CHAPTER 5

"Not Quite Good Enough"

Perturbations in Early Relationships

This chapter illustrates treatment when the duration and intensity of the child's problems shake up the parents' confidence in their ability to manage those problems without professional assistance. Sometimes the situation involves a circumscribed difficulty that can be managed relatively quickly through developmental guidance and emotional support. Other times, the presenting problems are sufficiently entrenched that improvement calls for additional intervention strategies, including attention to how the parents' personalities and parenting strategies are involved in the etiology or continuation of the child's problems. By definition, however, perturbations involve developmental strains that are superseded by the overall healthy thrust of the child's development and the positive features of the parent–child relationship. A careful assessment is important to lend perspective on the scope and severity of the problem and tailor the treatment accordingly.

We all wish we had had a perfect childhood. This wish is manifested in a profound human longing for a state of harmony where pain does not exist and every wish is fulfilled. The ubiquitous belief that this ideal state actually existed and the lingering mourning over its disappearance find expression in the cultural myths of a paradise lost. The wistful wish for perfect communion with another person is embodied in the archetype of the perfect mother, who has the power to protect us from harm and satisfy all our desires. The realization that we never had such a mother is the interpersonal equivalent of paradise lost and takes

the form of a disillusionment that can be experienced viscerally again and again. Erik Erikson (1950) articulated this frame of mind when he wrote about the inevitability of feeling incompletely cared for and the psychological struggle involved in achieving a state of basic trust:

> But, even under the most favourable circumstances, this stage seems to introduce into psychic life (and become prototypical for) a sense of inner division and universal nostalgia for a paradise forfeited. It is against this powerful combination of a sense of having been deprived, of having been divided, and of having been abandoned that basic trust must maintain itself throughout life. (p. 250)

The "Good-Enough" Mother

D. W. Winnicott attempted to rescue us from the tyranny of pining for the impossibly perfect mother by pointing out that we can make do with what he sensibly called "the good-enough" mother. Also known as the ordinary devoted mother, she is preoccupied during the first weeks of her baby's life with learning about and responding to his all-encompassing needs, and becoming progressively less completely absorbed in her mothering as the child matures and learns to tolerate delays of gratification (Winnicott, 1958). The transactional exchanges between the baby's maturation and the mother's ministrations gradually create a transitional interpersonal space where the child's needs can be met without unduly impinging on the mother's personal agenda, giving her the flexibility to care well for the child while also pursuing the duties and satisfactions attendant to her other roles.

This interpersonal space is where subjective perceptions and objective realities connect. It is the meeting place between the sense of self as a protected private space that cannot be known by outsiders and the part of the self that is engaged in a deep relationship with an indispensable partner. The inherent tension between privacy and emotional engagement means that "good enough" is a relative and abstract concept, a summary statement about a complex relationship. In moments of strife, we have a visceral negative experience because the relationship is not meeting our innermost needs. It is not only toddlers who can yell "I hate you!" because they lose track of their love in the midst of their disappointment and rage. Most adults also experience hatred at some point in the course of a long intimate relationship, although they may manage not to say it (a veritable feat of socialization). Only when the conflict can be placed within a broader emotional context is one able to reconnect with the more satisfying aspects of the relationship and conclude that the partner and the relationship itself are "good enough."

John Bowlby attempted to describe the main features of the interpersonal space between the private self and the self-in-an-intimate-relationship, suggesting that the initial stage of secure early attachment involves the baby's experience of being recognized and met by the mother's sensitive responsiveness to his signals of need. As the growing baby acquires greater self-regulation skills, a secure attachment is increasingly characterized by a mutuality of adjustments until it becomes a goal-corrected partnership, where mother and child can resolve conflicting individual agendas through give-and-take based on each partner's empathic awareness of the other's plans and needs (Bowlby, 1969/1982). A mature secure attachment is characterized by reciprocity, defined as the capacity to recognize and adjust to the other's experience, to repair lapses in empathy, and to restore mutual attunement following conflict. These are the key ingredients of satisfying intimate relationships across a person's lifetime.

A good-enough mother is able to love a good-enough child. She is capable of accepting the mismatches between her fantasies and the reality of the child's individual characteristics, and she stretches herself without crippling resentment to provide the kind of care needed by her particular child. Good-enough parents recognize that imperfection is the coin of the realm and are not crippled by guilt in response to lapses in attunement. Reciprocally, a good-enough child accepts (with more or less grace, depending on the moment) that the mother will fail to be attuned to all his wishes and maintains developmental progress with the understanding that frustration and disappointment are expectable and can be managed without lasting hatred or despair. The achievement of a secure enough attachment is a work in progress that accommodates the child's individual traits, temperamental style, and changing developmental capacities as well as the parent's capacity to be sufficiently available and loving depending on internal and external stresses. Such accommodation invariably involves periods of heightened tension and lack of synchrony between parent and child.

