Example: Helping a Fussy Baby

Mrs. Adams and her baby, 2-month-old Alexis, were referred for treatment by their pediatrician after a routine baby visit in which the mother broke into tears in response to the question: "And how are things going for you?" In the ensuing conversation, the pediatrician discovered that the mother was suffering from stress and dysphoria as a result of conflicts with her husband. She also blamed herself for her baby's frequent and intense bouts of crying. Mrs. Adams had read that maternal emotions are transmitted to the baby through the mother's milk, and she told the pediatrician that she worried that her "sour milk" and "tense muscles" were "messing up" her child because she could not set aside her sadness and anger while caring for him. The pediatrician made a referral for infant-parent intervention when the pediatrician's own efforts at developmental guidance regarding early colic did not relieve the mother's concerns and when the mother declined to see a psychiatrist for a consultation about her depression.

Mrs. Adams and her husband were in their mid-20s, European American college graduates from a middle-class background who had carefully planned the pregnancy so that the baby's birth would coincide with the last payment of their student loans and the beginning of some financial freedom. They had both been sorely disappointed when, instead of the idyllic pregnancy they had anticipated, Mrs. Adams suffered from constant back pain and the delivery was long and painful although otherwise uneventful. These experiences contrasted sharply with the perceptions that Mr. and Mrs. Adams had of themselves as young, athletic, competent, and pretty much in charge of their lives.

The initial two intervention sessions showed that Alexis was feeding well, growing well, sleeping 3 hours at a time, and waking up twice for nursing during the night. He was a very visual baby who followed his parents with his eyes as they moved around the room and was quick to turn toward new sights. His facial expression tended to be sober and it took some coaxing to get him to smile, but when he did he showed delightful dimples 酒窝 that gave his parents clear pleasure. He was very sensitive to sound, slept lightly, and startled easily. He had sustained periods of fussiness 哭闹 during the day, and he was difficult to console when he cried. His mother estimated that he cried for approximately 15 minutes at a time several times a day, and once a day he cried "for 2 hours solid, without a break," to use the mother's description. He was particularly difficult to soothe in the early evenings. When Mr. Adams returned from work, Alexis's mother often greeted him with an exasperated 恼怒的；极厌烦的 "You take him!" and went to the bedroom to rest. This greeting clashed with Mr. Adams's fantasy of coming home to relax and talk to his wife about the events of his day. The following exchange during the first session gave a clear indication of their very different frames of mind. Mrs. Adams said tearfully: "He can be good at times, but when he cries nothing that I do pleases him." Mr. Adams replied sternly: "Babies cry. What happens is that you fall apart 崩溃 too easily."

These divergent perceptions were fueled by the parents' different experiences during the day. Mr. Adams was immersed in pursuing a career in the computer industry and worked long hours, while Mrs. Adams had taken a 6-month leave of absence from her administrative position at a university and missed the social and intellectual stimulation of her work life. After 2 years of being happily married they now found themselves at odds 争执，意见不一致；争吵，不和 with each other, torn between their motivation to be perfect parents and their desire to continue the carefree lifestyle they had enjoyed before the baby was born. They were the first couple in their social circle to become parents, and after celebrating the baby's birth their friends resumed the pattern of partying and going to concerts that constituted their social life. As a result, Mr. and Mrs. Adams found themselves somewhat isolated from their friends because they did not feel comfortable leaving their young baby with a babysitter in order to go out at night, and they had no family in the area for substitute care.

No evidence of psychiatric problems or other risk factors emerged from the first two sessions, which were largely devoted to an assessment of the parents and the child and to trial interventions to determine the parents' motivation and openness to treatment. During the initial session it was clear that Mr. Adams believed that his wife was overreacting to Alexis's crying and Mrs. Adams felt on the defensive about the quality of her mothering. Although Mrs. Adams wanted her

husband to participate in the treatment, he declined on the grounds that the sessions would interfere with his work schedule. The clinician suppressed her strong urge to admonish Mr. Adams that his immersion in his work was endangering his marriage and that his primary commitment should be to his family. She realized that her own values were coloring her perception and that it was premature to recommend a course of action that would be perceived by the father as authoritarian and burdensome. The parents and the clinician agreed that Mr. Adams would attend the sessions whenever he was able to.

