Quinton (1984), children who had one parent with psychosis or affective disorder *and one healthy parent* did NOT show any increased risk for psychiatric disorder. The presence of a conduct disorder in one or both parents was found to be the most significant factor in the incidence of childhood psychopathology in that study. Furthermore, on long-term follow-up of those children, those who were exposed to hostile behavior on the part of their parents were up to four times more likely to have persistent behavioral disturbances than children who had not been exposed to hostile behavior.

> *Children of mentally ill parents may be as much victims of inadequate nurturing as they are heirs to their parents' genetic profile.*

Interpretations of these and other studies on the outcome of children whose parents are mentally ill must take into account several factors. Aside from consideration of the quality of the parent-child relationship, other intermediary effects of parental illness that affect the larger rearing environment include poverty, marital discord and family stress, each of which can independently adversely affect child outcome. Genetic influences are also obviously extremely important to consider. Tellegen et al. (1988) studied personality in twins reared together and apart and found that the rearing environment explained little to none of the variance in fundamental personality traits, which they found to have a high degree of genetic heritability. Similarly, affective disorder and schizophrenia have strong genetic underpinnings. Although such findings might lead one to believe that poor outcome is genetically determined, consider again the details of the outcome studies mentioned above. In Rutter's study, the condition of having one *healthy* parent *abolished* any risk from having a parent with psychosis or affective disorder. Furthermore, conduct disorder and hostility, which are thought to have low heritability (Robins, 1991) were found to have the most profound deleterious impact on child outcome. Thus children of mentally ill parents may be as much victims of inadequate nurturing as they are heirs to their parents' genetic profile.

Researchers in the field of developmental psychopathology are working diligently on the nature vs. nurture question. Sandra Scarr, in her 1991 presidential address to the Society for Research in Child Development, advanced a theory of developmental determination based on the idea that genetically inherited traits, in the context of a "good enough" family, operate to produce their own environments, which in turn are designed to allow for full expression of the individual's own particular genetic potential (Scarr, 1992). Though heavily oriented toward genetic determinism, she offers the following caveat to her theory:

> The entire theory depends on people having a varied environment from which to choose and construct experiences. The theory does not apply, therefore, to people with few choices or few opportunities for experiences that match their genotypes. This caveat applies particularly to children reared in very disadvantaged circumstances and to adults with little or no choice about occupations and leisure activities. (p.9)

This depicts the actual situation for many children of mentally ill parents. According to this view, once one drops below the theoretical cutoff line between adequate and inadequate parenting, genes (or the children who own them) may not even have a chance to achieve their potential; in Scarr's words, "Really deprived, abusive, and neglectful environments do not support normal development for any child (p.3)." This theoretical contstruct predicts that the situations in which one might be able to make the most difference (since we cannot yet alter what is genetic) would be when a parental mental illness is threatening to translate itself—or has already progressed—into a neglectful or abusive rearing environment for a child. This may represent the final common pathway hypothesized above, through which many different parental mental disorders exert a negative influence on child outcome.

How can this progression be blocked in vulnerable families? First, one needs to identify which families are most vulnerable. We know that the presence of mental illness in one parent does not indicate that a neglectful or inadequate rearing environment will necessarily ensue. Although it is impossible to predict which children are most at risk, several good rules of thumb can be derived from what we already know:

1) Children of parents with long-standing abnormalities of personality or histories of conduct disorder or serious antisocial behavior are probably at higher risk than those whose parents have other kinds of mental disorders.

2) Poverty, absence of social support, marital discord and other major psychosocial stressors compound the risk for children of mentally ill parents. In a five year follow-up of 2443 Australian infants, Sanson and her coworkers (1991) found that whereas single risk factors correlated with only *modest* increases in child maladjustment, combinations of risk factors were associated with markedly increased prevalence rates.

3) Families need to be followed closely and periodically reassessed over time. The quality of a mother's interaction with a child, the track record of kept or missed appointments, the nature and frequency of contacts with the health care system can all provide important clues to family function or dysfunction. Is the child showing signs of chronic distress, such as feeding or sleep problems or an abnormal affective connection with the caregiver? Is the same person caring for the baby this month as was caring for him or her two months ago? How are the parents feeling about just being with their child at various developmental phases? Mental illness, though often chronic, is not static—changes in the mental status of a parent over time can have major influences on the daily life of a family and a child in that family.

Obstetricians, neonatologists, pediatric practitioners, and professionals in home visitation programs for newborns are ideally situated to perform the work of identifying high risk infants. Although we have developed standardized interviews and assessment measures that delineate many of the important variables, it has not yet become common practice to do so. An individual's privacy notwithstanding, we need to ask ourselves why we tend not to start asking alot of questions until *after* a disaster has happened or the urine tox screen is positive or the abuse or neglect has been exposed. Cost-effective prevention may depend on asking "personal questions" of patients as part of routine obstetrical or pediatric care so that the appropriate families can be offered appropriate interventions. Again, time and some mechanism of reimbursement needs to be allotted in order to make such practices a reality.

Management of children at risk

Of course, it doesn't make sense to do the work of identifying vulnerable families unless such interventions exist, which leads to the question of what can be done for infants who are identified as high risk. First off, life and death decisions about the care of seriously ill newborn infants—particularly those of young, immature teenage parents—can be reviewed by a mental health professional, to assess the capacity of the parents to make informed decisions on such issues. After a baby leaves the hospital, simple things such as increasing the frequency of pediatric visits, offering clear anticipatory guidance to mothers and fathers about uncomfortable feelings that all parents go through, and educating parents about available social resources, can go a long way in establishing a working alliance with a mentally ill parent who may otherwise tend to feel disenfranchised and isolated. Parents with mental disorders can and should be referred for mental health care, which (depending on the disorder, the individual, and the mental health resource) can be extremely effective in

Mental illness, though often chronic, is not static—changes in the mental status of a parent over time can have major influences on the daily life of a family and a child in that family.

helping them to function better as parents. Child psychiatrists and psychologists are trained to help parents understand their children's needs and to help them interact in ways that foster healthy child development—they should be consulted whenever negative patterns of interaction between parents and their children get established. This requires an open dialogue and strong working relationships between pediatricians and mental health professionals, which is not always the reality, but might be enhanced by academic activities that bring the two disciplines together. Innovative intervention programs for infants and their parents, many of which have been described in this publication over the years, are showing tremendous promise. Infant day care centers, early childhood centers, therapeutic nurseries and other comprehensive interventions are proving to be effective measures in the prevention of child psychopathology (McGuire and Earls, 1991). At present, they are expensive and have not been fully evaluated; consequently, they are few and far between, but research continues to establish and validate their efficacy. Finally, and unfortunately, children need to be protected and, if necessary, removed from environments that are destructive to their development, and this needs to be done in as timely and humane a way as possible.

One of the most important aspects of getting mentally ill parents the help they need is the *way* in which they are helped to navigate the difficult process of identification, initial management, and referral of their problem. Parents often lose sight of the centrality of their own role in the complex process of their infant's development, and it is always motivating and empowering to reinforce this even in the midst of pointing out a problem. It is important to be clear about what the problem is and how interventions can help. It is also important to assume always that no parent *wants* to inadequately raise their child, and to appreciate and explore the complexity that underlies neglectful or disordered parenting. The pediatric office or clinic is an ideal place to coordinate the care of families at risk because it is a normative setting. I have found that parents who refuse mental health referrals often return repeatedly to the pediatrician for help with psychosocial problems. In these cases, more of the initial health management needs to be done within the pediatric setting, so that parents can be gradually introduced to mental health intervention in a way that helps them clearly recognize its potential benefits.

The finer points of referral

It is one thing for a pediatric practitioner to refer a family for family counselling. It is another thing entirely to have a family meeting within the pediatric office or clinic, allow the family to discuss some of the problem areas, point out how family dynamics are operating (in that very meeting) in ways that individual family members may not have been aware of, and suggest interventions that might be helpful. THEN, the clinician might say, "This is how family therapy works. Would you be interested in pursuing it with someone who is very skilled at helping people in this way?" Often they will agree to it, when originally, before such a demonstration, they would have turned it down. It is hard to overstate the extent to which preconceived ideas about mental health services can and do undermine referrals. Everybody has his own ideas about what mental health services are all about. The black box of "therapy" can be demystified, destigmatized, and detoxified by showing a family *how* it works rather than telling them to go do it. Similarly, when parents with newly identified substance abuse problems are handed a referral for a 12-step program, the compliance is often extremely low. But if instead, they are put on the phone with an Alcoholics Anonymous or Narcotics Anonymous member, the attendance rate at first meetings can approach 100% (Sisson and Mallams, 1981).

OLGA BAZHENOVA

A recent case of a difficult referral for a depressed mother further underscores the potential importance of being able to initiate and coordinate mental health services in the context of the pediatric clinic.

M.J. is a 3-year-old pediatric patient whom I have known since the age of six months. He is always brought to the clinic by his mother and grandmother, who jointly care for him. He refers to his grandmother as "Mama". His mother works part time and has always appeared quiet, withdrawn and overtly depressed, but for two years she politely refused all social work or mental health referrals, which were repeatedly offered. On a routine visit at age 2½ years, his mother appeared very distressed. When I asked if anything was troubling her, she shook her head "no" but began to cry. She then revealed (in the presence of her child and her mother) that she was thinking about leaving home, starting out fresh, and going where nobody knew her. In talking further with her, it became evident that one of the things that was bothering her most was that each night when she returned home from work, the child was paying less and less attention to her and was obeying only the commands of his grandmother (the primary caretaker). Though historically tolerant and understanding of a divided loyalty in the boy, the mother had in recent months

become exquisitely sensitive to even minor rejections from the child, and became suspicious that the grandmother was intentionally manipulating him away from her by spoiling him while she (the mother) was away at work. Indignant at such accusations from an "ungrateful daughter", the grandmother gradually stopped speaking to the child's mother, and in what seemed to be essentially an imitative behavior, the child proceeded to do the same. This infuriated the mother and intensified feelings of isolation and worthlessness that were part of her long-standing depression. Only after the two women had a chance (in the pediatric clinic) to talk out their frustrations in a controlled way were they able to set limits on their own power struggle over the boy, agree on how to manage the child's reactive behavior, and begin to open up communication to sort out their highly ambivalent feelings toward one another. In the process, M.J.'s mother began to realize that her anger toward her own mother was coming from sources other than their struggles over the boy, and yet she was still unable to talk about what it was that was making her feel so badly about herself. She continued to decline my offer to help her get started with mental health services.

I called her at home one afternoon to see how she was doing, and after about a minute of talking to her, I heard the following over the telephone receiver:

Male voice: Who are you talking to!
Mother: It's for me.
Male voice: Hang it up right now! Who is it?
Mother: It's for me . . . . it's M—'s doctor.
Male voice (angrily): Don't lie to me! Hang up the phone . . . . . give it to me.
Mother: Here, talk to him yourself, it's M—'s doctor.
Male voice: I don't want to talk . . . . give me the phone . . . hang it up!
Mother: Get away from me!
Male voice (yells): Did you hear what I said?
Mother (screams)
Phone connection gets cut off

I got a call a few minutes later from M.J.'s mother (on a pay phone), who apologized profusely and explained that the man who had interrupted the call was her father. She asked if she could come in and talk, and I met her in the clinic that evening. She described how her father, for years an alcoholic, had chronically brutalized her and her mother and did everything in his power to maintain constant control over them. He belittled her or physically beat her into submission at important times when she tried to exercise her own autonomy, and he was relentless when she made mistakes that he felt would jeopardize her future. Not even her mother was able to buffer the impact of her father's sadistic and autocratic rule over the household, and aside from being angry with her mother for not protecting her, she progressively saw herself as defective, inadequate, and deserving of punishment. She had been too embarrassed to talk to anyone about it, and she didn't want to jeopardize her child's situation in the household by rocking the boat. She was extremely embarrassed to talk to me about it, but the simple fact that I had happened to witness her father's pathology over the phone made her feel validated and understood. The fact that another human being now knew of the injustice in the household opened a floodgate of communication; the secret and the blame were no longer her own burden, and there was a new desire to sort out her troubled and conflictual feelings and get on with her life. At one point I discussed with her the paradigm of learned helplessness in depression, and how depressive thought patterns can take on a biological life of their own, beyond an individual's control. We discussed how psychotherapy might help her understand the unconscious influences of years of oppression, bring them to a level of awareness where she could begin to master them, and in doing so, begin to take more control of her life. She is currently in treatment in an outpatient mental health center near her neighborhood, is feeling better, and getting along much better with her mother and son, who is the most important part of her life.

Conclusion

In summary, the optimization of a primary health care provider's opportunity to help infants of mentally ill parents depends upon the following: adequate training in psychosocial aspects of patient care; a true working relationship between primary care providers and psychiatrists; a committment to honest and valid risk assessment; a willingness to meet families halfway in initiating management and/or referrals; and *time to do the work*. What stands in the way is a health system that persists in minimizing reimbursement (and therefore incentive) for such work, allowing pediatricians (or the people who work with them) essentially *no time* to address issues that we now know will have profound lifelong implications for the children they care for. Further research is sorely needed to establish the short and long term benefits of this kind of interdisciplinary care. The medium of a truly human connection between primary health care provider and family can be crucial in enabling mentally ill parents to get access to the kind of help they need. Parents need to be able to recognize fulfillment in their role as parents; opportunities to help them recognize the centrality of their role in their child's development should never be missed or overlooked.

In closing, I am reminded of the young impoverished single mother of a delightful 18-month-old girl who attends our pediatric clinic and lives in a two-bedroom apartment with nine other relatives. Despite the tensions of overcrowding and extreme social disadvantage, the mother remains upbeat and greatly enjoys life; the relationship between the mother and infant is exemplary: the child is engaged, interactive and affectionate, and the mother is very devoted to her. The last time she was in clinic, just before she left, I complimented the mother on what a great job she was doing with her child, and, in so many words, asked her if she realized how important her work as a parent was in determining her baby's future. She shook her head, no, and said, "I'll give her all of my love and everything I have, but I don't think she has much of a future. When she gets to high school, I'm not going to be able to afford nice clothes for her—the other kids won't think anything of her and she won't think anything of herself—and she may even end up hating me for it. I don't care, I just love her, but I don't see much of a future in that."

"Clothes" more important than "zero-to-three"? Whether due to mental illness, poor education, or a cruel lesson of poverty, such assumptions can eventually cripple the efforts of mothers who otherwise *embrace* the struggles of parenting for the sake of their children. It seems that working to change those assumptions and to help parents feel fulfilled in their role *might* have a chance of making a world of difference.

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Maternal Depression as a Context for Child Rearing

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"I'm down in the dumps today." "I'm really upset today." "I'm feeling blue today." All of us have bad days—days when getting out of bed is tough and we drag through the day. Otherwise simple tasks seem overwhelming. We're convinced that we can't do anything right, that it's hopeless to try to make things better. Nearly everyone feels depressed once in a while. But for some people, a whole set of symptoms that we call "depression" may last for weeks or months with little or no relief and interfere with normal everyday functioning and may even be life threatening. It has been found that women experience such depression more than men and that women with infants and young children are one of the groups with the highest rates of depression. What do we mean by "depression?" Just how common is it? How do we know that a mother is depressed? What do we know about the situations of these women? How does the depression affect their parenting? How are the children affected? What can be done to help? These are questions that are of concern to professionals who work with young mothers. These are questions to which researchers have provided some answers.

What is depression?

The American Psychiatric Association's Diagnostic and Statistical Manual of Medical disorders (APA, 1987) offers two primary categories of depression diagnoses: major depression and dysthymia (major depression includes bipolar disorders, which are more rare and will not be discussed). The core of symptoms includes depressed mood, loss of pleasure, apathy, low energy, interference with sleep, poor appetite, and negative views of the self and the future.

This definition only begins to describe the many depressed mothers whose particular symptoms may vary considerably. For some mothers, depression is characterized by many physiological symptoms (sleep, energy, and eating disorders). For other mothers, low self-esteem, low self-confidence, guilt, and pessimism predominate. For still others, depressed mood, lack of pleasure, self-absorption are most characteristic. Or any combination of the symptoms may be present. Depression may result in slowing down, but it may be expressed in agitated behavior. Depressed mothers may be apathetic, or they may be irritable. Symptoms vary in severity, in how long they persist, and how frequently they occur. Also, some women's depression is precipitated by an adverse life event, but others occur without any such stimulus. One feature of depression is that it tends to occur in bouts or episodes (varied in length and frequency) with periods in between in which symptoms subside (Angst, 1981). None of these qualities or feelings or behaviors that characterize depression bodes well for a mother's ability to provide the best mothering. Technically, of course, the criteria exist for helping us to know whether a mother's symptoms reflect a full-blown diagnosis of depression (APA, 1987). But these are less useful for understanding mothers' levels of distress, their difficulties in relating sensitively to their young children, and the distress their depression may impose on their children. More important for our purposes here is to summarize current knowledge about depressed mothers and their young children.