Striving to Restore Goodness

The concept of "good enough" applies to therapists as well. There will be inevitable omissions, misunderstandings, and distortions in the clinician's work. At times strong emotion will cloud good judgment and the clinician will say or do things that slow down or damage therapeutic progress. The key to a good-enough therapeutic intervention is to cultivate an attitude of self-scrutiny so that the clinician remains reasonably aware of rigidly positive or negative feelings toward different family members, is receptive to feedback about perceived failures,

cultivates a commitment to repair therapeutic lapses, and is capable of self-forgiveness for clinical mistakes. The parallel process between the vicissitudes of treatment and the ebb and flow of intimate relationships is a useful guideline for the work.

Perturbations as Transactional Processes

As defined by Anders (1989) and described in Chapter 2, a perturbation consists of a circumscribed stress in attaining a developmental milestone. Unlike more serious disturbances, perturbations tend to be short-lived and limited to one or a few domains of functioning. Sometimes perturbations are not clearly linked to environmental or maturational stresses. Other times the perturbation is a by-product of the difficulties the child is experiencing in attaining a new skill. When this is the case, the negative affect often dissipates once the milestone is achieved because the child reaches a new balance and the child–parent relationship is reorganized in response to the child's developmental spurt and the resulting changes in parental expectations.

Periods of emotional balance, however, tend to be short-lived. Young children work toward several different milestones at the same time but at different paces, with the result that development does not involve the orderly linear attainment of developmental milestones. A new perturbation is likely to set in soon after another one is resolved because the child is striving to acquire new skills simultaneously in several domains of functioning. The parents' and the child's developmental fluctuations and the recurrent mismatches in their respective developmental goals also make for inevitable perturbations. A perturbation may originate in the child, in each of the parents, or in the particular poorness of fit between the parents' and the child's wishes, anxieties, and strivings at a particular juncture in their lives.

Regardless of its source, the perturbation may affect the child–parent relationship by introducing conflict and decreasing trust in oneself and in the other. In spite of these stresses, a relationship can remain "good enough" even while undergoing perturbations when the parents retain some equanimity and humor about their own stress and fatigue, support the child's developmental strivings, and continue to create areas of pleasure in family life and in their relationship with the child. The clinician can play a pivotal role in upholding hope for the family by placing the stresses and struggles of the moment within a supportive developmental perspective.

The resolution of a perturbation can come about in a variety of ways, including attainment of a developmental milestone, mutual adap-

tation to the state of affairs, or a better parental understanding of the problem leading to beneficial changes for the child. Resolving a perturbation is not just a matter of passively "outgrowing it" because it always involves developmental change. The very use of the term "outgrowing" is a pseudo-scientific way of saying that we do not understand why or how a problem was solved. However, the term can be useful when it gives the message that many stressful periods neither last forever nor get worse over time but are temporary difficulties that precede more mature forms of functioning.

Parents often misinterpret a perturbation as "the child's problem" and do not recognize the contributions of the context in which it occurs. For this reason, perhaps the most frequently asked question for early childhood clinicians takes the following form: "Is this behavior normal?" Examples abound. Is it normal for an 8-month-old baby to bang her head against the floor? Does a 15-month-old suffer from unusually strong separation anxiety if he cries inconsolably when his mother leaves him at day care? Should we worry when a 22-month-old hides while having a bowel movement? Is a 2-year-old who routinely bites in response to frustration showing excessive aggression? Is a 4-year-old who touches her genitals telling us that she has been exposed to sexual abuse?

Parents, child care providers, teachers, child welfare workers, judges, and others who make decisions involving children often want to know whether specific child behaviors are temporary annoyances that will disappear over time or whether these behaviors indicate that the child is not developing well or has been maltreated. Clinicians encountering these questions typically find themselves thinking: "I wish I knew." Predicting the course of development and pinning down the precise etiology of specific behaviors are risky undertakings, and taking an unequivocal stance about the answers is more often an indication of personal hubris than professional wisdom. Behaviors occur in biological, developmental, and environmental contexts. Learning about these contexts is the first step in deciding whether the child's functioning is unfolding in expectable or worrisome ways.

The most judicious initial response to the question "Is this behavior normal?" is usually "It depends." Knowing about the context for the behavior is essential. Rushing to assuage uncertainty by answering "yes" or "no" to specific questions without additional information risks two kinds of errors: mistaken reassurance ("the child will outgrow it") or mistaken pathologizing ("the child is showing a disorder"). Failure to answer clearly, on the other hand, can make the clinician appear equivocal or inept. The same behaviors can have different meanings and lead to different outcomes depending on their context. Diagnosing and pre-

dicting the future course of a child's functioning is usually probabilistic at best. As the previous chapter makes clear, an understanding of the child's functioning in different domains is essential in order to provide a reasonably accurate answer.

The question "Is this behavior normal?" is best reframed as "Is this behavior harmful to the child or others? Does it cause distress? Does it interfere with important aspects of child development or family functioning?" From these points of view, it is less crucial to predict what will happen in the future than to act in the moment to alleviate present pain and dysfunction. Even when a pernicious behavior is likely to represent a temporary upheaval rather than a long-term problem, it is necessary to provide relief to the child and the family and enable all the players to remain positively engaged with each other.