Choosing an Initial Intervention Strategy

The clinician took all these circumstances into consideration in proposing infant massage as an initial intervention modality She hypothesized that learning to use specialized soothing techniques would set up a feedback loop between mother and baby that might enable Mrs. Adams to feel more effective and circumvent 绕过，避开 her defensiveness about her husband's perception that she was overreacting to the baby's crying. Mrs. Adams was receptive to this suggestion, which was in line with her explicitly stated wish during the assessment to learn cutting-edge approaches to infant care.

Massaging the baby offered mother and clinician opportunities to observe Alexis together and to give developmentally appropriate meaning to his responses. For example, on one occasion the clinician responded to the baby's fussing when she touched his stomach by saying: "You are telling me that your tummy is very sensitive. Let's massage your arms first." When the baby stopped fussing in response to this change, the mother commented: "I see what you are doing. You are letting him show you the way. This is good. This is good." She seemed more self-confident in touching Alexis and trying out different ways of holding him after this exchange.

The clinician also used the sessions to encourage Mrs. Adams to describe her own feelings and states of mind as she interacted with Alexis, and asked about the similarities and differences in the ways she and her husband interacted with the baby. This line of questioning led Mrs. Adams to reveal her conflicting feelings toward her husband, which included feeling critical because he was not responsive to the baby's distress, anger for his emotional distance from her, missing the happy times they had as a couple before the baby was born, and fear of being alone if he left her. The clinician listened supportively, sympathizing with the mother's experience and offering developmental guidance about mothers' and fathers' different ways of adjusting to the changes brought about by parenthood.

Adding Intervention Modalities

One month into the treatment, the clinician found out that Mrs. Adams often spent 2 or 3 days without going out of the house because she felt unattractive due to her weight gain and had little motivation to dress up just to stay at home with the baby. When she went grocery shopping, she came back to the house as quickly as she could. Commenting that what the mother interpreted as "baby blues" might have a strong component of "cabin fever," the clinician suggested activities that would get Mrs. Adams and the baby out of the house. Mrs. Adams was reluctant to follow these recommendations because she was afraid that the baby would start crying inconsolably in a public place and she would not know what to do. The clinician proposed going out together as part of the session after practicing baby massage for 20 minutes when she first arrived for the home visit. When Mrs. Adams was evasive about this offer, the clinician responded that this was a standing invitation and that she would repeat it in case the mother changed her mind. Two weeks later, Mrs. Adams reluctantly agreed to "try it next week" when the clinician brought it up again, and her appearance improved considerably when this schedule was adopted. Instead of wearing a bathrobe when the clinician arrived in the early afternoon, she was showered and casually but neatly dressed, and the baby was bathed and ready to go. These neighborhood outings—to the library, grocery store, park, or simply window shopping—gave the clinician an opportunity to point out to the mother Alexis's visual interest in the world and the positive response of passersby, who often greeted him and engaged in brief but friendly exchanges with Mrs. Adams about him.

Alexis sometimes cried during these outings, but the periods of active engagement interspersed with sleep outweighed the moments of distress.

The outings with the clinician dispelled Mrs. Adams's fears of what would happen if she took the baby out for long periods, and she started going out with Alexis outside the sessions as well. During one of these forays she discovered a gym that had babysitting services in a room adjacent to the exercise area so that the parents were easily accessible if needed, and she started going as part of resuming her daily workouts.