How common is depression in women with young children?

Researchers have consistently found that women are twice as likely to experience a depressive disorder than men (McGrath, et al., 1990). Further, there are times in women's lives when they are more susceptible to developing mood disturbances. One such time is the period following childbirth. In its mildest form, postpartum depression is often called "maternity blues." It may last from a few days to several weeks, but postpartum depression may also be severe and linger for months. An estimated 10 to 20 percent of women experience a postpartum depression (O'Hara, Zekoski, Philipps, & Wright, 1990). Rates of depression in mothers of young children are also high, with estimates ranging from 12 to 50 percent, depending on how depression is measured (Garrison & Earls, 1986). The high prevalence of depressive disorders in mothers of young children is reason to consider seriously how these disorders compromise parenting and child development.

Correlates of maternal depression

Given the data just reviewed, it would be easy to conclude that depression in women following childbirth or in the ensuing few years is related to the experiences of pregnancy, childbirth, the many adaptations required, or the burdens of rearing young children. These may, indeed, be contributing factors; however, there are additional factors to be taken into account in the life situations of depressed mothers. For example, an association between maternal depression and marital problems has long been noted, although researchers draw mixed conclusions about which is the cause and which is the effect (Gotlib & Hooley, 1988). Problems with the marriage may reflect the mother's disorder or it may also reflect problems in the husband. Psychiatric disorder is relatively common in husbands of depressed women, whether because two troubled individuals seek each other out or because depression in one person has a mutual negative influence on the other (Coyne, Kahn, & Gotlib, 1987). Other strains in life situations also coexist with maternal depression. Among these strains are inadequate social supports (Brown & Harris, 1978), economic strains (Belle, 1982; Lyons-Ruth, Connell, Grunebaum, Botein, & Zoil, 1984), an accumulation of stressful life events (Paykel, 1974), and having a child with a difficult temperament (Thomas & Chess, 1984).

The contexts in which maternal depression occurs are important for understanding the individual mother's behavior and needs. Yet we can no more accurately conclude that these contextual factors caused her depression than that her depression caused these factors. Our best understanding of depression is that it is an interpersonal as well as an intrapersonal process. There is not any single cause. Most likely a vulnerability to depression, whether it be genetic, cognitive, or interpersonal, is expressed when stressful events accumulate.

How do mother, family, friends react to mother's depression?

One of the most difficult aspects of depression both for the woman and her family and friends is that the symptoms often seem irrational or within her control. It is often hard to convey the powerful cognitive component of depression as it affects how mothers feel about themselves, the future, and the world. Therefore, others may view the depressed mother as perfectly capable of carrying out her responsibilities, if she would just resolve to do so. The mother may see herself as a failure, incompetent, overwhelmed, and helpless to change the situation. This cognitive component, along with the depressed mood, apathy, and physiological characteristics of clinical depression can result in the depressed mother feeling alone and misunderstood as she tries to deal with her depression and function as a parent.

Potential parenting impairments

Maternal depression does not necessarily lead to poor mothering; it is a hardship in mothering. For many depressed mothers, the impairing qualities of depression can and do touch critical areas of personal and interpersonal functioning. Research has shown that the central tasks of rearing are made more difficult, and that maternal depression can take a toll on mothers' abilities to care for, nurture, regulate, and teach the infant and young child.

The translation of depression into parenting is complex, however, depending on the specific qualities of the mother's illness, the "person" characteristics of the mother, the contexts of risk or protection in which mother and child are embedded, and characteristics of the child. The inroads on maternal functioning are, therefore, not uniform in kind or severity. Nevertheless, some patterned behaviors have been found in numerous studies of depressed mothers with their infants and young children. Each of these patterns, in theory at least, is an interference with good mothering and poses potential problems for the child. We will describe the clearest patterns that have emerged out of a diversity of research.

To begin with, **depressed mothers tend to think badly of themselves as mothers.** They feel overwhelmed, inadequate, and as having little control over their children's development (Cohn, et al., 1986; Coyne, et al., 1987). Such perceptions of their maternal role are continuations of their views of themselves generally. And, to some extent, their perceptions reflect accurately their interactions and relationships with their young children.

In the mother-infant relationship, the self-doubt and self-focus of these mothers are expressed in their **difficulties in providing adequate and appropriate stimulation to their infants.** These mothers interact less with their infants and evidence less pleasure in their infants than do well mothers (Goodman & Brumley, 1990). Depressed mothers tend to be less consistently aware of, and responsive to, their infants' signals, and less initiating of interactions. They vocalize less to their infants, and their vocalizing lacks the lilt and exaggeration that is characteristic of nondepressed mothers in "talking" to their infants (Bettes, 1988; Field, et al., 1985).

This under-involved pattern contrasts with another pattern that appears in other depressed mothers—and also in the behavior of some of the uninvolved mothers when they are in stressful situations. **Some depressed mothers stimulate the infant excessively,** in ways that interfere with the infant. Their stimulation lacks the tenderness and satisfaction characteristic of good mother-child interaction (Field, 1987). The heightened stimulation is by no means in tune with the infant's needs and rhythms. There is good evidence to suggest that the infant finds it aversive and disorganizing.

To best describe depressed mothering, it is necessary to focus on the interplay of mother and child behavior rather than on the mother's actions alone. A close look at the interaction helps in comprehending the links between depression-symptomatology, mother's responsiveness to her child, and the experiences that are created for and by the child in her care.

In the affective component of depressed mother-infant interaction—which carries so much of the quality of their relationship—these dyads often experience trouble. **Depressed mothers express little positive affect and much negative affect. Their infants have similar patterns.** The affective state of these infants has been described as unstable, hard to "read," and hard to bring under control (Field, 1987), a description fitting to their mothers as well. Thus, both partners contribute to the development and escalation of negative and disorganized interaction. The depressed mother often fails to respond contingently to the infant and to give the kind of affective feedback that helps the infant to regulate his or her affective state (Tronick & Gianino, 1986).

We have been reporting mainly on research findings on depressed mothers and their infants. Do the patterns of depressed maternal behavior continue into toddlerhood? Do new problems arise or old ones get resolved? Basically, research provides a picture of maternal continuities, although the developing child brings new capabilities and makes new demands on the mother.

As in their relationship with their infants, **depressed mothers are slow to respond to their 2-year-olds' overtures** (Rutter & Quinton, 1984). Their behavior has an overarching quality of downcast and negative tone. How much negative (downcast, anxious, irritable) affect dominates in mothers' relationships with their children, of course, varies. What is especially telling is that their children's levels of negative affect tend to covary with mothers' levels of affect (Radke-Yarrow, Richters, & Wilson, 1988). Although mothers' negative affect is often not specifically directed to the child, mothers' negative outlook spills over into critical, negative and nonsupportive comments and attributions to and about their children (Rutter & Quinton, 1984; Radke-Yarrow, Belmont, Nottelmann, et al., 1990).

A deficit in mothering that is of particular developmental significance is **depressed mothers' diminished verbal communication with their toddlers.** In this period when language acquisition and cognitive exploration are important developmental tasks, depressed mothers fall behind well mothers in verbal communication with their children. They speak less and are slower to respond to their child's verbal initiatives, and are nonrewarding of their child's linguistic efforts (Breznitz & Sherman, 1987).

Again, with respect to another critical developmental task of 2 & 3-year-olds, namely, to develop some control of impulses, and some acceptance of socialization rules and expectations, depressed mothers encounter difficulty. Regulating the willful toddler is not an easy task and often depressed mothers shrink from it. **They are often fearful of their young children and are unable to assert appropriate authority and limits.** At the other extreme, depressed mothers respond harshly. In either case, the young child's distress tends to be met by control techniques rather than by supportive behavior (Kochanska, Kuczynski, Radke-Yarrow, et al., 1987; Rutter & Quinton, 1984).

A risk to the young child derives from yet another kind of depressed mother-child interaction in which **the depressed mother draws her child into her own symptoms with unusual closeness and affection.** Indeed, sometimes the young child becomes a kind of comfort blanket to ease the emotional distress of very ill mothers. As this relationship develops, both mother and child become attuned to the other in what appear to be maladaptive ways often labeled enmeshment (Radke Yarrow, Richters, & Wilson, 1988).

Depressed mothers are not one group. They react and influence in diverse ways, but their diversity has some common strands: There are casualties from their impairments. Maternal behavior is less effective in aiding and guiding the infant's and young child's regulatory competencies, and it tends not to provide children with affectively positive, predictable, and confident parenting.

Costs and supports to the mother

We have stressed common themes and diversity in depressed mothers' impairments in relating to their young children. We need to underscore the fact that there are depressed mothers who can mask and control their symptoms. But, there are, undoubtedly, costs to these mothers. Mothers who manage are able to do so out of various histories and resources. The causal factors underlying the mother's depression and the characteristics of her depression, its severity and chronicity, may affect how much she can shield her child rearing role from her personal distress. The woman's satisfaction in other areas of life and her interpersonal supports are other factors. The way in which the mother's depression is defined by her and by her family and friends has a bearing not only on her behavior with her children, but also on her inclination to seek or accept help. Depression typically is not acknowledged as a treatable illness, as evidenced by the low rates with which depressed individuals seek help from mental health professionals. Shame, guilt, anger, and hopelessness may be prominent in the mother's feelings and those of her family and friends.

All of which is to say that a picture of the depressed mother would be woefully incomplete unless account is taken of the broader circumstances of which she and her child are a part. As we have already noted, maternal depression is associated with risk factors of many kinds. Prominent among them are marital discord, conditions of severe social disadvantage, and traumatic childhood histories. The behavior of the individual depressed mother is relation to her child needs to be viewed in terms of these contexts. Neither mother nor child can be understood or treated in isolation from them. The "causes" and "cures" of impaired maternal functioning are likely to be multiply based, sometimes firmly rooted in individual psychopathology, sometimes in the pathology of the "system," and, more than likely, in both.

Infants and young children of depressed mothers

In a host of studies, maternal depression has been linked with emotional and behavioral difficulties in their infants and young children. Because infants and toddlers spend many of their waking hours close to their mothers, maternal depression may have a very early impact. Research supports this expectation. Indeed, infants' sensitivity to mothers' depressed affect has been demonstrated in two very different types of studies. In an experimental study, nondepressed mothers were asked to simulate depressed affect (Cohn & Tronick, 1983). Infants as early as 3 months showed heightened distress levels, protests, and gaze aversion. Observations of infants of depressed and nondepressed mothers in more natural circumstances (Field, Healy, at al., 1988) led to the conclusion that maternal depression fosters a depressed interactional style in infants that is displayed to mothers and strange adults alike.

That depressed behavior in mothers is readily "mirrored" in this way (Field, 1984) by infants and becomes generalized across contexts is an important finding because it suggests a mechanism through which depressed behavior may be initially transmitted from parent-to-child. These findings are consistent with the literature indicating mothers' crucial socializing role in the development of emotion regulation in infants (Emde & Sorce, 1983). Infants learn emotional and behavioral regulatory skills by repeatedly referencing mothers' facial expressions across a variety of situations. Mothers whose emotional displays are appropriately regulated (i.e., that are situation-and context appropriate), foster similar regulatory skills in their infants. By contrast, dysregulated maternal affect, such as depressed mothers' persistent dysphoria, fosters similar dysregulated, depressed affect in infants.

Important to note, however, is that the depressed behavior of infants of depressed mothers may disappear if their mothers' depression is not chronic. Field (1992) has reported that first-year infants are more prone to developing a depressed interactional style if their mothers were depressed during the infants first 6 months than are infants of mothers whose depression alleviates during this time. It would appear that infants can rebound effectively from short-term bouts of maternal depression (e.g., post-partum depression that is short-lived). Issues of chronicity and severity of maternal depression are undoubtedly critical in the degree to which infants are at risk for behavioral disturbance (Goodman, 1990).

The qualities of depressed mother-infant interaction described earlier, of nonresponsive, inconsistent, insensitive mothering (see Teti & Nakagawa, 1990, for a review) have consequences for the attachment relationship. Disturbances in attachment are more frequent in infants of depressed mothers (Teti, Gelfand, & Messinger, 1992). In this study, insecure attachment characterized 63% of the depressed mother-infant relationships compared with 21% of the non-depressed mother-infant dyads. These infants have been denied the secure maternal base which is important in organizing infants' behavior toward others and facilitating their ability to negotiate and resolve developmental tasks. With insecure attachments (following Bowlby 1969, 1973),

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the development of a mental representation of the caregiver as loving, trusting, and nurturant, and of the self as worthy of love and support is at risk in these children.

As we look for pathways from maternal depression to infant problems, there appear to be certain common problems despite the diversity of ways in which depression may affect mothers' behavior. The uninvolved mother, the intrusively stimulating mother, the affectively dysregulated mother all have a common disorganizing effect on the infant's regulatory and affective processes.

These vulnerabilities of infancy continue into post infancy. Toddlers of depressed mothers show more negative and less positive affect when interacting with their mothers than do children of nondepressed mothers (Cohn & Campbell, in press; DeMulder & Radke-Yarrow, 1991). Moreover the specific affect displays by the toddler (e.g. irritable or depressive or anxious) correlate rather highly with the affect displays of their mothers, suggesting as one avenue of transmission a direct influence of mother's mood on the child.

Psychiatric evaluations of toddlers of depressed and nondepressed mothers have also revealed more problems in the children of depressed mothers. Between the ages of 1½ and 3½ years, problems were significantly more frequent in disruptive behavior, anxiety, and depressive affect (Goodman, 1987; Radke-Yarrow, et al., 1992). Higher levels of dysregulated, out-of-control aggression, and marginally higher levels of hostility appeared among 2-year-old toddlers of depressed mothers during interactions with same-aged peers relative to 2-year-old toddlers of nondepressed mothers (Zahn-Waxler, Iannotti, et al., 1980). In turn, dysregulated aggression at age 2 related positively to maternal reports of externalizing behavior (i.e., aggressive, "acting-out" behavior toward peers and adults) at age 5. Other data indicate that preschool and school-age children of depressed mothers are more inclined to be noncompliant and develop coercive interactional styles with their mothers (likely a function of depressed mothers' inability to set effective, consistent limits with their children), to show attentional and intellectual impairment and poor school achievement, to have poor peer relations, and to be at risk for a variety of depressive and anxiety disorders (see reviews by Downey & Coyne, 1990; Gelfand & Teti, 1990; Goodman, 1992).

Again, just as depressed mothers have been characterized as heterogeneous in their depressive symptoms and their interactions with their children, child outcomes, too, are not uniform. A history of impaired mothering has multiple and varied costs. How children cope with these adversities depends on many factors involving mother, child and interpersonal context.

Interventions for depressed mothers: Guidelines

Where is a mental health practitioner to begin? First, and perhaps most clear from our review, the mother's depression requires direct intervention. Efforts to minimize the severity and chronicity of her depression are likely to result in the depressed mother being better able to maintain good parenting and in better outcomes for the child. Depression is a highly treatable disorder, especially with a combination of drug treatment and either a cognitive or interpersonal-systems psychotherapeutic approach (Manning & Frances, 1990). However, many people are reluctant to seek or persist with treatment, and the depressed mother may need support even to make that choice.

A second set of goals for mental health professionals involves taking into account the health of the depressed mother-child relationship, an important, albeit challenging task. The goal of such work might be sensitizing mothers to appropriate mothering practices with infants and young children. In our experience, depressed mothers do not necessarily lack the skills important to good mothering, but may be too overwhelmed by their depression and life circumstances to use them effectively.

Of course the specific goals for the mother-child relationship will depend on the developmental stage of the child. For mothers of infants, goals may be increased sensitivity to the baby's cues, more contingent responsiveness, provision of developmentally appropriate toys, providing variety in daily stimulation, and a hazard-free environment. For mothers with toddlers, continued sensitivity needs to be combined with respect for the toddler's growing autonomy. Discussion of limit setting (what to do, when to do it, how to do it) and the importance of consistency may be helpful. The depressed mother might be encouraged to attend to patterns of her discipline attempts and her toddler's response, noting what works and what doesn't. A common benefit of such work is an increase in the mother's sense of efficacy in the parenting role, which may be a major boost in her fight against depression.

As a first step in work on the mother-child relationship, mental health professionals may wish to establish a better understanding of how depressed mothers feel about their baby or young child. For example, they may see the baby as contributing to their own distress. Depressed mothers who see their child as "difficult" may be particularly at risk for experiencing current and future problems in the parent-child relationship. Yet, indeed, the woman may be dealing with a temperamentally difficult child, or even a child with a chronic illness or handicap, and require special guidance and support for that challenging task. Some children are more difficult than others, and a fussy-prone baby requires a different kind of adaptation from mothers (e.g. patience and consistency) than would a quiet, ea baby (who might require a greater amount and more varied stimulation from mother). The "goodness-of-fit" between mother and child may be even more important in depressed mother child dyads than it is with well dyads.