The pediatrician T. Berry Brazelton (1992) coined the term "touchpoints" to highlight the well-known principle that regressions in behavior tend to occur before a spurt of developmental achievement. Touchpoints require a heightened deployment of energy that strains the child's resources. Learning to walk, for example, demands extraordinary effort and is often accompanied by frequent night wakings, increased crying, separation anxiety, and tantrums in response to even minor frustrations. Once the child learns to walk, the emotional landscape changes both for the child and for the family. The child is absorbed in the exuberant joy of practicing the new skill and the parents are thrilled with their baby's accomplishment. The juxtaposition of frustration with dramatic developmental progress often represents an optimal opportunity for dialogue between parents and professionals about the promise hidden in these potentially vulnerable transitional periods because the child's competence is enhanced or constricted by the parents' response (Brazelton, 1992; Brazelton & Sparrow, 2001). The concept of touchpoints helps parents to appreciate that healthy development is not always conflict free.

Like touchpoints, perturbations range along the continuum from manageable stress to constriction and distortion in development. However, touchpoints are linked to specific developmental transitions, while perturbations can occur as the result of a range of circumstances and may become the kernels of ongoing difficulties that reemerge in new guises at each new developmental stage. These recurrent core conflicts are likely to reflect not only the child's challenges but also mismatches between the child's needs and the capacities of the parents and the environment to meet those needs. The discipline of developmental psychopathology has been instrumental in refining clinical practice by increasing understanding of the dynamic and transactional nature of development (Cicchetti & Sroufe, 2000). A person may move from normal function-

ing to pathological behavior and vice versa, and he may have many areas of competence even while struggling with psychopathology. The following clinical example illustrates this coexistence of different modes of adaptation.

Example: A Competent Mother Who Feels No Pleasure in Her Baby

The mildly depressed mother of a 4-month-old baby expressed anguish about feeling no pleasure in her baby, but she quickly mobilized herself to pick up the child and feed him when he began to cry. This mother's depression interfered with her ability to be joyfully attuned to her baby, and she worried incessantly that she was hurting her child by not being a good mother. However, her capacity to recognize her baby's signals of distress and to respond to his basic need for food remained intact.

The baby, in turn, had a predominantly serious facial expression and often averted his gaze when the mother or the clinician tried to engage him. He seldom smiled spontaneously and had not yet acquired the delightful belly laughter so characteristic of this age. On the other hand, he responded promptly to his mother's and father's soothing when he cried. He also ate well and slept through the night, indicating good regulation of biological rhythms. His weight, height, and head circumference were appropriate for his age.

The first step in the intervention consisted of using emotional support and developmental guidance to help the mother become more conscious of her appropriate responses to her crying baby and of his ability to be soothed by her care. This approach proved clinically helpful in strengthening the mother's self-esteem and gave her hope that she could gradually expand her responsiveness to him. As treatment progressed, the therapist guided the mother's attention to her inner experience in response to the baby's different expressions of emotion. The mother reported that whenever the baby became happily excited, she cringed with fear that he would quickly revert to being serious and withdrawn if she could not sustain his enthusiasm due to her depression. The therapist guided her in experimenting with smiling and laughing in response to the baby's enthusiasm. As she did so, the mother found that, contrary to her fears, the baby did not escalate his excitement beyond her capacity to tolerate it. This realization allowed her to respond to an increasingly broad range of her baby's signals. The baby became more expressive, vocalizing loudly and using movement and facial expressions to signal his moods and wishes. The mother's mood brightened in response and she was no longer depressed by the time treatment ended when the baby

was 8 months old. In this example, the mother's motivation to get better, the baby's responsiveness, and the availability of effective intervention acted synergistically to bring about a successful outcome in the course of a few months of treatment.

Parents and mental health professionals often recognize a perturbation primarily in retrospect, once it has been resolved. Prediction is imprecise at best, and the parents may be so absorbed in the strong emotions of the moment that they find it difficult to maintain a long-term perspective while the perturbation is going on. Knowing about the emotional strains inherent in normative child development allows parents some objectivity as they struggle with the intense affect and self-questioning that can accompany developmental perturbations. Developmental guidance enables the parents to differentiate between normative stresses and the areas of conflict that brought them into treatment. The capacity to distinguish between expectable developmental perturbations and areas of persistent conflict improves the parents' ability to successfully address the perturbation.