As Mrs. Adams focused less on her fear of the baby's response, the clinician started asking more explicitly about the marital relationship. Mrs. Adams eventually revealed that their sexual relationship had become a salient 突出的，显著的 issue in their mutual dissatisfaction. Both of them were too tired and conflicted with each other to resume having sex, and both of them worried about what this meant about their relationship. Mrs. Adams reported that her husband berated her for being interested only in the baby, but he stayed up working, watching TV, or listening to music long after she went to bed even on weekends. The clinician normalized this situation as a frequent response of couples to the birth of a baby and spoke about fathers' fears of being superseded by the baby in their wives' affections. She suggested that Mr. and Mrs. Adams begin hiking together with Alexis during the weekend instead of exercising separately while the other took care of the baby. She also encouraged the mother to use a babysitter so that the couple could go out occasionally either alone or with friends and offered advice on how to interview applicants and gauge their trustworthiness. These suggestions proved welcome and beneficial. Mrs. Adams's harsh criticism of her husband and fear of abandonment softened. Soon after their first date after the baby's birth, the father actually participated in a session and asked about how to decide whether to ignore or respond to the baby's crying. This question led to a productive discussion about different personal styles and babies' capacity to adjust to their mothers' and fathers' distinct ways of relating to them.

These interventions illustrate the usefulness of integrating modalities that encourage behavioral change with clinical attention to defense mechanisms and other components of inner experience. When Mrs. Adams initially declined the clinician's suggestions for doing activities outside the home, the clinician explored the reasons for her refusal and tailored her interventions to circumvent the internal obstacles that Mrs. Adams described. During their outings together, the clinician provided emotional support and reality testing by showing the mother that the overwhelming stresses she anticipated when going out did not occur. As Mrs. Adams's trust in the clinician increased due to improvement in the most immediately salient areas of concern, therapeutic attention turned to the more emotionally charged topic of the marital relationship. Here again, empathic listening, normalizing of negative attributions by developmental guidance and reframing, and suggestions for active behavioral change led to rapid improvement.

The Outcome

After 3 months of weekly treatment, there were major transformations both in Alexis and in his mother's internal experience and parenting behavior. Mrs. Adams was more active, more enterprising, and in a better mood, and she commented that she had discovered parts of the city that she had never known while she was working. Her negative attributions to Alexis diminished substantially when she began to perceive his crying as a sign of distress rather than as an indication that he had an angry and rejecting nature. In response to her greater sensitivity and self-assurance in handling him and aided also by maturation, Alexis became cuddlier and cried less, reinforcing the mother's increasing self-confidence in ministering to him. Mrs. Adams's heightened need for her husband's complete acceptance and anger when he was not emotionally supportive diminished when she became better able to understand that his emotional upheavals were often an indication of his self-doubts in facing his new responsibilities as a father. Last but not least, the couple resumed their sexual relationship. The session in which Mrs. Adams reported this event timidly but with clear relief marked the beginning of the end of treatment, with the last session occurring 2 weeks later.

In this example, baby massage was an initial intervention that brought quick improvement to the interaction between mother and baby and enabled Mrs. Adams to adopt a more reflective stance both toward her baby and toward her conflicted marital relationship. She realized that the baby's crying was not an enduring personality trait but rather a response to a stressful internal state, and she became less self-blaming when her ministrations did not immediately help Alexis to stop crying. This understanding was linked with a new appreciation of her power to assuage or exacerbate conflict with her husband through her responses to his behavior. In working toward these changes, the clinician framed this young couple's marital and parenting challenges in the context of the normative stresses of being new parents. This developmental frame defused the mother's defensiveness, instilled hope, and fostered her readiness to experiment with new ways of responding. The very concrete contributions to the mother's mood of physical exercise and activities out of the house should not be underestimated. In addition, the beneficial effect of the improved mother-infant relationship on the marital relationship exemplifies Robert Emde's important observation regarding the effects of relationships on relationships (Emde, 1991).

It bears noting that the mother's childhood experiences were not a focus of this intervention. She talked during some sessions about childhood encounters with her mother, father, and siblings that made her feel lonely, angry, and inadequate, but the clinician thought that there was no need to pursue the chains of associations related to these experiences because the mother and the baby were making satisfactory progress with a focus on the present. If the chosen modalities of intervention had not yielded the desired results, a probing of the "ghosts" from the past and their influence on present circumstances would have been considered a possible additional treatment modality (Fraiberg et al., 1975).