Finally, a third goal in working with a depressed mother may be helping her to recognize the context in which her depression emerges. For example, what about the established relations between maternal depression and marital problems? The spousal relationship may be an important focus of intervention. As part of such work, assessment of psychopathology in the husband may be helpful, not only in revealing the need for treatment by the husband, but also in better understanding the depressed mother and her efforts at parenting.

Similarly, other contextual correlates of maternal depression may suggest further goals of intervention. Amongst the areas to consider are financial hardships, inadequate social supports, and an accumulation of stressful events. Information about these contexts may suggest additional goals for intervention. For example, the depressed mother may greatly benefit from having time for herself. In order to accomplish this goal, she may need help in more effectively managing her time or in learning how to access social and community supports that might provide the needed relief. Similarly, the depressed mother could be encouraged to give high priority to the troublesome or dysfunctional relationships in her life, ideally enlisting the cooperation of the involved individuals, and taking advantage of mental health professionals when the woman working together with her relationship partners is not enough to solve the problems. Altering the context in which the mother's depression is embedded, while a more distal intervention than, say, improving mother-child interaction, may also be primary prevention for the child (Goodman, 1984).

In sum, we have described both common themes and diversity within the group of depressed women who are mothers of young children. Mental health professionals' concern about the young child of a depressed mother is warranted by the research findings. The findings also suggest goals for intervention: minimizing the depressed mother's symptoms which are known to interfere with parenting, sensitizing her to mothering practices that are appropriate to her child (taking into account the child's age, temperament, and other relevant characteristics), and helping her to resolve the issues which contribute to the woman's depression.

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Treating the Relationships Affected by Postpartum Depression: A Group Therapy Model

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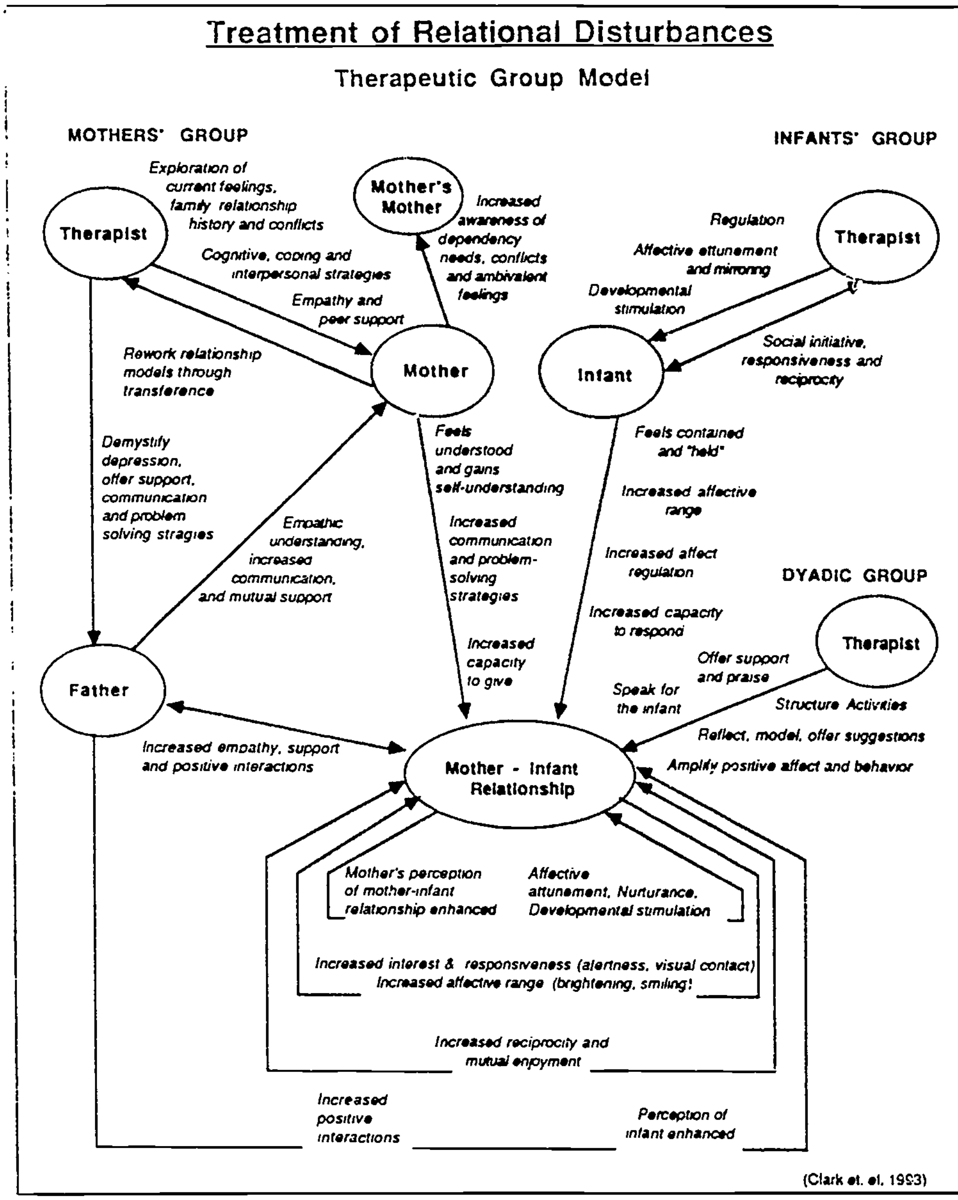
As many as one in five mothers of newborns experiences a depression that lasts for at least two weeks. Thirty to 70 percent of these depressed women may experience the disturbance for a year or longer (Cutrona, 1982; O'Hara, 1984). Many researchers and clinicians have described depressed mothers' difficulties in providing physical care, protection from harm, and positive emotional responsiveness for their infants during a critical period of their early development (Weissman, Paykel and Klerman, 1972; Brown and Davidson, 1978; Cohn, Campbell, Matias and Hopkins, 1990). The distress and unresponsiveness seen frequently among infants of depressed mothers are likely to maintain, and perhaps increase the severity of the mothers' depression. Meanwhile, fathers (and other family members) may be mystified by the mother's depressive symptoms, afraid for the safety of both mother and baby, and overwhelmed by practical and emotional demands.

Traditional treatment approaches for postpartum depression include individual psychotherapy for the woman, medication, and at times psychiatric hospitalization. Individual psychotherapy is a mode of treatment that can ignore the impact of depression on the woman's multiple roles and relationships. Psychotropic medication may also be prescribed, a treatment that poses conflicts for women who are breastfeeding. Hospitalization is another traditional therapeutic approach for postpartum depression. However, the lack of mother-infant units in the United States makes it virtually impossible to hospitalize an infant with a mother on a psychiatric ward. Since psychiatric hospitalization means a separation between mother and infant, mothers often experience feelings of loss and guilt due to the separation. They can experience difficulty in bonding and attachment to their infants which can contribute to the continuation or exacerbation of depressive symptoms.

Postpartum depression is an illness that affects relationships. This article describes a therapeutic approach to treating relationships, one that addresses not only the needs of the mother with postpartum depression, but those of her infant, of their relationship, and of the family as well. The model involves 12 weekly group sessions that include separate simultaneous treatment groups for mothers and for their infants. Each session also includes a dyadic group time for mothers and infants together. Two of the 12 group sessions include spouses or partners as well. The overall goals of the group therapy approach, which has been underway since 1988, are: 1) to ameliorate depressive symptoms in the mother; 2) to address individual conflicts related to the mothers' own experiences of being parented; 3) to reduce social isolation; 4) to provide an environment for the infants that is emotionally responsive and supportive of their development; 5) to facilitate positive mother-infant interactions; and 6) to support improved functioning within the family.



Treatment of Relational Disturbances

Therapeutic Group Model

(Clark et. al. 1993)

The theoretical foundations for our model

Psychodynamic, self-psychology, family systems, and developmental theories and studies have influenced the way we conceptualize relationship issues for depressed mothers, their infants, and other family members. This conceptual framework has led us to integrate specific cognitive, behavioral, and interpersonal strategies with a therapeutic approach that allows mothers to explore past relationships and their impact on current feelings and relationships.

The psychodynamic concepts central to our approach include Winnicott's "holding environment" (1965), Fraiberg's "ghosts in the nursery" (1975), and Bowlby's formulation of an "internal working model of relationships" (1969) that can and does influence the mother's expectations and interpretations of her infant's behaviors.

Emde's notion of emotional availability (1981) and Stern's description of "affective attunement" (1985) help us to understand what seems missing in the relationships between most depressed mothers and their infants. Kohut's (1971) theories of self-psychology describe the concept of "mirroring" an infant, a process more complex than imitation since it requires observing, understanding, and responsively mirroring a young child's internal feeling states. Mirroring is very difficult for depressed mothers, who often avoid looking into their infants' eyes either in an attempt to spare the child the sight of the mother's rage or because of their own fear of being engulfed by the infant's gaze and needs. Because their feeling states, especially positive ones, are not being responded to differentially by their mothers, the infants and young children of depressed mothers often look sober, sad, or "flat."

The family systems theories of Minuchin (1974) and others are useful in conceptualizing relationship issues within the current family of the depressed mother and in her family of origin. Our group therapeutic work is structured to allow mothers to become more conscious of their roles and positions in the structure of their families of origin as these are replayed in relationships with other group members and the male and female co-therapists. As mothers become more aware of previous roles and limiting intergenerational patterns, they are able to begin to differentiate from those patterns.

Demos (1982) and Vygotsky (1978) describe ways in which parents and other caregivers structure infants' experience. Demos describes the mother's affect, particularly positive affect, as an "organizer" for the young infant, whereas her negative affect can often disorganize the infant. In his work on the "zone of proximal development," Vygotsky describes the caregiver as providing "scaffolding" which expands the baby's level of capability. Although Vygotsky wrote about scaffolding in terms of problem solving and communication, the concept is apt on an emotional as well as a cognitive level. Since mothers who are depressed often have difficulty in noting the state of the infant and being able to gain, focus, and sustain the infant's attention, our developmental therapy group is designed to provide the baby with affectively and physiologically organizing relationships as the mother's depression is improving.

Though relationship issues are conceptualized from a psychodynamic and family systems perspective, the therapeutic approaches also utilize the interpersonal therapy of depression described by Klerman, Weissman, Rounsaville, and Chevron (1984), the cognitive strategies of Beck (1976) and Burns (1989), and Yalom's writings on aspects of therapeutic groups (Yalom, 1985; Vinogradov and Yalom, 1990). Because depression can be maintained and exacerbated by social isolation, an active interpersonal approach seems appropriate and has proven effective. Cognitive-behavioral approaches can challenge feelings of helplessness and hopelessness and promote positive coping strategies. These approaches are designed to help women express and validate their feelings, examine negative thought patterns, and develop other ways of being able to experience themselves in the world. It is equally important to examine the connection between the past experiences and current relationships of mothers with postpartum depression. As women's dependency needs increase during the last trimester of pregnancy and after childbirth, their relationships with their own mothers become reactivated in their relationships with their husbands. If women were disappointed in the nurturance they received from their own mothers and their husbands cannot meet their present needs, women may experience frustration, disappointment, and even rage. Repairing a strained, distant, and conflictual marital relationship thus becomes another task for the therapeutic work.

Goals for the group model

In order to address all the important relationships affected by postpartum depression, the group model is designed with specific goals in mind for mothers, for infants, for the mother/infant dyadic relationship, and for the family's relationships. These are listed below:

For mothers:

1) To recognize interpersonal, intrapsychic and cognitive patterns contributing to their current depressive symptoms; 2) to provide strategies for reducing depressive symptoms; 3) to participate in a group process designed to broaden social support which reduces the sense of isolation; 4) to increase the awareness of their own needs (e.g. dependency, nurturance, safety) and enhance their ability to address those needs for themselves and their infants; 5) to expand perceptions of their infants and of themselves in the parenting role; and 6) to increase their capacity for empathic care for their infants, including the ability to focus on their infant's immediate physical and social-emotional needs.

For infants:

1) to increase their differentiation, range, and regulation of affect; 2) to show a greater interest in and responsiveness to others; 3) to experience feelings of comfort, effectance, and self-worth; and 4) to expand and consolidate developmental skills.

For the mother-infant dyadic relationship:

1) to provide a safe atmosphere for mother to explore alternative ways of interacting with her infant that support her infant's growth and development; 2) to provide opportunities for mutually enjoyable interactions for mother and infant; 3) to promote reciprocity between mother and infant; and 4) to enhance the mother's feelings of competence in the parenting role.

For the family relationships:

1) to demystify depression for spouses and family members; 2) to identify and respond to the needs of spouses/partners; 3) to promote a sense of connectedness through increased spousal empathy and communication; and 4) to enhance joint problem-solving strategies.

Referral and assessment

Group members are identified and referred by primary health care and mental health providers. Early referrals are encouraged to permit intervention before the mother's sense of repetitive relationship disappointment, frustration, and anger toward her infant become consolidated. Mothers, infants and fathers participate in an intake assessment process which includes a clinical interview regarding their experiences of depression, themselves, and family relationships. Several self-report assessments assist the mother in recognizing her needs and those of her infant. The infant participates in a developmental/psychosocial assessment. The mother and infant are then videotaped for five minutes of free play, and the videotape is reviewed with the mother to assess how it is alike or different from the dyad's typical experience. Preliminary goals for the mother and infant individually and together are developed with the mother.

Group structure

The main participants in the group itself are mothers and infants (the mean age for the infants seen is 9 months, but the range has been from 1-24 months). The optimal number of families for the group process is between 5-7 families. The group meets weekly for twelve weeks and is two hours in length.

Each group session is designed around a core theme, e.g. depression, ambivalence, nurturance, communication, self-esteem and competence, independence/dependence, and safety. The mothers assist in choosing the topics for the last one or two sessions. Therapists have a session guide (see pages 20 and 21) that outlines issues and materials for each session. However, the group therapeutic process follows the mothers' leads.

The relational therapeutic group model is structured to address the individual emotional needs of mothers, infants, and family members, as well as their needs in dyadic and family interactions. This is accomplished by structuring sessions in a two-part format. During the first 1½ hours, mothers and infants meet in separate groups. Mothers meet with female and male co-therapists. In the infants' developmental therapy group, each infant is paired in an ongoing relationship with a therapist. In the last half hour of the session, mothers and infants reunite for dyadic group activities including interactive games and movement, baby massage, toys, and music. A group leader coordinates and conducts these sessions, in which each mother/infant dyad is joined and supported by a dyadic therapist. Fathers or significant partners are invited to two of the 12 group sessions. They meet together in a separate group and then join the mothers to discuss their mutual feelings, needs, and communication patterns. On these occasions, fathers also join mothers and infants in "triadic" activities.

The relational dimensions of the model

Of fundamental importance to the model is the therapist's relationships with family members. Through their experiences with the therapist, a parallel process occurs in which family members are then able to bring more to their interactions with each other.

Consider first the mothers' therapy group. During their group sessions, mothers are given an opportunity to express their current feelings and conflicts as well as to explore their family relationship history and its impact on their current relationships with their infants and partners. The therapists encourage expression and exploration of feelings through a variety of means, including drawing, reflection, and role plays. The group serves to recreate the original family, and issues are likely to be brought up by one member that address the concerns of other participants as well. The use of male and female co-therapists in the mothers' group tends to encourage exploration of issues related to members' families of origin. In addition, one therapist can follow the process of the group while the other follows content, allowing for more careful attunement to participants.

As mothers' needs for support, validation, and nurturance are addressed in the group sessions, mothers become less angry, self absorbed, and helpless and are better able to be supportive, validating and nurturing in their relationships with each other, their infants, and their partners. And as mothers' insights into their family of origin's relationships are enhanced, their ability to put "ghosts in the nursery" to rest is increased, thereby allowing them to be less conflicted and more emotionally available and responsive in interactions with their infants.

Infants in the developmental therapy group are involved in one to-one consistent interaction with the therapist, who provides affective attunement, responsive caregiving, and developmental stimulation. Many of the infants have had little opportunity for face-to-face interaction, manipulating objects, and exploring the environment. Infants' therapists amplify the babies' interest and responses and display a wider range of affect than these infants of depressed mothers may have experienced. While following the infant's lead by responding to cues and needs, therapists provide a clear and safe structure for the infant, resulting in increased regulatory capacities, affective range, and social initiative and responsiveness. In this way, the infants become more reinforcing to their mothers, making possible more reciprocal, mutually satisfying interactions.