It is always difficult to determine whether unsettling states of mind and troubling behaviors are temporary aberrations or persistent problems. In a groundbreaking longitudinal study demonstrating the importance of contextual factors in guiding the course of development, Sameroff and his colleagues found that infants' individual functioning in the first year of life was not predictive of their cognitive or mental health functioning at age 4. When these investigators assessed the relationship between individual infant functioning and the quality of the environment, they found that highly competent infants living in high-risk environments had worse scores at age 4 than did low-competent infants living in low-risk environments. The findings are noteworthy because the measures of individual functioning included 13 robust indicators of early competence between birth and 14 months, including the infant's perinatal physical condition, mental and psychomotor development indices on the Bayley Scales of Infant Development at 4 and 12 months, and observations of infant temperament and response to stress. The findings led the authors to conclude that focusing on environmental risk is more useful than focusing on the child's individual characteristics in predicting the course of an infant's cognitive and emotional development (Sameroff, Bartko, Baldwin, Baldwin, & Seifer, 1998). At the same time, individual characteristics help determine how children respond to the environment and how the environment responds to them. Developmental outcome is best understood as the product of the continuous dynamic and interdependent transactions between the child and the environment (Sameroff, 1983; Sameroff & Fiese, 2000).

This point of view has important implications for intervention because it shifts the therapeutic focus of attention from attempts to change the individual child to identifying and addressing the environmental factors that impinge negatively on the child and enhancing the conditions that have a beneficial influence on development.

How is this done? Enlisting the parents' collaboration is key. Relationship-based treatment is particularly adept at adopting the vocabulary most likely to engage the parents on behalf of the child. Talented clinicians often display marvelous versatility in describing the child's or family's predicament by using the particular terms that best suit the parent's sensibility, even when this vocabulary does not reflect the clinician's own preferred theoretical framework. For example, clinicians working within a psychodynamic paradigm may find themselves using concepts derived from temperament research to describe the mismatch between an infant and a parent's emotional styles when this terminology is the most compatible with the parent's perspective. Clinicians with a cognitive-behavioral or social learning theoretical orientation may couch their interventions in psychodynamic language when this is more congruent with a parent's style. Perhaps the current prevalence of theory-neutral terms such as "affect regulation" and "sensory processing" is rooted in a cultural *zeitgeist* that favors psychological explanations based on brain architecture and function rather than internal experience. In response, CPP is organized around the meanings that parents and children give to their experiences and incorporates intervention strategies rooted in a variety of theoretical approaches.

Developmental Transitions and the Child–Parent Relationship

Perturbations are often ushered in by the child's maturational timetable because the effort to master a developmental milestone is typically accompanied by increased irritability and unpredictable fluctuations between the child's demands for autonomy and need for parental assistance. In the first months of life, frequent crying, night wakings, feeding difficulties, and other manifestations of neurological immaturity may be mistaken as evidence of the child's difficult temperament. During the toddler and preschool years, issues of socialization and discipline become preeminent as parents and child confront the questions of "who, when, and how" in relation to mobility, toilet training, sexual curiosity, sharing, and the myriad day-to-day negotiations regarding what is allowed and what is forbidden. These constant struggles trigger bouts of negativism and temper tantrums in the child and, not infrequently, in the parents as well. If the parents blame the child in any way, they may respond with anger, withdrawal, and punitive attempts at discipline

that backfire because they are not geared to the child's developmental needs. Unwanted child behaviors can become entrenched when the parent unilaterally tries to banish them. For example, thumb sucking, using transitional objects such as pacifiers or a security blanket, and touching the genitals in social situations offer comfort and are generally temporary unless they reflect more entrenched difficulties or set the stage for a power struggle between parent and child.

Perturbations of Psychobiological Rhythms

In the first months of life, the child is acquiring regular cycles of sleeping, eating, and elimination. The physiological arousal associated with these processes may result in unexplained early crying (also known as colic), described as the heightened crying demonstrated by many healthy babies in the window of time between 4 weeks and about 4 months of life. The scientific debate about the causes of early crying and effective ways of alleviating it remains unresolved, but there is consensus that it can lead to heightened parental distress, lasting parental perceptions of the infant as vulnerable, and, in extreme cases, harmful parental responses and child abuse (St. James-Roberts, 2001).

Heightened early crying is a good example of a developmental "touchpoint" because it can either be a source of temporary stress that is resolved without lasting sequelae or it can lead to a persistent perturbation in the child–parent relationship. Cross-cultural evidence shows that many healthy and well-developing babies engage in persistent and inconsolable crying in the first 3 months of life and that this behavior tends to peak toward the later afternoon. Efforts to understand the causes for this universal early peak in crying, while still inconclusive, have yielded a variety of explanations that include evolutionary and neurophysiological hypotheses regarding its survival function. There are also strong cultural influences on how intense early crying is interpreted by parents. For example, middle-class parents in industrialized Western countries tend to find it aversive, whereas impoverished mothers in Northern Brazil interpret it as a manifestation of the baby's robustness and self-assertion (Scheper-Hughes, 1993). The early peak in crying is associated with "the crying paradox," meaning that depending on the parental and social context, the baby's crying can elicit solicitous care or may bring about repeated visits to health providers and even become the immediate trigger for shaken baby syndrome and other forms of child abuse (Barr, 2001). The same individual child behavior acquires different meaning depending on its context.

Maternal perceptions are an important ingredient in activating one or another outcome in the range of possibilities. Longitudinal studies with community samples indicate that mothers of "early high criers" do

not differ from other mothers in caregiving sensitivity and their babies do not differ in quality of attachment and other measures in the second year of life (Stifter, 2001). On the other hand, studies with clinical samples indicate that inconsolable crying may trigger in the parents acute stress, feelings of helplessness, aggressive fantasies, and guilt. Compared to community controls, infants referred to a fussy baby clinic were more likely to show behavior problems as toddlers in spite of early treatment that was deemed successful at the time (Papousek & Papousek, 1990). It is possible that these highly reactive infants had constitutional vulnerabilities that emerged in other areas as they became toddlers and their parents felt unequipped for the new caregiving challenges facing them. These findings highlight the importance of not focusing interventions narrowly on a discrete behavior.

Maternal self-efficacy is an important predictor of outcome. Mothers can acquire learned helplessness in relation to their difficult-to-soothe babies. When a mother feels that she has failed to respond adequately to her baby's crying, her later responses will be negatively affected by this perception. This sequence was demonstrated in a study where maternal expectations of success or failure were manipulated in a laboratory task in order to study the impact of these expectations on subsequent behavior. Mothers were asked to press a series of buttons to stop a tape-recorded baby's cry. Conditions were set to make it either very easy, difficult, or nearly impossible to succeed. Mothers who were first exposed to the "nearly impossible" condition were less successful when they were later exposed to the easy condition. The perceptions based on their initial performance affected their later capacity to respond. On the other hand, this expectation of failure disappeared when the mothers were told that success in the first condition was unrelated to success in the next condition. When the mothers were encouraged to expect success in the second session, they were considerably more effective in spite of their failure in the first session (Donovan & Leavitt, 1985). Maternal effectiveness in alleviating the baby's crying easily becomes a litmus test for self-perception and social judgments regarding the mother's skills. These findings highlight the centrality of attending to parental motivation as an intrinsic component of efforts to change behavior.

Dymphna van den Boom designed an intervention offering low-socioeconomic status (SES) mothers individualized help with their irritable babies. The intervention focused on mother–child interaction and consisted of one 2-hour home visit every 3 weeks during a 3 month period. The intervention began when the babies were 6 months old, past the age when excessive crying is likely to abate spontaneously or when self-sufficient mothers have found their own distinctive ways of handling it. Babies and mothers in the intervention group showed posi-

tive outcomes in individual behavior and in child–mother interaction at the end of the intervention when the babies were 9 months old and on follow-up when the babies were in their second and third year (van den Boom, 1994, 1995).

This study shows that individually tailored developmental guidance can improve child and parent functioning even when the difficulties are not within the clinical range. Mothers in van den Boom's study did not ask for help with their babies but accepted it when it was offered and used it effectively. Long-lasting beneficial results were obtained by intervening during a window of time when the type of intervention and the child behaviors targeted for change were well matched with the mothers' motivation to make use of treatment. This process has important policy implications. A society that cares for its own long-term well-being should attend to its future citizens by providing parents with support in raising their children before there is a critical need for clinical intervention.

Pediatric care providers play a key role in early identification and referral because they monitor the baby's health and adequate development in the first years of life. They can be effective early interveners in alleviating perturbations and guiding parents toward effective childrearing practices. They can also use their professional credibility to make early mental health referrals when the difficulties do not remit with the interventions offered in the pediatric setting. The following case example illustrates the key role that primary health providers play in early identification and referral when the convergence of risk factors sets the stage for a negative outcome for the baby.

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 that gave his parents clear pleasure. He was very sensitive to sound, slept lightly, and startled easily. He had sustained periods of fussiness 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 "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 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 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 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 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).

Conflicts over Self-Regulation

Parents and their children start to communicate with each other from the moment they first meet, and many of these communications involve queries about who is expected to do what in their relationship. The answers are provided in the moment-to-moment transactions during daily routines such feeding, sleeping, soothing, and toileting as well as in the realms of protection from danger, intimacy, and expression of affection, socialization, discipline, exploration, and play. Perhaps the most pointed disagreements among people who care about raising children well—including parents, teachers, clinicians, and child development experts—involve the optimal balance between protecting the child from distress and allowing the child to endure frustration in order to promote coping capacities. There is a broad range of opinion regarding such questions as the following: Should a small child ever be allowed to cry herself to sleep, and if so, at what age? How should one respond when a child is showing distress, anger, or frustration at not being able to master a skill? At what age can a child be spoiled by too much attention or indulgence? What is the appropriate way of managing a tantrum, and how does this response change with the child's age? What are appropriate distractions and redirections when the parents need a respite?

The underlying theme in all these questions is the issue of how best to promote self-regulation within a culturally and developmentally appropriate context. High levels of unregulated arousal interfere with adequate functioning in key domains, including self-care, the ability to form and maintain satisfying relationships, and readiness to learn. Although newborns are almost completely dependent on the mother for the regulation of their biopsychological processes, they are active partners from the very beginning through gazing, closing the eyes, head turning, thumb sucking, arching, snuggling, and many other behaviors that elicit or shut off stimulation. As babies mature, they are increasingly self-assertive in synchronizing biological rhythms and guiding the maternal behaviors that minimize negative affect and maximize positive affect (Schore, 2003). This mutual attunement of mother and baby is

the essential substrate in the development of attachment. The mother's contingent responsiveness predicts the child's secure attachment and competence in age-appropriate developmental tasks, suggesting that attachment can be understood as the dyadic regulation of emotion (Sroufe, 1996).