JOHN ARMS

During dyadic group activities, the therapist's role is multifaceted. The leader of the whole session paces the activities and offers general suggestions for ways that mothers may want to engage their infants in interactive games, or soothe and comfort them. The therapist for each dyad offers support and praise, amplifying positive affective behavior, modulating negative responses, reflecting, modeling, and providing scaffolding or structure. Therapists use strategies such as speaking for the infant and engaging mothers in the process of wondering about their infants' cues or behaviors. Again, the therapist responds to each member of the dyad, enabling each partner to respond better to the other.

Lastly, therapists are involved with fathers and family members. This involvement is critical given the powerful role of the social environment in depressive illness. Therapists provide family members with information aimed at demystifying depression. They also offer emotional support and strategies for increasing communication and problem-solving. In this way, fathers and family members who may have been overwhelmed with increased responsibility and legitimately fearful for the safety of their partners and children can be more empathic, understanding, and supportive to mothers and their infants.

Training of therapists and ongoing supervision

Therapists include psychiatry and psychology interns, fellows and students, volunteer therapists and allied health professionals. The therapists are trained in a relational perspective and are given materials to further acquaint them not only with the symptoms and effects of postpartum depression but also with the meaning of depression for the women, for their infants, and for family relationships. The training includes information regarding child development during the first two years of life and specific instruction in individual and dyadic group therapeutic approaches. The dyadic work receives special attention. The shift from being the infant's therapist to working with the dyad is complicated. It demands that the therapist be able to offer empathy to and establish trust with the mother in a way that will permit often intense therapeutic involvement.

Sessions are videotaped and supervisors observe behind a one-way mirror. Direct supervision occurs for 1½ hours,immediately after each group session. During this time, the therapists review and discuss the events, discussions, and interactions that have just occurred. During each supervision session, therapists focus on the emotional and relational issues for each mother, infant and family, using their growing understanding of the family to develop ideas and strategies for therapeutic intervention in future sessions.

Results

Group participants' gains are evaluated through pre- and post group assessment of mothers' mood and personality, level of parenting stress, and perceptions of their infant's temperament. Infants' developmental and psychosocial status and the quality of the mother-infant interactions are also assessed. Results of an evaluation of this approach indicate that the group is effective in reducing mothers' depressive symptoms and levels of stress in the parenting role. Infants exhibit increased social responsiveness and a range of emotional expression. Mother-infant interactions are more positive and reciprocal in nature by the end of the group with mothers experiencing more enjoyment and feelings of competence in the parenting role (Clark, Fedderly, and Keller, 1991).

In addition, mothers are asked to complete a client satisfaction questionnaire at the end of the twelve weeks. Mothers are reminded of the goals they set for themselves, their infants, and their relationships with their infants and asked the extent to which they feel they have achieved these goals. All mothers have reported gains in each area, with most mothers feeling a strong sense of improvement and achievement. Mothers are asked which aspects of the adult and dyadic group they found helpful. Mothers reported that sharing feelings about themselves as parents, discussing what they find difficult and enjoyable with their infants, and sharing feelings about their marital and other relationships are helpful. All mothers completing the questionnaire indicated that they would recommend the group to a friend.

Mother-Infant Group
Mother's Group Session Guide

Session #7 Promoting Safety, Health, and Security

Goals: — To identify physical and emotional safety needs of infants and mothers.
— To identify means for meeting those needs for both mother and infant.
— To increase awareness of the effect of depression on feelings of safety for mother and infant.

Materials 1. Check-In:
-Questions or comments about last weeks group?

2. Introduce topic of safety.
-Both physical and emotional (and in relation to this group).

3. Who or what helped you to feel safe and secure as a child?
Who was there to protect you? Who was not?
Do you remember a time of feeling alone, unsafe, or unprotected?

Handout & Pens 4 Have each member generate a list of:

	Ways I feel/have felt safe	Ways I feel/have felt unsafe
Prior to pregnancy		
During pregnancy		
Since birth of child		

5 Discuss how each member's needs for safety as an adult have been met or not and how else they could get needs met.
-What are barriers to safety in your life right now?
-How has depression affected sense of safety for mother and infant?

6. Bridge to Dyadic Group
-Discuss children's needs for safety.
-What do you do to help your baby feel safe? (Physically and emotionally)
-Does the group feel safe to you and/or your baby?
-Discuss health check and immunization information

HANDOUT. Safety Information Sheets and Health and Immunization Cards

A sample group session and a case vignette

Safety and security are very real concerns for mothers with postpartum depression, their infants, and their worried partners. The Mothers' Group Session Guide and Dyadic Group Session Guide, reproduced on pages 20 -21, illustrate the ways in which themes of promoting safety, health and security can be introduced, explored, and reinforced.

In the mothers' group session devoted to promoting safety, health, and security, therapists gently explore how physical and emotional safety were provided for mothers as children by their parents. It is clearly suggested that having been unprotected as a child makes it difficult to provide safety for an infant. The mothers discuss feelings of safety in their present life circumstances and relationships. By joining with them empathically regarding their experiences related to safety, the therapists are enabling them to begin to empathize with their infants. The mothers discuss the emotional and physical safety needs of their infants, as the session moves toward a bridging segment, shifting the focus to the infants in preparation for dyadic work.

The case vignette that follows describes work with Jane, Steve, and their three-month-old daughter Carla. Safety and security were important issues, among others, in this family, who used the group experience well as a beginning for further work.

Mother-Infant Group
Dyadic Group Session Guide

Session #7: Promoting Safety, Health, and Security

Goals: —To increase mothers' recognition of their proactive role in keeping their child physically safe.

—To help mothers understand the link between their child's experience of physical safety and emotional security.

—To help mothers experience themselves as capable of keeping their child physically and emotionally safe.

Materials	**Activity**	**Facilitators**
Tape Recorder Raffi tape	WELCOME SONG: "Mr. Sun"	Immediately prior to group: Check in with mothers about how things are going for them as you escort them to dyadic group from children's group.
	ACTIVITY #1: Check-in Time Facilitator briefly introduces today's theme and goals. Ask each mother to share: (1) one thing she does to help herself feel safe and secure; and (2) one thing she does to keep her baby safe (either physically or emotionally).	
Chairs	*ACTIVITY #2: Trot, Trot to Boston* Each mother will be seated on a chair, holding her baby so that he/she is facing her on her lap. She will then gently" bounce her baby to the following rhyme: "Trot, trot to Boston Trot, trot to Lynn Be careful little ______ So you don't fall in." Upon saying "fall in", each mother will dip her baby backwards between her legs, supported by her arms. She should then bring her baby up gently and give him/her a reunion hug.	Comment on the child's affective response to this activity. Once again, this can be done by speaking for the child. E.g.: "Ooh, Mom that was exciting!" I like it when you keep me safe and hug me." Also, comment on the mother's ability to make the activity fun and safe. E.g.: "______ seems to enjoy this activity. It may be a little scary but you make it safe for him/her to try it." Amplify positive initiations, responses, facial expressions and feelings of both.
Rocking boat, Poppin' pals, Sesame Street Pop-up toy, Jack-in-the box	*ACTIVITY #3: Toy Exploration* This activity is designed to promote the fun of safe surprises. Children can enjoy an element of surprise with these toys as their moms help them explore and feel safe. In the elevator game, mothers lie on their backs, lower babies to their faces, kiss, rub noses, raise babies again. "Down, Down, Down, Up, Up, Up", etc. Physical security is of some concern with the elevator game and poppin pals.	Support/encourage the mother in her efforts to interest her child in safe and fun play. E.g.: "What kind of rocking do you think ______ would feel comfortable doing?" Comment on and amplify the child's response to the surprise of the toys and the mother's ability to introduce this type of play in a way that is sensitive to her baby's need for security. E.g., Speak for the baby: "Mom, this is kind of scary, I need to check in with you to feel safe." Emotional security is also important. "______'s not sure about this elevator rick, but she really smiles at your reassuring kisses."
Lullaby tape Family's own items: -blanket -plush toy -bottle	*ACTIVITY #4: Snuggle Time* Each mother will select one or two of her child's favorite security items. While rocking and snuggling with her child, she can talk with her child about how it feels to hold his/her blanket, etc. securely and reflect on her baby's enjoyment of safety in her arms. Help moms contain and comfort baby's who are squirming/arching.	Help moms get organized and started. Help moms with containment. Reflect how mothers may be feeling. Encourage soft crooning voice, gazing at the baby, etc. Help moms develop their talks with baby if they need assistance. Speak for the baby: "Mom I like being in your arms." "I need some settling and calming. It feels great to be held."
Tape Recorder Raffi tape	CLOSING: *Song:* "The More We Get Together"	Group Hug: "Good-bye! Take Care! See you next week."

Staff of our hospital's Acute Psychiatry Service referred Jane to the Parent-Infant Clinic. Jane, her husband Steve, and their three-month-old daughter Carla initially seemed to be working hard to keep intense feelings in check, yet appearing overwhelmed by the events that had followed Carla's birth.

Jane had experienced the birth of her daughter as a total loss of control. She perceived her newborn daughter's cries as personal attacks, which she could not stop and to which she often responded with her own explosive verbal attacks. This led her into what she described as a circle of frustration, anger, and guilt and then back to frustration over her sense of guilt at being angry at her little baby. She was helpless and wanted to "forget it all."

This sense of helplessness seemed to pervade the family. Steve did not know what to say or do, but because of his sense of responsibility for his family felt that he "should know what to do". Likewise, Carla appeared helpless and unable to regulate her feelings, tolerating only brief, fleeting moments of human contact. The human face seemed to be unpredictable and scary for Carla, and she actively avoided eye contact.

This family's strength was in their recognition that they indeed needed help. As a family they were willing to take the risk and try to understand what was happening. To help mothers and their families feel safe enough to take the risk and explore difficult, painful aspects of themselves and their relationships with others is a critical element of what we like to refer to as a "therapeutic" assessment. We were not just gathering data but joining with Jane, Steve, and Carla, conveying to them respect and concern for their difficulties, offering them concrete steps that might be helpful while at the same time acknowledging the effort it would take for them to join with us in this process.

In her initial group sessions, Jane "went through the motions"—she appeared to be trying to smile away her depression. We were able, however, to address Jane's intense self-criticism with cognitive therapy techniques: identifying and challenging dysfunctional automatic thoughts (e.g., "if I cannot stop the baby's crying, I am a bad mother, and therefore worthless because mothering is my main role").

An early group session which focused on ambivalent feelings, coupled with the videotape replay of her play interaction with Carla, helped Jane to connect her current feelings of anger with her own painful experience of being the recipient of her mother's physically abusive acts and her equally painful experience of her father's passivity and neglect. Initially she was unable to attach affect to this experience, reporting the events in a rather matter-of-fact fashion. However, with support of the other group members and facilitation by the group therapists, Jane was able to feel and re-experience her own sense of pain and anger as a child. A poignant moment occurred while Jane watched a segment of videotape in which Carla appeared to be reaching towards her. At first Jane perceived Carla's reaching up to touch her hair as an attack (the baby had pulled and it had hurt a little). Then, with supportive encouragement she was able to discuss, although without emotion, a specific incident in which she had been hit repeatedly by her own mother. The therapist asked her how that was for her. She responded by describing it as "just embarrassing black and blue marks" that were revealed when she wore shorts. The therapist wondered with Jane if it had hurt when her mother had hit her up and down the backs of her legs, and as she reflected her eyes filled with tears.

What emerged during the course of the next several group sessions was the amplification of Jane's anger towards Carla and a heightened sense of her circle of frustration. She expressed the desire to not be in group any more—"it makes me feel worse." She verbalized her frustration with the group and was able to directly ask the group therapists to focus more on what she could do about these intense feelings. Jane expressed clearly an important aspect of the group, which is to move from exploration of current and past relationships to more active strategies that mothers can use to cope with depression and improve the quality of their relationships with their infants and others. Jane began the process of becoming less of a passive participant—trying to smile her depression away—and more of an assertive, active collaborator in improving her relationship with her daughter.

Steve was an important figure in facilitating Jane's more assertive response to group. He attended the regularly scheduled sessions for the fathers and in addition began to show up at the clinic at other times. He often lacked the words to describe what was happening at home and was not sure what to do, but he knew that the family needed help. These unannounced arrivals on group session days led the therapists to schedule additional family sessions. During these sessions Steve's concerns regarding the intensity of Jane's anger and the safety of Carla emerged. Even though Jane was not able to ask for help, Steve could. When Jane wanted to leave the group, Steve would suggest that she call and talk to someone about it. Taking an active stance in getting help for his family was particularly helpful in increasing Steve's sense of competence as a husband and father.

Safety and security became a central issue for this family. Jane's explosive outbursts towards Carla and rough handling had raised the concern of the group therapists. The therapists explained clearly to Jane the (mandated) reporting steps that would be taken to ensure the safety of Carla as well as the whole family. In addition, the emphasis of the group session on Safety, Health and Security encouraged Jane to become more active in her care of Carla.

In the infant group, Carla's therapist actively took steps to create an environment which facilitated regulation and allowed for more human contact. The therapist found that Carla was most responsive to smooth, soft and gentle voice tones, smooth movements, and smiles, in contrast to the abrupt, angry interactions with her mother. Carla's therapist amplified and exaggerated her verbal tone and facial features to convey safety, security and containment. She positioned Carla so that she could make use of the therapist's face, and so that when eye contact was made, the therapist could again expand and amplify these moments.

Carla responded well to these interventions. She became more regulated in her behavior, more soothable, and more interested in aspects of her environment. She began to tolerate more eye contact and face to face interactions; however, these interactions were fleeting and more the exception than the rule. Jane captured her relationship with Carla by stating, "When I come near her she acts as if she is scared of me... She looks fearful and turns away... who can blame her when she gets scowled and screamed at?"

Because shared mutual attention was so difficult and Carla's neediness for Jane was perceived as so pervasive, Jane stressed and took pleasure in Carla's motor development, a conflict-free sphere of development. Jane and Steve focused on and strongly encouraged five-month-old Carla to sit independently, to reach out and get what she needed, and to crawl and walk. Carla responded to this challenge demonstrating precocious motor development. The visible evidence of Carla's motor development was particularly reinforcing to Jane because it alleviated concerns that she had damaged her baby and it raised her hopes that Carla would not always be so needy of her.

Now it became the goal of the infant dyadic therapist, with support from the group therapist, to assist Jane in recognizing Carla's delays in social-emotional development; to amplify the times of mutual eye contact or a shared smile; and to promote and support both Jane and Carla's enjoyment of each other's touch. Jane

frequently resisted attempts to look at this aspect of her relationship with Carla. Infant massage, one of the rare dyadic group activities that Jane and Carla enjoyed, became an important avenue in attempting to meet these goals. During this time Jane was more receptive to hearing Carla's voice as "amplified" by her therapist. Most importantly, massage was an activity that Jane could "take home" with her to support the development of her relationship with Carla.

As the 12-week group came to an end, Jane reported improvement in her depressive symptoms as well as more enjoyment in her relationship with Carla. Jane specifically stated that she learned from listening to others in the group that being a "perfect" parent was unrealistic, that feeling angry isn't bad, that she isn't alone in how she feels, and that she can enjoy being with her daughter. However, she was not secure in her relationship with Carla, still using terms such as "tense" and "frustrating" to describe some of the times when they interact. The group had been successful in alleviating the intensity of Jane's depressive symptoms and lessening her anger toward her baby. She also experienced an increased capacity to see her daughter as an individual separate from her projections. These projections had led to Jane's viewing Carla as the abuser, making her feel both incompetent and angry. The group also assisted Jane in recognizing the importance not only of Carla's physical growth but also of her emotional development. With this recognition, both Steve and Jane were receptive to continued dyadic and family therapy focused on improving the quality of their relationships with Carla and with each other.

Conclusion

There is a need for early identification, during pregnancy or the postpartum period, of women who are at risk for depression. The assessment and treatment approaches that are offered to these women and their families must be relationship-focused. It is important to address the mother's individual needs so that she can respond appropriately and consistently to the developmental and psychosocial needs of her infant. An integrative group therapeutic approach which supports the mother's increased awareness of her own experience of being parented provides an opportunity for her to begin resolving her limited internal working models of relationships. This is crucial in enabling the mother to provide an environment that supports her infant's capacities for regulation and the development of human attachments during this critical period. Clinicians working with families in which a mother is experiencing postpartum depression must address the importance of treating the relationships, not just the depression. ◆

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Previewing: An Intervention Strategy for Psychiatrically Ill Parents of Infants and Toddlers

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An almost palpable sense of conflict permeates the interaction between a psychiatrically ill parent and that parent's infant or toddler. Clinical observation of such dyads reinforces the impression that, regardless of the nature of the parent's psychiatric disorder, patterns of an adaptive attachment are not evolving. The lack of a nurturing rapport has significant repercussions for both baby and parent. Without a supportive milieu that promotes the mastery of new developmental skills, the infant is apt to fall prey to devastating uncertainty and apathy. For the parent, repeated failed interactions might evoke feelings of hopelessness and incompetence.