Struggles over autonomy often reflect a mismatch between the child's and the parent's agendas about self-regulation. Parents might believe that they need to direct the child's development by deciding what and how much the child should eat, when and how long the child should sleep, the timing of toilet training, and what responses to expect from the child in a variety of situations. The child, on the other hand, may have a different subjective appraisal of what feels safe and comfortable and may respond to unilateral parental directives with refusal, noncompliance, or emotional withdrawal.

Mismatches and misattunements are normative in parent–child interactions (as in all other intimate relationships), and the repair of miscommunications is an integral component of growth-promoting relationships. The absence of miscommunication may actually suggest that something is going awry in the developmental process. Very high mutual coordination between mother and baby as they vocalize with each other is an early indicator of risk for disorganized attachment, perhaps because it signals vigilance, overmonitoring, wariness, and an excessive effort to please as a way of counteracting these concerns. Very low coordination is also a predictor of anxious attachment, suggesting that a rigid adherence to one extreme of mutual coordination or the other bodes ill for the kind of reciprocity that underscores safe intimacy between child and mother. In contrast, midrange coordination predicts secure attachment, most likely because it indicates flexibility and ease in tuning in and out of the interaction in response to a variety of factors. The value of midrange levels of maternal responsiveness in predicting better child outcomes suggests that perturbations in the parent–child relationship may occur when parents are either disengaged or overinvolved with the child (Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2001).

There is a very broad range from disengagement to overinvolvement and from permissiveness to authoritarianism, and specific answers to the question of what constitutes the "golden mean" can vary greatly depending on the person's cultural background, personal values, and individual style, although there is general agreement that either extreme can hurt the child's competence. Parents are often told that they are the "experts on their child" and should follow their intuition, but this statement is of little value when the parent does not know the principles, norms, and timetable of child development and when the child's behavior feels like an enigma that is impossible to decode. Telling a befuddled

parent that he is an "expert" can feel to the parent like an additional stress when it represents one more indication of his inability to live up to the expectations of others. It is more useful to recommend a plan of action where the parent and the clinician can observe the child's behavior together, reflect on it, and try out possible solutions. This approach conveys to the parent the clinician's respect for the rich complexity of development and a sense of partnership in problem solving.

The example that follows illustrates intervention with a perturbation involving an autonomy struggle around feeding, one of the most common difficulties in infancy. It is estimated that approximately 25% of normally developing babies and 80% of infants with developmental handicaps have feeding problems, a phenomenon that is associated with later eating disorders, behavioral problems, and cognitive deficits (see Chatoor & Ganiban, 2004, and Maldonado-Duran & Barriguette, 2002, for reviews and two alternative theoretical formulations of this issue). Self-regulation in feeding is achieved in a developmentally predictable fashion as babies develop communication systems with their caregivers that enable them to experience, communicate, and respond to signals of hunger and satiation. This process moves from the dyadic coordination of signals between infant and caregiver to the child's readiness to eat independently. Problems may occur at any stage of the process, either because the child's signals are weak or ambiguous, because the parents superimpose their own interpretations on the baby's signals as a result of their own preconceptions or conflicts over food, or because feeding becomes the domain in which broader conflicts are played out.

Example: Difficulties Feeding Amelia

The following example illustrates the treatment of a feeding perturbation between 10-month-old Amelia and her mother. The pediatric nurse practitioner referred them because the mother was force-feeding Amelia due to her fear that the child's food refusal would result in anemia. By the mother's report, the feeding struggles began 2 months earlier, when Amelia was weaned from the breast at 8 months of age. Since then, Amelia had lost interest in food, turning her face and pushing the spoon away when her mother tried to feed her. Although Amelia continued to gain weight and grow adequately, the conflict over food had become so intense that the child was now crying as soon as her mother started carrying her toward her high chair for a feeding.

Amelia was her parents' third child. The parents were a couple from a remote rural village in El Salvador who had immigrated to the United States 3 years earlier. Mr. and Mrs. Sanchez were in their early

30s and had two older children, a 12-year-old boy and a 10-year-old girl. Although the pregnancy with Amelia was unplanned, both parents considered it a gift from God and a sign of His approval of their migration to this country. Everybody called Amelia *la Yanquicita* (the little Yankee), particularly when she protested or was otherwise upset. Her strong signals of pleasure and displeasure were considered an American characteristic that contrasted with their cultural expectations that girls should be stoic and compliant. Although they felt sometimes challenged by Amelia's strong temperament, the parents were also amused by how different she was from their older children. The moniker *la Yanquicita* reflected their sense that Amelia belonged in the country of her birth in a way that neither the parents nor the older children could hope to. This seemed to give them both pride and some emotional distance from her, as if she were a bit of a foreigner in their eyes but also a bridge to their new country.