Outward signs of conflict between a psychiatrically ill parent and infant or toddler may be summarized as follows:

- **Psychopathology often surfaces during the pregnancy**, either for the first time or in the form of a relapse.
- **Psychiatrically ill parents are unable to sustain coherent mental images (representations) of their infant or of interaction with the infant.**
- **Psychiatrically ill parents tend to shun interaction with the infant**, sometimes refusing even to see the baby.
- **Psychiatrically ill parents fail to display the gestures most parents seem to use intuitively to entice the infant to interact**, including maintaining direct eye contact with the infant for a prolonged period (visual cuing); communicating through exaggerated speech cadences (vocal cuing); cradling the infant's body (appropriate holding behavior); and sensitive feeding behavior (Papousek and Papousek, 1987).

This last point merits special emphasis, because the intuitive behaviors of psychologically healthy, adaptive parents shape the infant's experience to such a large degree. The infant or toddler is engaged by the parent's subtle, nonconscious expressive cues (Christensen and Rosenthal, 1982; Harris and Rosenthal, 1985; Rosenthal and Rubin, 1978). Expressive cues include body gestures and motions, facial expressions, visual patterns of gazing or aversion, and vocal intonations. Intuitive behaviors and expressive cues are nonconscious manifestations that occur automatically. However, parents might be made conscious of these behaviors (e.g., through intervention), and these behaviors might then be used in a more intentional fashion by the parent to promote a certain response in the infant. Aside from promoting interactions characterized by **rhythmicity** (Tronick and Weinberg, 1990), **reciprocity** (Brazelton, Koslowski and Main, 1974), **empathy** (Hoffman, 1984) and **affect attunement** (Stern, 1985), the mother's intuitive behaviors create an atmosphere that is conducive to predicting and rehearsing imminent developmental change with the infant. Thus intuitive behaviors confer a **prospective** orientation onto the parent-child relationship. This orientation is seldom seen in the relationships between psychiatrically ill parents and their young children.

The dilemma of early childhood development for psychiatrically ill parents

Although psychiatrically ill parents have diverse diagnoses and unique individual histories, virtually all the psychiatrically ill parents of infants and toddlers with whom we have worked at the Child Outpatient Unit of New York Hospital-Westchester Division view developmental change in their children with dread and foreboding. They cannot imagine, as adaptive parents do, that their child's mastery of new skills and growing autonomy will generate increased, more sophisticated intimacy and harmony in the parent-child relationship. Instead, psychiatrically ill parents fear that maturational change will irrevocably sever the intimacy of their relationship with their child. (And, sadly, such an intimacy seldom exists even in the present for such parents and their children, since they lack the repertoire of intuitive behaviors that would engage the child in a mutually rewarding exchange).

Their fears and inhibitions about anticipating imminent development and the possibilities for change in their relationship with their infants seem to propel psychiatrically ill parents into one of two equally dysfunctional positions: 1) becoming overly enmeshed or preoccupied with the child in a desperate effort to stave off developmental changes that will make the infant more autonomous; or, 2) shunning any interaction with the infant in order to preempt the experience of loss.

The previewing process

A third possibility is offered by the intervention protocol devised at New York Hospital-Westchester Division. Taking note of the disturbed patterns of interaction we observed among psychiatrically ill parents and their infants and toddlers, we worked to design a treatment approach that:

- Could be used with the full spectrum of psychiatric disorders;
- Could be used as early as pregnancy; and,
- Could be communicated easily to parents during clinical sessions, yet incorporated into daily life at home.

In addition, we were interested in an approach that would help psychiatrically ill parents to:

- Become more aware of the manifest and latent content of their mental representations of their child;

- Improve their interpersonal skills and intuitive behaviors;
- Predict their infants' imminent developmental skill, as well as the interpersonal changes likely to follow new skills; and,
- Accept with some equanimity the losses and rewards of developmental change.

In support groups to raise awareness of developmental changes conducted with psychologically healthy parents, we observed a process that was strikingly absent in parents with psychiatric illness. These groups were support groups designed for first-time mothers interested in learning more about infant development. The interest they showed in learning more about infant skills was a sign of their psychological health.

From this experience, we learned that adaptive parents typically make predictions about their child's future, imagine their children mastering imminent developmental skills, and create opportunities to expose the infant to the physical sensations of the new skill, as well as to the changes in the parent-infant relationship that will occur once the new skill is consolidated. We labeled this process **previewing.**

Previewing is a continuation of the process that begins in pregnancy as part of physical and psychological preparation for the birth of a child. As psychologically healthy expectant parents fantasize about the infant during this time, they tend to predict the infant's gender, personality, and appearance. Although anxieties about possible damage to the fetus are common, particularly in the final trimester, psychologically healthy parents-to-be also fantasize about a rewarding relationship with the prospective infant.

The two key features of previewing are **representation** and **enactment.** Representation refers to a reflective state during which the parent generates mental images that may encompass past or present experiences or speculations about the future. Adults who were exposed to nurturing environments during childhood are usually able to represent imminent developmental skills in their children. Adaptive parents are able to sense when a new skill is imminent and to envision the infant crawling, for example, or walking or talking. Infants exposed to this degree of nurturance begin accumulating memories of adaptive interaction which motivate them to look forward eagerly to the onset and mastery of new skills.

Enactment, the second feature of the previewing process, refers to the "rehearsal episodes" orchestrated by the parent to help the child practice the new skill in a supportive fashion. For example, parents noticing their infants' kicking motions might envision that full-fledged crawling is imminent. To foster the emergence of this skill, they may manipulate the infant's body to simulate crawling. The pleasure that parent and child share in the exercise serves to reassure each of them that the child's new developmental achievement will have a positive meaning for their relationship.

Our clinical team was optimistic about teaching parents with psychiatric illnesses previewing techniques that joined mental representations and physical enactments. Our clinical experience has taught us that:

- Previewing **enhances the ability to represent imminent developmental change.** As developmental predictions are achieved and, hence, validated, parents renew their enthusiasm about changes in the relationship with the child. In turn, the parent's confidence is automatically conveyed to the infant, who becomes more responsive. Thus,
- Previewing promotes a **cycle of mutual responsivity and mutual awareness,** dispelling negative expectations.
- Previewing **infuses optimism into the dyadic exchange by boosting the self-esteem of parents.** Once parents recognize that they can predict and modulate the course of the infant's development, they become eager to elicit new skills and are reinvigorated in their nurturing roles.

The case vignettes that follow illustrate the use of previewing with parents with a wide range of psychiatric conditions, during pregnancy and the first three years of their children's lives.

Previewing in pregnancy

In her late teens, Tiffany P. was diagnosed with schizo-affective disorder, a disorder characterized by psychotic symptoms and extreme variations of mood. She was treated with antipsychotic medication. She married, and at age 22 became pregnant. When the pregnancy was confirmed, her psychiatrist referred her to the Mother-Infant Psychotherapy Service.

In her first visit, Tiffany said that she wanted to discontinue her medication because she "feared that the drug would hurt the baby." The psychiatrist agreed and planned to see Tiffany in the clinic on a weekly basis during the pregnancy. In addition, concerned that Tiffany would have difficulty adjusting to a non-medicated state, the therapist assigned a social worker to make weekly home visits as a supportive intervention.

In the opening phases of the psychotherapy, Tiffany described three dreams that had become recurring since she had learned of her pregnancy. In the first dream, she tried to take off her wedding band. "I couldn't get it off," she reported. "My hand had gotten so fat. Finally, when I got the ring off, I put it in my jewelry box. But the next day, I couldn't find it. My husband told me the ring had fallen onto the floor. I said it was in the jewelry box. When I looked, I saw the ring had fallen out onto the floor." (It is significant here that Tiffany added the word "out," as opposed to simply repeating the phrase, "fallen *onto* the floor." The word "out" may be associated with her unconscious thoughts concerning abortion, miscarriage, and not carrying the fetus to term).

In the second dream, Tiffany went to the closet to get a hanger. "I got the hanger, twisted it, then put it on the floor under the bed. I don't know why." She added, "I had to do it. It was like a compulsion." In the third dream, gazing up at the sky, Tiffany suddenly saw her former dog, a pet that had died several years earlier. Describing the dream, Tiffany said, "The dog was all scattered and broken up in pieces. His eye was crooked, his leg was attached to his ear, and his tail was hanging off in space."

The quality of Tiffany's dream imagery is typical of the mental representations of psychiatrically ill expectant parents. Their representations often include lurid symbolism and gross distortions about the infant's appearance. These distortions are fueled by the ambivalence experienced by the mother. They may even describe fantasies of violent acts toward the infant. The rapid deployment of previewing techniques with Tiffany during her pregnancy enabled her gradually to predict a positive future for herself and her baby.

We have found several diagnostic strategies to be useful when treating psychiatrically ill expectant parents. First, since a parent's tendency to predict infant behavior and then to attribute specific meaning to the infant's behavior begins during pregnancy, we ask the expectant parent to envision how various skills that the baby can be expected to acquire in the first years of life will affect their relationship. Above all, we make sure to ask the parent to describe the emotions aroused by these anticipated changes. If the expectant parent has difficulty representing a future relationship with the infant, it is likely that some "ghost in the nursery" (Fraiberg, 1980) exists.

We also explore the expectant parent's perceptions of the likely timing and speed of the developmental process. Not infrequently, parents with psychiatric illnesses expect that their infant will display developmental changes in a precocious fashion. Such an expectation may exacerbate expectant parents' underlying anxiety about childrearing, giving them a sense that they will be under constant pressure to "keep up" with a child's rapid growth.

Treatment involves helping the expectant parent to envision the unborn infant and providing basic information about how early development proceeds. In discussing each domain of the child's development, the therapist emphasizes how the child's achievement of each new skill is likely to influence a parent's perceptions of the child and of their relationship. The goal is to allow the parent to see development as a predictable process and to anticipate their own likely reactions to new skills that their infants will manifest.

Previewing in early infancy

The B. family was referred to our clinic because Mr. B. had made homicidal threats against his wife and three-month-old son Jonathan. During the initial evaluation, the infant failed to respond to visual and vocal cuing and seemed pervasively apathetic. Mrs. B. seemed detached, emotionally flat, and uninterested in getting involved in any kind of interaction with her infant. She was diagnosed as having an adjustment disorder with depressed mood.

Mr. B., diagnosed previously with paranoid schizophrenia, told us that he often felt an impulse to hit the baby. During extensive individual treatment to help him curb his abusive tendencies, Mr. B. learned about previewing. For example, he helped Jonathan rehearse the act of rolling over. During the enactment, Mr. B. became sensitive to the use of eye contact and soothing vocalizations. A few weeks later he reported that "because I sensed it was hard for the baby to roll over on his own .... I felt he was a person to me."

Jonathan displayed a hearty response to his father's previewing exercises. Within a few weeks of his father's entrance into treatment, the baby's apathy had begun to lift.

Intervention with a psychiatrically ill parent after the birth of the child introduces a new element into the equation. The infant is no longer an abstract being with whom the expectant parent conducts imaginary conversations, but is now a flesh and blood entity. Consequently, previewing explorations should begin by comparing the parent's representations of the infant during the pregnancy with representations of the infant in the present, as well as predictions about the infant's future status. This strategy enables the therapist to compare the infant's observable behaviors with the parent's perceptions of these behaviors.

While listening to the parent describe the baby, the therapist might note the parent's sensitivity to the infant's somatic, socio-affective, cognitive, and motivational cues. After exploration of the parent's mental representations of the infant, the next step is to introduce enactment exercises. The parent should be encouraged to predict a developmental skill that the infant is likely to exhibit soon (e.g., rolling over). Next, the parent is asked to imagine enacting the skill with the infant. The focus here is on the parent's emotional reactions to new developmental skills. Then, the parent and therapist devise a rehearsal to introduce the infant to the physical sensations of the new skill. The parent then practices the developmental skill with the infant. By monitoring the infant throughout, the parent determines when the child wishes to stop the enactment.

Deirdre M.'s psychiatrist referred her to our clinic because of his concerns about her relationship with her first-born son Patrick, then three months old. At age 13 and later at age 19, Deirdre suffered two psychotic episodes. She had cut off her hair in response to voices telling her to hurt herself. At 19, Deirdre was diagnosed with borderline personality disorder.

Deirdre met Patrick's father when she was 24. Six months later, without planning, Deirdre became pregnant. The couple decided to marry and raise the child.

When asked about her pregnancy on her first visit to our clinic, Deirdre responded, "I just don't remember." She had only dim memories of Patrick's attainment of early developmental milestones (which

for most parents are indelible points of reference). She told the therapist that she often forgot what her son looked like when she was away from him.

Close observation revealed that Deirdre rarely gazed at Patrick or vocalized with him. She held him infrequently. Even when she did, her grasp was awkward. When Patrick cried, Deirdre would shake him roughly.

When asked, "What do you think Patrick is feeling now?" Deirdre would shrug, laughing inappropriately, or say, "I think he feels okay." When the therapist commented that he would soon be picking up small objects, Deirdre blurted out abruptly, "He can't do that yet."

On the basis of our observations of the already conflicted relationship between Deirdre and Patrick, we recommended weekly treatment of Deirdre and Patrick together. In addition, Deirdre continued treatment with her adult psychiatrist, and a social worker made weekly home visits to provide further support and monitoring.

During the initial weeks of the treatment, Deirdre's responsiveness to Patrick improved significantly. Although she remained relatively silent during interactions, her intuitive behaviors became more coordinated and she evolved a fairly sophisticated set of facial expressions that she used with Patrick. Deirdre seemed to be becoming more aware of her son's developmental changes.

Although a mother's growing awareness of her infant as a developing individual would typically be seen as a sign of adaptation, for parents with histories of psychiatric illness, awareness of future developmental change may signal instead a period of great vulnerability. Moreover, when a psychiatric disorder is chronic and severe, such vulnerable periods may recur whenever the emergence of new developmental skills threatens the parent's tenuous sense of control.

From the time Patrick began to crawl at 7 months, Deirdre engaged in a series of self-destructive acts in rapid succession. First, she became pregnant. She announced to the therapist her decision to have an abortion but refused to discuss either issue. At the following session, Deirdre reported that she "felt great" after the abortion and that having another baby would have "interrupted her plans." Throughout the session, she appeared euphoric. A few days later, Deirdre arrived at the clinic with a close-cropped haircut that dramatically altered her appearance. When the therapist commented on the hairstyle, Deirdre fidgeted, then acknowledged that she had intentionally singed her hair in the oven. Several weeks later, Deirdre came to a session with a facial burn. When questioned about this, she said that she had burned her face intentionally while spraying with kitchen chemicals. She said that she had felt "very angry" but that the burning had "calmed (her) down." Deirdre denied having experienced auditory hallucinations. However, it was agreed to add antipsychotic medication to her treatment at this point.

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As the therapist held Patrick in a sitting position facing his mother (a technique that promotes self-other differentiation), Deirdre verbalized the feelings that may have precipitated her actions. "Patrick understands me and I understand him," she said, describing her relationship with her son as "very close."

Deirdre's self-mutilating acts coincided with emerging skills in her son, and signified a desperate attempt to assert control. She reported "relief" after the abortion and the other self-mutilating acts (common behavior among people suffering from borderline personality disorder).

It is important to recognize that Deirdre's self-destructiveness did not cause her to stop therapy. She has continued the infant-parent therapy, her individual therapy, and the relationship with her social worker. Her relationship with her husband is stable. Patrick is now 3 years, 2 months old. Aside from some mild language delay, he is developing adaptively and relating well to his parents and other people.

The work with Deirdre and Patrick illustrates two very important observations concerning intervention with psychiatrically ill parents of young children:

1. Any developmental change can trigger maladaptive behaviors in parents with severe psychiatric illness.

2. When a parent's mental illness is chronic, successful negotiation of one developmental change does not guarantee that the next change in the child will not threaten the parent's emotional stability. Therefore, treatment must be an ongoing process in order to protect both parent and child.

Previewing with toddlers

Lewis T. was the 25-year-old father of a 2½-year-old daughter, Shelley. Almost 15 months prior to attending our clinic, Lewis, then a third-year medical student, had begun to experience a constellation of disabling symptoms—nervousness, palpitations, and agoraphobia. These were diagnosed as acute panic reaction. Despite pharmacologic treatment, Lewis' panic attacks had grown steadily worse, causing him to drop out of medical school.