Pregnancy and childbirth had been normal and uneventful. The delivery had taken place at a local hospital with a high percentage of Central American patients. Mrs. Sanchez reported that she had received excellent medical care, although she missed the midwife who had delivered her older children in her Salvadoran village. Amelia had been a healthy baby who ate well, slept well, and fit in smoothly with the family routines. Her crying was described by her parents as "energetic" but easy to understand. When Amelia continued crying in spite of her mother's ministrations, Mrs. Sanchez offered the breast, which became the primary way of soothing.

Mr. Sanchez had a steady job in construction, and Mrs. Sanchez had returned to her part-time job as a waitress when Amelia was 4 months old. While the mother worked, Amelia was left in the care of the next-door neighbor, an older woman who also cared for her own 3-year-old grandson. The parents were pleased with this child care arrangement because they trusted their neighbor and had a social relationship with her. Amelia had known this woman from family visits before she started staying with her for a few hours at a time, and the parents did not notice any pronounced changes during transitions. In their view, things were going well with their family although the possibility of deportation due to their undocumented status was a constant source of anxiety.

The First Home Visit

During the first home visit, the parents greeted the clinician politely, but after some awkward exchanges they professed surprise at the pediatric nurse practitioner's referral because they did not see anything wrong with the way they fed their daughter. Mrs. Sanchez reported that when

asked about Amelia's feeding routine during a well-baby visit, she explained that Amelia did not eat well and for this reason the mother held her face with one hand while pushing food in her mouth with the other. Amelia's efforts to fight back were not particularly distressing to Mrs. Sanchez because she believed that it was much more important to keep Amelia well nourished than to give in to the child's lack of interest in food. Both parents spoke with much feeling about the high infant mortality rate in their village. They were clearly determined to make sure that their children would be healthy and strong.

At this point, the clinician was faced with a dilemma because of the contrast between the concerns expressed by the pediatric nurse practitioner and the parents' conviction that the feeding struggles were a minor nuisance relative to the danger of malnourishment and anemia if Amelia refused to eat. The parents' point of view was understandable given the pervasiveness of malnutrition in their home country and their firsthand knowledge of children who died in infancy. Mr. and Mrs. Sanchez were experienced parents who had already raised two children successfully. If the clinician tried to persuade them that Amelia was growing well and in no immediate danger of developing anemia, she risked losing her credibility by being perceived as someone who failed to grasp the importance of appropriate early nutrition. Compounding the divergence of perspectives was the fact that Mr. and Mrs. Sanchez strongly believed that "parents know best" and should set clear directions for their children. Their culturally appropriate emphasis on the primacy of parental authority contrasted with the prevailing professional *zeitgeist* in the United States that babies develop better when their parents are responsive to their signals and follow their lead.

The initial home visit observations made clear to the clinician that Mr. and Mrs. Sanchez were caring, competent parents with well-defined ideas about how to raise their children. The older children could not be observed because they were at school, but Amelia was a healthy baby who crawled, babbled expressively, and showed a range of appropriate emotions—from initial wariness and social referencing with the mother when the clinician first arrived to chortles of delight when her father bounced her on his knees after she became restless. At the same time, Amelia repeatedly hit her mother's face and chest without apparent reason while she sat on the mother's lap. As she spoke to the parents, the clinician found herself divided between her professional loyalty to the pediatric nurse practitioner who had made the referral, her own conviction that forcing food can have damaging repercussions for a child and might explain Amelia's out-of-context hitting of her mother, and intense sympathy for these caring and hard-working parents as well as a wish to please them by agreeing with their point of view. An immigrant herself

from a Spanish-speaking country, the clinician was nevertheless taken by surprise by her unexpectedly strong identification with the parents and her reluctance to address directly the question of Amelia's feedings.

Searching for a Port of Entry

In an effort to reconcile these conflicting internal responses, the clinician decided to buy herself some time by postponing a decision about how to focus on the feeding situation. She searched instead for ports of entry that would create areas of commonality with the parents and help to establish her legitimacy as an intervener. She engaged the parents in lighthearted conversation about the differences between the United States and Latin countries, highlighting the commonalities that immigrants share in adjusting to a new country. This conversation led to Amelia's status as the only American citizen in the family and to the changes occasioned by her birth. Remembering that Amelia's lack of interest in food had begun with weaning, the clinician asked how the mother had decided that it was time to discontinue breastfeeding. Mrs. Sanchez answered that her breast milk had been steadily diminishing since she returned to work. Amelia had become irritable, a behavior that the mother interpreted as signaling that the child was hungry and that it was time to increase the amount of solid food. Mrs. Sanchez was surprised when Amelia did not take well to this change and refused solids instead of welcoming them, but both parents thought it was just a matter of time until the child got used to the new diet. In the meantime, they saw no other alternative but to force her to eat.