Lewis was now responsible for the daily care of Shelley, who attended a preschool program. Janet, Mrs. T., was a social worker. Recently, Shelley's teacher had complained that the child had begun biting and scratching other children. When the family came to our clinic for assessment, we observed that Lewis became preoccupied during exchanges with his daughter. (He explained that he couldn't focus because he feared a panic attack.) When Shelley attempted to engage her father and failed to elicit a response, she threw toys around the room in frustration. Janet reported that in recent weeks Shelley had begun to regress developmentally, resuming habits such as thumb-sucking.

After we explained previewing techniques to Lewis, he expressed the desire to "try predicting," but then became agitated. "I can't think about the future," he blurted out. As we explored his inability to preview imminent change in his daughter, Lewis revealed that he feared becoming like his father, a man who had committed suicide after losing his job because of a sudden illness.

Lewis entered individual psychotherapy and also continued to attend sessions with Shelley to enhance his previewing skills. He recognized that his efforts to stifle change were in essence being transmitted to his daughter, who was *regressing* developmentally, rather than moving forward. Gradually, Lewis began previewing Shelley's expected developmental progress. With the therapist's guidance, he enacted several "pretend" sequences with his daughter that involved upcoming family celebrations. As Lewis' previewing capacities improved, he became correspondingly more enthusiastic about interacting with his child. Shelley, meanwhile, relinquished her antisocial and regressive behaviors and resumed adaptive developmental patterns.

Specifically, Lewis would predict an oncoming skill that his daughter would soon manifest. Then, he would discuss with the therapist how the skill might be best rehearsed with Shelley. Since Shelley's language skills were improving on a daily basis, Lewis devised several make-believe enactments during which he introduced Shelley purposely to new words. One such make-believe enactment involved zoo animals. Using stuffed animals, Lewis introduced his daughter to the words "giraffe," "elephant," and "monkey."

Previewing when the child's prognosis is unfavorable

We have treated several women who became depressed when they learned of their positive HIV status and who are mothers of HIV positive infants and toddlers. Some of these children have since progressed to full-blown AIDS. HIV-positive infants may manifest a variety of developmental disabilities. Although the progression of pediatric AIDS is unpredictable, previewing techniques can nevertheless be helpful. First, parents may be helped to understand the reasons for discrepancies between their expectations and the skills their baby actually manifests. In addition, previewing helps parents to anticipate and adjust to the sense of loss they frequently experience when the child becomes sicker or loses ground developmentally. When infants and toddlers are likely to outlive their mother with AIDS, mothers can preview the impending separation and arrange for the child's adoption. We have also worked to support and strengthen the previewing skills of foster and/or adoptive parents as they assume the challenging task of caring for very young children who have lost their parents to AIDS.

Previewing in adaptive parents

Twenty-eight-year-old Barbara P. enrolled with her two-month old firstborn daughter, Kim, in our clinic's weekly support group, designed to enhance mothers' familiarity with the developmental process. During her initial months in the group, Barbara displayed extremely competent intuitive behaviors.

After attending the group for approximately six months, however, Barbara arrived at a session appearing uncharacteristically withdrawn and listless. She reported that earlier in the week Kim had begun showing signs of readiness for weaning. The baby had "turned her face away" from her mother and "rejected" the breast. Barbara reported an "overwhelming sadness." She was convinced that weaning would result in a loss of the intimacy she had previously enjoyed with Kim. Because her depression was so acute, Barbara entered individual psychotherapy in addition to the support group. During the treatment, previous episodes of loss suddenly surfaced. For example, she spoke extensively about her father's death several years before.

Why did Barbara experience this depression? As an adaptive mother, she anticipated imminent change in her baby before it became manifest and was usually able to prepare for it. This time, however, the **meaning** Barbara associated with the imminent change—loss of intimacy—triggered overwhelming sadness, perhaps, ironically, because Barbara, unlike many parents with severe psychiatric illness, could see clearly that Kim's developmental progression was inevitable and that reining in the infant's development to perpetuate intimacy was not a possibility for this adaptive mother.

Conclusion

We have seen all too often what happens when parents with serious psychiatric and interpersonal difficulties are not assisted in their roles as parents of infants and toddlers. Lacking an interactive partner with whom to explore developmental skills, infants may initially exhibit distress and irritability which, if unattended, may progress into entrenched patterns of withdrawal, then pervasive apathy. Developmental change, for the child, is unlikely to be associated with interpersonal meaning. Any parent whose child is apathetic or withdrawn is likely to experience rejection; for adults with psychiatric illness, this experience reinforces the negative self-esteem and lack of control that accompany their illness. We have found that even when relationships between very young children and their psychiatrically ill parents are quite worrisome, intervention using previewing techniques can lead to improvement. As parents are helped to understand the predictable nature of developmental change and are encouraged to master new skills with the infant, strong bonds of attachment may be forged within the dyad. For parents whose vision of the future is clouded by ambivalence, detachment, or despair, a growth-enhancing relationship with their infant may offer precious hope.

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Providing Integrated Treatment for Parent/Infant Dyads At Risk because of Parental Emotional and Mental Illness

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Let us assume that adults with mental illness will bear children and that they will want to be responsible parents.

Let us also assume that pregnancy and the early years of parenthood may be particularly difficult for people with existing mental illness or emotional problems, and that the experiences associated with pregnancy, childbirth, and parenting can precipitate emotional disorders.

Let us assume that although they can be amazingly resilient, very young children need consistent, responsive caregiving that parents with mental illness may need specialized support to provide.

Finally, let us assume that we should take seriously the Outpatient Regulations Handbook, 1991 of New York State's Office of Mental Health, which describes the goal of psychiatric rehabilitation as "to assist persons disabled by mental illness to be successful and satisfied in obtaining and maintaining the specific community roles in which and through which they have chosen to live" (p. 32).

What system of services would assist adults with mental illness to be "successful and satisfied" in the "community role" of parent? How can protection and care be provided for the parent with, or at risk of mental illness; for the infant; and for their relationship?

The medical model of symptom and specialty care that has shaped the traditions of mental health institutions and professions tends to fragment, rather than integrate psychiatric care for families with young children. For example:

- Adult psychiatric patients are typically treated individually to improve their symptoms and level of functioning; their role and functioning as parents may never be addressed.
- Adults who have been hospitalized for psychiatric illness may be discharged with no investigation about the responsibilities for the care of very young children

to which they may be returning, or their ability to tolerate the demands of parenting. (This circumstance has changed in New York State as a result of increasing awareness of the incidence of neglect, abuse, and death among young children left in the care of a parent with mental illness. Documenting the presence of children in a patient's household is now mandatory at hospital admission and discharge, and during outpatient care.)

- Pharmacological treatment for psychiatric disorders may be discontinued during pregnancy, with no alternative therapy offered.
- Mothers and newborns are discharged from the hospital after childbirth with no assessment of the mother's emotional well-being and resources or needs for social support.
- Pediatric primary care providers focus solely on the baby's physical health, with no observation of the parent/infant relationship or attention to parents' wellbeing and mood.
- Infants are left to share the isolation of their parents with mental illness, perhaps to be referred for treatment in child psychiatry clinics at age five or six when their disturbed emotional adjustment or uncontrollable behavior are noticed in school.

Fragmented care will not do. We need both continuity of care for the pregnant and parenting adult with mental illness and joint care of the parent/child dyad.

But who can take on this task? Where is the clinical base capable of: 1) reaching out and finding the at-risk parent/child dyad in the community; 2) organizing care so that mother and child do not get lost among unconnected services; and 3) offering a multidisciplinary therapeutic approach comprehensive enough to meet complex needs?

The Parent/Infant Therapeutic Program (PITP), sponsored by the Child and Adolescent Psychiatry Service in the Department of Psychiatry at Gouverneur Hospital has tried to become such a clinical base. PITP was funded in 1986 by the New York State Office of Mental Health as one of four pilot projects designed to care for parents with mental illness and their children under 5 who were at risk for developmental problems. PITP uses a comprehensive, multidisciplinary therapeutic strategy within the network of the hospital's clinics and the social agencies that serve the "working poor," ethnically diverse (Hispanic, Chinese, African American, and Caucasian) population of the lower Manhattan community where the hospital is located. The model for PITP drew on the author's many years of experience in providing the mental health component of a multidisciplinary family health care center in the Bedford Stuyvesant neighborhood, as well as continuing clinical encounters with mothers with treatable mental illness whose psychiatric care seemed inadequate.

Since PITP began, the program has received more than 400 referrals from all parts of the city. A number of referrals do not meet admission criteria and may be referred to other community agencies. Despite intensive outreach, some accepted referrals receive consultation or crisis intervention during the screening/intake process but do not become engaged in longer term treatment.

PITP has served 123 families intensively, for periods ranging from 8 months to more than four years. Nearly 45 percent of the target parents have a major mental illness. Of these, 25 percent meet criteria for a DSMIIIR diagnosis of schizophrenia, paranoid type; 75 percent have affective disorders, with depressive psychotic pathology predominating. The remaining 55 percent of target parents referred to PITP have had acute or long-term emotional problems, justifying the diagnosis of dysthymic or anxiety disorders and/or borderline personality. Their symptoms included depressive moods, suicidal thoughts, and poor impulse control. Their difficulties have been exacerbated by the stress of pregnancy and childbirth. An increasing number of mothers with depressed mood have revealed sexual and physical abuse in their own childhood; they are motivated for treatment by fear that they might harm their child. HIV-positive women and their children are also coming to our attention.

Families served by PITP include two parent families; three generational families (teenage mothers) with the fathers only tangentially involved; and single mothers living with their children.

PITP: A comprehensive, community-based model

PITP is designed to provide a safety net for the parent with mental illness, the offspring at risk, and the family under stress. The clinical team must address three tasks simultaneously:

1. Ongoing treatment of the parent's mental illness or severe emotional disturbance (which is likely to have been manifest before pregnancy and/or childbirth), with the goal of stabilization, rehabilitation, and maintenance of "good enough" parenting;

2. Promoting and protecting the child's development, beginning during pregnancy and continuing through the first three years of life, with special emphasis on facilitation of a healthy attachment to a functional mother, prevention of separation or foster care, and early detection of neuro physiological deviations; and

3. Support for the family in distress, combined with a search for extended family who can support the fragile mother and her child(ren).

PITP's treatment approach includes nine elements:

1. Acceptance of referrals of pregnant women and parents with emotional and mental disturbances (e.g., affective disorders, postpartum depression, schizophrenia, severe anxiety and personality disorders, and dual diagnosis with drug abuse) together with their children (birth through 4½ years) who are at risk of or presenting with developmental delays, disturbances, or disabilities).

2. Establishing a network to reach this target population through outreach, consultation, and collaboration with psychiatric inpatient and ambulatory services in Gouverneur Hospital and other hospitals in the city; ob/gyn, pediatric,

and child development clinics; and child welfare, child care, family court, and resource and referral agencies.

3. Facilitation and monitoring of the parent's individual out-patient and, when necessary, in-patient psychiatric treatment, through liaison with treating psychiatrists at Gouverneur and other psychiatric facilities, connecting adult psychiatric treatment with early childhood intervention.

4. Intensive team intervention with the mother/infant dyad as primary "patient," with inclusion of fathers, siblings under age 5, grandparents, and/or other important family members.

5. Home visits for assessment (using the HOME inventory) and crisis intervention.

6. Monitoring of pediatric and other clinical specialty care and collaboration between PITP clinicians and child care, protective services, and family court staff.

7. Group therapy for pregnant women and mothers with their children.

8. Case management for social service needs.

9. Educational workshops for parents on a range of topics.

The course of treatment

When a pregnant woman or mother/child dyad is referred to PITP, the mother first comes to the clinic for a screening consultation with two staff members. Our staff includes a psychologist, a mental health nurse, a psychiatrist, a social worker, an educational therapists, and a case manager. Three staff members are bilingual in English and Spanish. The case manager received special training so that she can serve as a simultaneous interpreter for Spanish-speaking families during assessments, clinical interviews, and group therapy sessions. Staff members of the Asian Bi-cultural Clinic at Gouverneur Hospital are involved in the treatment and interpretation for Chinese families who speak Cantonese or Mandarin.

Our intake assessment includes a parent interview, including a mental status examination; a child assessment using the Denver Developmental Screening Test or the Bayley Developmental Scale; and observation of parent and child in interaction around feeding or play, with interaction videotaped if the parent gives permission.

If the parent is already in psychiatric treatment, PITP makes contact with the treating institution or psychiatrist. Otherwise, the target parent is referred to Gouverneur Hospital's adult psychiatry department for evaluation and treatment.

Each mother/child dyad comes to PITP for one or (preferably) two 75-minute sessions each week. Visits may also be scheduled on an emergency basis when needed. (Although PITP conceptualizes the dyad as the primary patient, hospital administrative procedures require the registration of mother and child separately. Each visit must then be documented in individual medical charts.) Each session makes use of three distinct therapeutic modalities: individual treatment of the mother, individual treatment of the child, and time together to enhance their interactional experiences.

Mothers and non-mobile infants are usually assigned to one therapist. The therapist engages with the baby in motor stimulation, vocalization, and game-playing, encourages the mother to interact with her child and experience the infant's responses.

When the child begins to walk or is walking at referral (and when mother and child are ready for the separation), two clinicians from the PITP staff are assigned to each family, one to the mother, for developmental education and child-centered psychotherapy, the other to the child or children for play therapy. It has been our experience that older infants (as young as 10 months) and toddlers in the families we see seem to become frustrated and angry when mother and therapist are talking "over the head" of the child and the mother has not yet learned to respond contingently (through gestures or other communications) to her child's need for attention while the conversation with the therapist continues. During the time that the mother is seen individually, then, the toddler is offered the enriching experience of an accepting and corrective social relationship with a trustworthy adult.

We believe that all mothers participating in PITP need the attention offered by individual therapy related to their relationships with their children. Regardless of diagnosis, parents use well opportunities to explore their feelings about the child and to connect them with their own past and current emotional experiences.

During the portion of the session that focuses on parents' direct interaction with the child, clinicians work with parent and child together. Clinicians use techniques such as "modeling," "coaching," "transactional therapy," "floor time," and review of videotapes for "therapeutic teaching" of parents.

In accordance with our comprehensive family approach, we apply all three interventions flexibly, including fathers, grandparents, and siblings under five in ongoing sessions as appropriate. Much of our work involves three generations. Not infrequently a mother is not able herself to care for her child during an acute episode of a chronic or recurring mental illness. Nevertheless, her emotional connection to her child remains strong. Honoring this connection while protecting the child can be difficult indeed. When a close relative (typically the grandmother) can assume parenting responsibilities, PITP can work with the grandmother, the Child Welfare Administration, and the Family Court. The mother may be able, even in the midst of mental and emotional turmoil, to stay involved in treatment and to continue participation in her child's upbringing with our supervision. The powerful (and for many, unfamiliar) experience of play in PITP's interactional sessions have helped the target parent, the child, and the participating father or grandparent to improve their emotional communication and strengthen their relationships. One very depressed mother told us, "You taught me how to play. I did not know how to play as a child."

While team treatment demands sensitive collaboration, it also provides support for therapists facing often overwhelming demands. Another important support for the therapeutic team is PITP's case manager, who is knowledgeable about and involved in the care of almost all participating families.

Periodic case conferences review the family's experience in PITP and pull together information from the parent's individual (adult) psychiatric treatment, the case manager, and crisis intervention that may have occurred. Staff from agencies outside the hospital who are involved with the family are invited to these conferences.

Clinical vignettes from the Parent-Infant Therapeutic Program

Four vignettes illustrate the ways in which elements of PITP interact to serve the complex needs of our community's diverse population.

The PITP experience and adult psychiatric care

All target parents receive ongoing treatment and supervision of their psychiatric illnesses or conditions outside of PITP, in the hospital's adult psychiatry clinic or elsewhere. This separation has proven to be therapeutically effective. When a parent with mental illness takes responsibility for her own psychiatric care, the experience strengthens her sense of reality about her treatable illness. Within the PITP program, she is engaged by the team as a responsible person in the parent/child interaction, and her position as a parent is strengthened within her family constellation. PITP staff are also able to monitor and address the not-always-benign effect of psychiatric medication on parenting, as our work with Patti Miller illustrates.

Patti Miller, 32 years old, suffered a postpartum psychosis after the birth of her daughter, Jennifer. She was diagnosed with schizophrenia, paranoid type, and received anti-psychotic medication by injection every month. Initially, a homemaker helped Mrs. Miller with Jennifer, and Mr. Miller was an attentive father.

Mrs. Miller responded well to the medication and also became very attached to her therapist on the PITP team. As weekly PITP sessions continued, however, the therapist noticed that Mrs. Miller's movements were becoming increasingly lethargic and stiff, and that her affect was flat. Jennifer, now six months old, responded to her mother's increasingly problematic caregiving with avoidant behavior, "flat" facial expressions similar to those of Mrs. Miller, and occasional outbursts of banging her hands on the table.

When the therapist questioned her directly, Mrs. Miller said that she did feel drowsy and stiff after receiving her injections. The PITP therapist discussed her observations with Mrs. Miller's psychiatrist, and the medication regimen was modified. As a result, Mrs. Miller's affect and relatedness became more lively and appropriate, with positive results for Jennifer.

The opportunities available to Mrs. Miller within PITP to demonstrate her competence as a parent, combined with her close, ongoing relationship with the PITP therapist resulted in the therapist's ability to explore a parenting difficulty as a side effect of medication rather than as an intractable symptom of psychopathology.

Serving an ethnically diverse population

For reasons that are not yet fully understood, we have had very different experiences in our efforts to serve Hispanic and Chinese families in our community. The hospital has an Asian Bi-cultural Clinic (ABC), and the adult psychiatry clinic includes Spanish-speaking staff. However, only 10 percent of PITP families are Chinese, while 55 percent are Hispanic.

Iris Lee and her seven-month-old son, Wong Chen, were referred to PITP by staff of the Asian Bi-cultural Clinic. Mr. Lee, Wong Chen's father, had been diagnosed with schizophrenia, with episodic psychotic exacerbation of the illness, and was being treated with medication. During an interview with Mrs. Lee, the ABC therapist noted her affectless mode of relating to her son and her comments that "the baby is not like other babies. He has a personality like his father, and his empty smile."

The ABC therapist brought her observation to the attention of PITP staff and became involved in intensive outreach efforts to involve the family in child-centered psychotherapy, including Cantonese interpretation. Wong Chen seemed essentially physically healthy, but his facial expression was solemn and he actively avoided eye contact. Mrs. Lee said that her son "wants to sleep all the time" and that when he cried, it meant "that he is tired." She said that she picked him up only for feeding and then propped the bottle, because she was busy with household chores and the care of her husband and his elderly, sick parents.

We learned that Mrs. Lee had been born in China and that her emigration was part of an arranged marriage. She had not been told about her prospective husband's chronic mental illness and felt deceived. Although Mrs. Lee could not express her feelings directly, the ABC therapist and PITP staff observed signs of her inner rage.

With constant effort, the co-therapists successfully encouraged Mr. and Mrs. Lee to attend PITP regularly. The baby showed a rapid self-righting response and developed into a smiling, lively, related toddler. Unfortunately, Mrs. Lee interpreted her son's emerging exploratory behavior negatively. She claimed that Wong Chen was as "stubborn" as his father and needed spanking. Staff were concerned about the risk of physical abuse. Interestingly, Mrs. Lee found her own

solution by going to work and placing Wong Chen in out-of-home child care.

Although PITP had no more direct involvement with the Lee family, Mr. Lee's continuing psychiatric treatment in the Asian Bi-cultural Clinic provided us with an opportunity to follow Wong Chen's development, which appears satisfactory.

It has been our experience with other Chinese families that involvement with PITP is terminated when the child starts to walk and is enrolled in day care or supervised by members of the extended family. In contrast, Hispanic families have tended to use PITP as a community "holding environment," referring friends for treatment and attending PITP's annual Christmas party regularly, long after termination of treatment. PITP's Spanish speaking case manager has been active in connecting isolated pregnant women or new mothers, many with undocumented status, with other members of the Hispanic community. She has also connected parents with concrete services, often as part of crisis intervention, and has engaged in advocacy on behalf of older siblings and other family members.

Angela Quinones lived in the Bronx but, like so many Hispanic women, came to Gouverneur Hospital for prenatal care. She was referred to PITP by clinic staff because of her severe symptoms of depression with homicidal ideations. Shortly before her due date, Ms. Quinones called the PITP case manager because she was hemorrhaging severely. An immediate emergency admission to the nearest hospital was arranged, and Ms. Quinones gave birth to a son by Caesarean section. The PITP case manager arranged for homemaker care and home visits from PITP staff, and Ms. Quinones was referred to a mental health clinic near her home for continuing psychiatric care. However, Ms. Quinones and her son Jorge attend mother/infant group therapy sessions at PITP regularly, and PITP staff monitor her psychiatric treatment. At 6 months, Jorge is developing well.

Providing continuous protective support

PITP has now had considerable experience in long-term work with psychiatrically ill parents and their young children. Nearly half of all the children in dyads referred to the program were under one year of age at the time of referral, and one-fourth of families have been followed from pregnancy through childbirth and into early infancy. The majority of the infants we have seen have been essentially healthy, but their development has been affected by the experience of being cared for by a parent with serious mental or emotional illness. The goal of PITP is to protect these children during their vulnerable early years, and to maintain and strengthen their capacities for relating until they can reach out to find nurturing relationships for themselves in school, community activities, and friendships. In the context of PITP's supportive environment, the strong self-righting responses of infants and young children have served as reinforcing feedback to involve the mothers in continuing treatment efforts; the children's progress also encourages the therapeutic team.

Ongoing involvement with vulnerable children also permits early identification and treatment of developmental problems. When developmental delays or disabilities have become apparent in children participating in PITP, they have begun to receive specialized therapies as needed in addition to the interactional dyadic treatment and play therapy offered by PITP. Some children are likely to need continuing therapy in the Child and Adolescent Psychiatry Clinic after they reach age five.

Both of Owen Green's parents had serious schizophrenic illness, paranoid type. When Owen was seven months old, a community mental health facility referred the Green family to PITP. At the beginning of our work with both parents, they fought constantly, each accusing the other of neglecting Owen. During one fight, Owen was endangered and the homemaker in the household notified the Child Welfare Administration. Placement in foster care was a real possibility, but PITP was able to connect Mrs. Green with her own mother and arrange a kinship placement for both Owen and Mrs. Green with the grandmother. This action preserved Owen's caretaking environment and family connection. Because of his uncontrollable psychotic behavior, Mr. Green was separated from the family. Mother, grandmother, and child continued to receive individual and interactional treatment at PITP.

Now about to graduate from PITP, Owen has a high intellectual potential, normal physical development, and an endearing capacity to relate to others. However, whenever Owen must encounter a new environment, such as day care, pre-kindergarten, and now elementary school, his adaptation becomes precarious. He shows signs of withdrawing into isolation or transient aggressive behavior toward peers. Owen has needed continuous protective support and individual play therapy with his therapist at PITP. We hope that he and his family will continue to find the ongoing assistance they need.

Challenges to implementation of a comprehensive, community based model of care for parents with mental illness and their young children

In creating and continuing the Parent/Infant Therapeutic Program, we have confronted three major challenges. So far we have overcome each barrier or threat to PITP's existence. Underlying problems remain unresolved, however, and the struggle to stay in operation, added to the enormous difficulty of the work itself, is wearisome. The challenges we face, and that we believe others involved in similar work also confront, include:

- Administrative and clinical resistance to the concept of the parent/child dyad as primary patient;
- Inadequate or fragmented funding; and
- Training and teamwork.

Treating the dyad

Although we see parent and child as an inseparable unit for psycho-developmental assessment and early mental health care, the notion of the dyad as "primary patient" is still an alien concept to many administrators and clinicians. In general, primary health care professionals hesitate to refer mothers and their young children to child psychiatry services, often because they themselves lack regular communication with psychiatrists or fear that parents will see psychiatric treatment as stigmatizing.

The inadequacy of currently available official diagnostic formulations of mental illness in infancy represents another conceptual barrier to comprehensive dyadic treatment. Official diagnostic formulations are not yet available for the subtle regulatory disorders, disturbed relatedness, and delays in emotional and cognitive development in infancy that can be linked to or exacerbated by dysfunctional interactions between caregiver and infant. Diagnoses need to be able to differentiate the contributions of infants and parents to malign interaction in order to make interpretations that can guide intervention appropriately. For example, is one seeing an "eating" or a "feeding" disturbance?

At present, New York State's Medicaid program will only provide reimbursement for mental health treatment of illnesses or conditions listed in the American Psychiatric Association's Diagnostic and Statistical Manual (DSMIII-R Axis I). These are largely limited to severe manifestations, such as autism and reactive attachment disorder of infancy. There is one exception: treatment of a "parent-child problem" identified under V code 61.20 for "conditions not attributable to a mental disorder that are a focus of attention or treatment" is reimbursable.

Comprehensive needs, fragmented funds

An intervention program for parent/infant dyads at risk because of parental mental illness that is located in a community-based child psychiatry setting can command the clinical expertise to provide early preventive and ongoing clinical care for the vulnerable mother and her offspring, at risk or with disabilities, in the context of their family. Yet given the complexity of the clinical task with such dyads, such an intervention program must be connected to a full range of clinical specialty services and other institutions and agencies that serve young children and their families.

Although interagency and interdisciplinary collaboration is emphasized in the language of federal legislation (e.g., Part H [infant/toddler services] of the Individuals with Disabilities Education Act [IDEA]), State administrators continue to struggle with the financial implications of collaboration. And PITP, based in a community hospital, faces continuing uncertainty and ambiguity.

Currently, PITP operates with funding from an annual grant of state Office of Mental Health funds to the host (Gouverneur) hospital. PITP is also expected to earn fee-for-service revenue. When state funds came from a "demonstration grant" program, annual budget crises in state and city occasioned annual fears for the program's survival. Only intensive advocacy, including telephone calls and letters to legislators and presentations to legislators and administrators, allowed PITP to survive. Thanks to this advocacy, however, our supporters now appreciate the value of the comprehensive package of care that PITP provides for a neglected target population. PITP's funding now comes from a "line item" in the "budget to localities," contributed to by both state and city.

This change gives PITP a more stable base of funding, but the total program budget still relies heavily on fee-for service income. And fee-for-service reimbursement presents many barriers to the provision of comprehensive health care.

Consider PITP's experience. Half of our patients are covered by Medicaid. Medicaid will reimburse Gouverneur Hospital for only one clinic visit per patient per day, regardless of the specialty service attended. Thus if, during a PITP session, a staff member identifies the need, in a family covered by Medicaid, for an additional emergency pediatric or adult psychiatric visit on that day,if she makes an immediate referral, while the family is in the hospital building and likely to follow through, the staff member jeopardizes the chances of PITP's being reimbursed for its own services that day. Medicaid does not reimburse for "no-shows," a reality of clinic life when a program serves parents who are dealing with the realities of infant illnesses, uncertain weather, and difficult public transportation in addition to their own depression or other debilitating mental illness. We refuse to "overschedule" as a way to improve reimbursement rates; we must protect the specific time set aside for patients who are able to keep and value appointments.

Other services that make PITP a comprehensive program strain the budget. These include case management, home visits, outreach to patients and community agencies, Cantonese and Spanish interpretation, and transportation for participants and staff.

Specialized training

PITP's emphasis on comprehensiveness and continuity of care depend on solid teamwork among staff. Staff members come from a range of disciplines, but each member has acquired additional training, specific knowledge, and clinical experience in work with our unique group of patients—parents with mental or emotional illness and their infants at risk. The work requires knowledge of psychiatry, child development, and medical and nutritional content. Skill is required in psychotherapy, play therapy, family-centered work, liaison and consultation, community outreach and advocacy. Personal qualities of social and cultural sensitivity, empathy, flexibility, and the capacity to tolerate feelings of frustration and helplessness are needed.

In addition, each treatment team and the staff as a whole must be able to recognize and accommodate different specialty backgrounds and individual styles.

Finding such highly qualified staff will be a challenge for any program trying to replicate or expand a comprehensive model. "Triple-board training" (see Constantino, this issue) in pediatrics, adult psychiatry, and child psychiatry is ideal, but rare. At Gouverneur, psychology and social work students who are already receiving training in child psychiatry have the option of rotating through PITP during their internship or field placement. Nurses in specialty training for mental health at Columbia University School of Nursing can have a two-semester field placement at PITP, supervised by our nurse specialist.

Expanding the scope of PITP

The PITP is funded as a clinical service program, a circumstance which regrettably does not allow sufficient time for formal research. However, integrating a research project with clinical service could advance both research and service goals, providing a range of clinical cases for researchers and offering a structure for self-monitoring clinical interventions.

In addition to expanding our training efforts, we would like to develop a larger Family Support Group Program, including respite care for mother and child. We would also like to be able to offer consultation, assessment, and intensive therapeutic support when indicated to families of infants and toddlers with disabilities identified through Part H of the IDEA.

We would like to see a family-centered parent/infant intervention program in every community-based child psychiatric outpatient clinic. A comprehensive approach recognizes that major mental illnesses are lifelong conditions, requiring ongoing medical and supportive care. When individuals with mental illness take on the responsibilities of parenthood, their attachment to the child becomes a powerful motivator even under the duress of emotional turmoil. Support for adults with mental illness in their parenting role can be a powerful tool for stabilization and rehabilitation, and a comprehensive, continuing program can offer a reliable safety net for the developing family. ✦

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Letter to the editor

As a psychologist who has worked with several delightful "autistic spectrum" children during the past ten years, I was very pleased and encouraged to read the articles in the recent *Zero to Three* (October/November 1992, Vol. 13, No. 2). When I began working with these children, my County Mental Health Department included an early intervention program for at risk or atypical infants and their families and a division of developmental disabilities. Both program collaborated with the public schools' special programs such that parents of children with autism or PDD could reasonably expect truly interdisciplinary diagnostic and intervention services. Some supervisors and specialists challenged the appropriateness of offering psychotherapy to these children and saw my efforts to promote imaginative interaction and enjoyment of the social world as subversive of their behavioral goals or the more "realistic" goal of helping the parent accept the child's disability and/or "set limits" on their child's behavior problems. This was certainly frustrating to me and confusing to parents, but at least the parents were faced with dialogue about their child's needs and offered some choices. Today the situation is much different. Due to the steady decline of public funds there is no early intervention program, there is no developmental disabilities program, and all of the Mental Health staff with expertise in developmental disorders have been laid off. Some autistic/PDD children will now be found in various special classes and some in the mainstream but with the simplified "diagnoses" of brain damage or behavior disorder and the unfunded prescription for teacher or parent education to achieve better "management" of the child. Fortunately many parents will be dissatisfied with the approach and continue to struggle to find ways to nurture their child's unrealized potential.

Reading the articles in *Zero to Three* brought back to me many happy memories of important interactional moments in my work with children who had seemed unable or unwilling to engage in reciprocal communication. Such moments are among the great rewards of this work. Often they confirm that through the long periods of obscurity children have been attending, wanting to engage and working up to it in the various ways that their cognitive/sensory processing style allows. I would like to describe a few of these moments by way of thanking Dr. Greenspan and his colleagues for their inspiration and also as encouragement to others who are inclided to follow their integrative approach.

Matty was an attractive 4-year-old with broad though uneven developmental delays, some motor stereotypies and head banging, some echolalia and a few stock words which, with prodding, he might combine appropriately such as to say "want cookie" or "open door". His mother had the impression he was taking in much more than he could reflect, even though on standardized tests both receptive and expressive language were impaired. Though usually self-isolating, Matty showed pleasure over a few special stimuli including fish. I had tried bringing some pretty photographs of fish to my sessions with him hoping to engage him. He showed no interest. One day after I had visited a local marine life center I talked to Matty about it and asked him if perhaps he had visited there with Mom or Dad? He seemed to be listening as I talked about my observations and he responded with what I recognized initially only as having the cadence of two sentences. Asking him if he could repeat, I caught something like "De effa sufa. Vusa ess." Finally I understood "elephant?" Matty nodded. "Elephant ... suffer? ... suv ..." I persisted, "Suvel," corrected Matty, "De elephant pooed and peed on the shovel; it was a mess! Ha." With heroic effort he had put together these words to converse with me about a vivid and amusing event in his life.

Another 4-year-old had entered our program with much difficulty due to her extreme fear of changes in routine and separation anxiety which her parents learned to cope with, aiding her in taking tiny steps toward change. Megan had language far more developed than Matty but spoke in a very rapid whisper of television cartoon narratives. She paced and flapped her hands, cowered at ordinary noises and in her first weeks in the class frequently burst into tears and/or wet her pants at such events as crayons breaking. Her teacher, Mary, emphasized language pragmatics and used total communication (sign and speech) to facilitate language growth in the young students, most of whom had communication delays. Megan had continued to present herself as a nervous little mouse, always whispering, usually in private jargon or about fantasy characters. One day her teacher proceeded with the snack-time routine of individually presenting the juice and cookie to each child with signs and words, requiring the appropriate response according to ability level before giving the snack to the child. As she proceeded from child to child, Megan was quivering, but that wasn't unusual. After about the third repetition of "Look at me, tell me, say ... I ... want ... cookie," Megan raised her arm, slammed her fist on the table and shouted, "MARY, PUT THAT COOKIE ON THE TABLE NOW!!!"

Timmy presented more classic autistic features than Megan or Matty. He seemed to look through people, spoke in a sing-song voice and resisted the involvement of others in his idiosyncratic preoccupations. He very gradually but steadily allowed my intrusion. He allowed me to follow him into a dark closet and eventually was sympathetic to my pleas that it was getting hard for me to breathe; could we please go out? Then he titrated my presence by throwing a blanket over me and weighting it down with various objects. He was amused by my wiggles that set the objects toppling. After a year we were, I thought, well beyond this point. Timmy was subtly affectionate and building a larger repertoire of favorite things to do with me. I was disappointed when he objected to me joining in singing along with a music tape we had discovered in the room. He gasped, stuttered, said "No, no!" and clapped his hand over my mouth. This went on for weeks until one day Timmy himself sang the entire sequence of words and melody at which point he was happy to have me join in. My premature joining had interfered with his learning process.

My anecdotes add little to the rich observations of the previous contributors. I only reaffirm the necessity to remain open to the communicative intent of seemingly stereotypic behavior and utterances, and recommend the delightful outcomes of meeting the idiosyncratic expressions half-way.

Ellen Lowery, Ph.D.
Child Haven, Fairfield, CA
Author, "Autistic Aloofness Reconsidered", *Bulletin of the Menninger Clinic*, 49(2), 1985, 135-150.

Publications:

The IFEEL Pictures: A New Instrument for Interpreting Emotions, *Clinical Infant Reports* #5 (1993) - edited by Robert N. Emde, Joy D. Osofsky, and Perry M. Butterfield (International Universities Press, Inc., 59 Boston Post Road, Madison, CT 06443) $50.00 (tent.).

Infant Facial Expressions of Emotion from Looking at Pictures (IFEEL Pictures) is a research procedure, still in an early phase of development, for exploring the ways in which parents and others "read" and interpret infant emotions. The IFEEL Pictures began as a by-product of work on infant facial expressions of emotion that included an interest in their development, their variations, and their communicative value for caregivers. Since emotional expressions can be thought of as the language of infancy, a technique for exploring caregivers' responses to pictures portraying standard infant emotional expressions may be useful for both researchers and clinicians interested in variations in caregiving.

This volume reviews the conceptual and empirical background for the IFEEL Pictures, the practical and descriptive

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ZERO TO THREE Notes

by Eleanor S. Szanton

As the new Administration takes shape in Washington, there is excitement in the air. The increased attention to the needs of young children is heartening, as is the perspective that this concern is an investment in our common future. This does not mean that the Administration wishes to bring or return the locus of control of children's programs to Washington. It does demonstrate a strong commitment to helping federally-supported services be better organized, supported and monitored at the state and local level.

There is a new feeling of optimism among child advocates, as well, that this is an opportunity to rethink the present system of discretionary funding for programs for infants/toddlers and their families. Our country already spends hundreds of billions of dollars on the health, education, protection, and daily care of its children. Surely we can work together to design services that are better integrated, include our youngest children, and have a commitment to more effective service for **all** families in need, in ways that are meaningful. **ZERO TO THREE** referred to this in its recent publication, **Heart Start: The Emotional Foundations of School Readiness**, as "a determination to make services not only available but attractive, understandable and fully useful to the persons they are intended to help." (1)

Our own commitment to the integrated services issue comes from our daily witness to how infants and toddlers develop. Realizing that physical, cognitive and social or emotional development are entirely intertwined in very young children, we know that, for example, an agency concentrated on one aspect of infants' health or nutrition *must* be committed to working with the agency that is concerned with their daily care.

States are ahead of the federal government in this effort. Tennessee is experimenting with a single pot of human service money for young children. Five states—Florida, Georgia, Kentucky, Minnesota and Rhode Island—are using the Pew Foundation's Children's Initiative to construct a more seamless web of services at the local level. To its credit, the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health & Human Services has funded a number of experiments in better integrated services and resource centers (2)

However, real, meaningful service integration will need help from Congress. Only Congress can review ways in which programs such as the Supplemental Feeding Program for Women Infants and Children, the Family Support Act (welfare reform), The Child Care and Development Block Grant, Medicaid (including the Early and Periodic Screening, Diognosis and Treatment/EPSDT Program), Maternal and Child Health (Title V of the Social Security Act), Part H of The Individuals with Disabilities Education Act (IDEA), Head Start (including a variety of programs for infants and toddlers under the Head Start umbrella), Child Abuse Prevention, Adoption Assistance, the Immunization initiative, and the Children of Substance Abusers Act can develop common service strategies. Congress can, if it chooses, take the lead by providing states with significant carrots and sticks to work more closely towards integrating the funds they receive from Washington.

We hope the Executive branch will also set up a zero to three task force, made up of high level people from a variety of departments, agencies and bureaus to discuss ways in which initiatives for this age group can be expanded and better integrated, without necessarily requiring significant new funds.

It is then timely that **ZERO TO THREE/NCCIP** should be publishing its ***Preliminary Report*** of its ***Case Study of Six Community Service Systems.*** This case study is of six communities that are experiencing success in the use of preventive approaches to serving infants, toddlers, and their families. The communities differ in geographic boundaries, populations served, stages of service system development and approaches used. The communities selected to participate in the study are: Fremont County, Colorado; North Lawndale, Chicago, Illinois; Scott County, Indiana; Kent County, Rhode Island; Snohomish County, Washington; and Travis County, Texas.

The study was designed with the understanding that much more is understood about exemplary programs than about the integration of a variety of programs into a system of services that addresses the needs of an entire community. It is charting the evolution of these six communities' service systems and documenting the systems' responses to emerging challenges, such as changing demographics or new health care crises, their states' budget crises, and a plethora of federally funded categorical programs.

The communities were selected based on their commitment to

- Universal access to services;
- Linkages across a range of levels of care and service system needs;
- Family involvement, in service planning and delivery;
- State level support and encouragement;
- Professional development opportunities for staff; and
- Inclusive, mainstreamed, non-categorical settings for services.

These six criteria more often than not go together. They add up to a commitment to putting families at the center, rather than one or more agencies. When a community has a commitment to one, it often has it to a number of them.

The lessons learned are not always "news." Rather, the study's relevance and value for funders and planners may come from its documentation of the "real world" experiences of these communities as they try to implement acknowledged best practice. The experiences of community representatives and the case study team have much to teach about what promotes success in zero to three services—and what impedes it.

It is very impressive to see a community evolve a shared vision and to become **e pluribus unum**, one out of many service agencies, often against very heavy odds.

Individuals who would like to learn more about this study should contact Virginia View or Kim Amos at the **ZERO TO THREE** offices.

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1. ZERO TO THREE/National Center for Clinical Infant Programs, *Heart Start: The Emotional Foundations of School Readiness* (1992, Arlington, VA).
2. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Division of Children and Youth Policy, *Efforts to Promote Community-Based Service Integration* (October 1991, Washington, D.C.)

Publications *continued from page 36*

features of the instrument, and its psychometric properties. The volume includes descriptions of studies which used the pictures for comparison among groups of adolescent mothers, mothers at risk for child maltreatment, depressed mothers, and mothers of premature infants. Other studies described used the pictures as projective story stimuli and as a task for assessing mothers' and young children's verbal communications about affect. Exploratory studies carried out in Argentina, France, Israel, Japan, and Sweden are also presented in the volume. While the IFEEL Pictures have been used primarily for research, the editors suggest that the instrument provides a vehicle for understanding parental misconceptions and problematic expectations that may be helpful in planning early preventive interventions.

Contributors to the volume in addition to the editors include Doreen Ridgeway, Mark Appelbaum, Anne Culp, Rex Culp, Carolyn Zahn-Waxler, Elizabeth Wagner, Nathan Szajnberg, Jarmila Skrinjaric, Martin Drell, Della Hann, Suzanne Denham, and Ann Lodge, among others.

Depression Runs in Families: The Social Context of Risk and Resilience in Children of Depressed Mothers (1991) - Constance Hammen (Springer-Verlag New York, Inc., 175 Fifth Avenue, New York, NY 10010) $49.00.

This book is designed, notes its author, to come to some conclusions about the meaning of the assertion that "depression runs in families." It reviews research on the risk to children due to parental affective disorder and presents results from the UCLA Family Stress project, which began in the early 1980s to study the childhood origins of depression. This project investigated the diagnostic and psychosocial functioning outcomes of children at risk over time and also explored areas thought to mediate children's risk for negative outcomes, including children's cognitions, family stress, parent-child relationships, characteristics of the parents, and the characteristics of resilient-seeming children.

The UCLA study found overwhelming evidence of significant psychiatric disorder as well as impairment of functioning in social, academic, and mother-child relationship spheres in children of unipolar depressed mothers. The children of bipolar mothers revealed significantly **less** severe disorders and more adaptive psychosocial functioning than the unipolar children. "Clear, consistent, and strong evidence" emerged of the importance of psychological and factors for children's outcomes. Children's negative self-concept, acquired through negative interactions with a critical or noninvolved depressed mother, was a significant predictor of future depression. Children's depression was associated with stressors, of which maternal depression itself was one. In addition, both unipolar depressed women and their children appeared to generate stressful events such as interpersonal conflict.

The author observes that "when the child as well as the mother or another member of the family is depressed, the potential for conflict, resentment, disappointment, and feelings of abandonment is multiplied." Clinical interventions need to deal with the realities of impairment, recurrence, and family context, she suggests, noting that "clinical interventions aimed solely at intraindividual change—treating the illness within—do not go far enough in considering the consequences for other family members or the conditions that create relapse."

Parenting: An Ecological Perspective (1993) - edited by Tom Luster and Lynn Okagaki (Lawrence Erlbaum Associates, Inc., Suite 102, 365 Broadway, Hillsdale, NJ 07642) $59.95, cloth; $27.50, paper.

In his foreword to this volume, Urie Bronfenbrenner notes that this volume is the first to bring together in one place the results of research on parents and children collected from the perspective of the ecological paradigm articulated by Bronfenbrenner some 15 years ago. Chapters address the influences on parenting behavior of: parents' own childhood experience; the development of parental beliefs; the ecology of adolescent motherhood; children's temperamental characteristics; the marital relationship; personal social networks; parental work; and neighborhood and community. Given such support for the view that parenting behavior is multiply determined, editors Luster and Okagaki observe that studies which examine multiple influences at one point in time, or over time, contribute to the understanding of parental behavior through examining: 1) additive or cumulative effects; 2) the effects of a moderating variable; 3) mediating variables; 4) links between characteristics of the person and the context over time (selecting or creating environments and evoking responses); and 5) developmental pathways, or links between early contexts and later contexts.

In reviewing research that has attempted to answer the question, "What is the role of personality versus environmental factors in shaping parental behavior?", Joan Vondra and Jay Belsky conclude:

> The effects of a troubled and/or problematic childhood for parenting difficulty and dysfunction appear to depend very much on opportunities to rework poor relationship experiences. When children have alternative relationship models available to them and/or can participate in a supportive relationship amidst the stressors of their childhoods, when young adults can rework relationship issues by their long-term involvement (whether personal or professional) with a caring and supportive individual, the relationships they create with their own children need not mirror the hardships of their upbringing.

Longitudinal Studies of Children at Psychological Risk: Cross-National Perspectives (1992) - edited by Charles W. Greenbaum and Judith G. Auerbach (Ablex Publishing Corporation, 355 Chestnut Street, Norwood, NJ 07648-2090) $54.50.

This volume grew out of a 1988 conference that was sponsored by the Martin and Vivian Levin Center for the

Normal and Psychopathological Development of the Child and Adolescent of the Hebrew University of Jerusalem in order to promote effective communication among researchers and practitioners with different perspectives on the long-term effects of early exposure to a variety of risk factors. Chapters deal with the longterm effects of very low birthweight, the relations between toxic substance ingestion during pregnancy and child development, and parents as mediators of risks in children. Contributors include Frances Degen Horowitz, Edward Goldson, Sarale E. Cohen, Arthur H. Parmelee, Leila Beckwith, Marion Sigman, Linda Siegel, Nathan Fox, Sydney Hans, Ann Pytkowicz Streissguth, Joseph Marcus, Aaron Auerbach, Anat Ninio, and Rachel Levy-Schiff, among others.

In a chapter on neurobehavioral functioning from infancy to middle childhood in children at risk for schizophrenia because of parental diagnosis, Judith Auerbach, Sydney Hans, Joseph Marcus, and Aaron Auerbach report findings of neurointegrative dysfunctioning in approximately half of the children of schizophrenic parents, a number which exceeds that found in children born to parents with other types of mental illness or with no mental illness. The authors note that the picture for the majority of infants with mentally healthy parents or parents with a mental illness other than schizophrenia is one of continuity in development for well-functioning infants or of improvement for poorly functioning infants. In contrast, among offspring of parents with schizophrenia, only 50 percent of well functioning infants continue to perform well in childhood, and two-thirds of poorly functioning infants of parents with schizophrenia continue to have difficulties in both motor and cognitive functioning in childhood.

The authors suggest that intervention with vulnerable children of parents with schizophrenia include not only intervention directed to attentional or visual-motor deficits but also efforts to affect changes in the child's resiliency by strengthening his coping skills.

Conference Call:

June, 1993

June 14-18: The *Seventeenth Annual Quality Infant/Toddler Caregiving National Workshop* will be presented by Alice S. Honig in Syracuse, New York. For information, contact Alyce Thompson, Syracuse University, Quality Infant/Toddler Caregiving Workshop, 201 Slocum Hall, Syracuse, NY 13244-1250, tel: (315) 443-2757.

June 17-20: The *National Women's Law Center,* through its Women in Prison Project, will host the Seventh National Roundtable for Women in Prison, with the theme, "A Vision Beyond Survival," in Washington, D.C. Speakers will include Angela Davis, Shyryl Brissett-Chapman, Angela Browne, and Stephanie Covington. Contact Jan Britt, National Women's Law Center, 1616 P Street, N.W., Washington, DC 20036, tel: (202) 328-5160.

June 23-25: *Bank Street College of Education* will hold its 6th Annual Infancy Institute in New York City with the theme "Infants, Toddlers, Parents: Supporting Their Growth." Featured speakers will include Abbey Griffin, Maria Elena Orrego, Louis Torelli, and Ellen Galinsky. A choice of site visits will be available. Contact Nancy Balaban or Virginia Casper, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 875-4713 or 4703.

June 25-27: The *Language and Cognitive Development Center* will hold a conference in South Hadley, Massachusetts entitled "New Ways with Autistic and Other Children with Pervasive Developmental Disorders." Speakers will include Arnold Miller, Eileen Eller Miller, and Bernard Rimland, among others. Contact Janice Melvin at 1-800-666-LCDC or (617) 522-5434.

June 27-July 30: *Wheelock College* will hold its 18th Annual Advanced Seminars in Child Care Administration in Boston, Massachusetts. These week-long seminars include courses in caring for infants and toddlers; a trainer of trainers course for family child care professionals; a National Early Childhood Staffing Seminar co-sponsored by the Child Care Employee Project; a National Leadership Institute for Family Child Care co-sponsored by the National Association of Family Day Care; and a National Leadership Institute for Child Care Resource and Referral co-sponsored by the National Association of Child Care Resource and Referral Agencies. To receive a catalog, contact Patricia Day, Wheelock College, Advanced Child Care Seminars, 200 The Riverway, Boston, MA 02215, tel: (617) 734-5200, ext. 279.

July, 1993

July 15-17: *The National League of Cities* will sponsor a national conference entitled "Your City's Families," to be held in Minneapolis, Minnesota. Contact the Children and Families in Cities Project, National League of Cities, 1201 Pennsylvania Avenue, N.W., Washington, DC 20004, tel: (202) 626-3030; fax (202) 626-4043.

July 30-August 1: The *Margaret S. Mahler Foundation* and the *Rene Spitz Gesellschaft* will cosponsor the Second International Mahler Symposium, to be held in Cologne, Germany, on the theme, "The Development and Disorders of Object Constancy." Presenters will include John McDevitt, Phyllis Tyson, and Salman Akhtar. Contact Herman Staples, M.D., 24 Green Valley Road, Wallingford, PA 19086, tel: (215) 566-1054, fax: (215) 566-2773.

August, 1993

August 5-6: *DuPage Easter Seal* will sponsor a clinical workshop in Villa Park, IL on "Advanced Therapeutic Intervention for Infants and Children with Neuromuscular Dysfunction." Georgia DeGangi will be the instructor. Contact Continuing Education Department, DuPage Easter Seal, 830 S. Addison Avenue, Villa Park, IL 60181, tel: (708) 620-4433.

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