The pediatric nurse practitioner had explicitly objected to this practice, so that the parents' statement to the clinician that they intended to continue forceful feeding was a covert challenge. In a politely indirect way, they were telling the clinician that they were the parents, knew what they were doing, and intended to continue with their routines. Rather than addressing their statement directly, the clinician asked if the older children had been weaned the same way. The mother responded that she had breastfed the older children until they were older because they grew up in El Salvador and she did not need to go far from them in the course of her daily work.

This reminiscence led to a wistful conversation in which the parents spoke at some length about the differences between daily life in an American city and the slower pace of a rural Salvadoran village. The clinician commented: "Some things are harder here and some things are harder there. In the United States there is more money, but in our countries there is more time for the family." Both parents nodded in agreement, and the mood became sadder but more relaxed as the con-

asked about Amelia's feeding routine during a well-baby visit, she explained that Amelia did not eat well and for this reason the mother held her face with one hand while pushing food in her mouth with the other. Amelia's efforts to fight back were not particularly distressing to Mrs. Sanchez because she believed that it was much more important to keep Amelia well nourished than to give in to the child's lack of interest in food. Both parents spoke with much feeling about the high infant mortality rate in their village. They were clearly determined to make sure that their children would be healthy and strong.

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versation turned for a while to the daily routines left behind and the difficulties of adjusting to life in this country. After a silence, the clinician went back to the topic of weaning by asking: "How did Amelia respond when you decided to wean her?" The mother said laughingly: "She screamed! She hit my breast and she tried to lift my blouse all the time. She threw her bottle on the floor." Both the mother and the father then took turns describing specific ways in which Amanda had shown her displeasure, including sleep disturbances and increased irritability during the day. The child looked soberly at the adults as they talked, while her mother absentmindedly caressed her hair or rubbed her back. Turning to Amelia, the clinician said with a lot of feeling: "You missed your mommy's milk. There is nothing that tastes so good. No wonder you don't want to eat anything else." There was a silence, as if the parents were surprised by the possibility that Amelia had indeed felt that way. The clinician then found herself confident enough to articulate her wish to find a bridge that would enable the pediatric nurse practitioner and the parents to understand each other better. She said: "You know, I can see how well Amelia is doing and how much you know about raising children. The nurse cannot come on home visits and she does not know about ways of raising children in our countries. I would like to get to know you better so that I can explain to her how you see things and tell you how she sees things so that there isn't tension between you when you go for your appointments. Can I ask permission to come next week and watch Amelia while she eats?" The parents agreed that the clinician could return the following week in time for Amelia's lunch.

The Outcome

When the clinician arrived the next week, the struggle over food between Amelia and her mother had already started. Mrs. Sanchez was trying to feed Amelia small pieces of chicken, and the child spat them as soon as the mother put them in her mouth. After watching quietly for a while as the tension between mother and child increased, the clinician said: "I can see how strong minded she is and how worried you are that she is not going to grow well if she doesn't eat." The mother sighed in frustration. She seemed tired and humiliated. She offered Amelia a baby cup with milk, which the child held by the handle and drank from readily. The clinician said: "She is so good already at holding her cup and drinking by herself.... " The mother nodded, but she was clearly more interested in having Amelia eat the chicken than drink the milk. The clinician added: "You know how you call her *la Yanquicita* because she seems more American than Salvadoran? Maybe I can give you an idea. American children really like to do things on their own, even when they

are still babies. Amelia is using that cup really well to drink her milk. It is hard for parents like us that children want to be so independent, but do you think maybe Amelia will fight you less if she can feed herself?" The mother replied that Amelia would not eat solids at all if left to her own devices. The clinician said: "I was watching her last week and I saw how much she likes to use her hands and her mouth. She was picking up those plastic cubes and bringing them to her mouth, remember? Maybe if you give her some sweet but healthy food that she can pick up, like grapes and pieces of banana, she will start eating them." Mrs. Sanchez commented that Amelia ate in the evenings when her brother fed her because he teased her by pretending to eat her food himself and then put it in her hand when she reached for it. She then put it in her mouth. Mother and clinician laughed at this description, and the clinician then asked what Mrs. Sanchez thought of that. She said: "He is a child, so he can do it. I am her mother and she should respect me." The clinician answered: "I agree with you. I think she wants to respect you, but she is still having a hard time missing your breast milk. Some children take weaning hard, and I think Amelia is one of them."

In the next session, Mrs. Sanchez greeted the clinician with a shy smile, saying: "I think she heard you. She started eating." Surprised, the clinician asked, "What do you think happened?" The mother said: "I thought of what you said that she missed my milk. Maybe I weaned her too fast and she got mad at me. She eats for my son and for my neighbor, so maybe the problem is with me." The clinician said softly: "You are the one she loves the most." The mother said: "I get mad at her that she is so stubborn. But then I decided to try what you said. I let her get really hungry, and then I put some banana and grapes and some boiled chicken on her tray and I did not even look at her, I pretended to be doing something else, and she started eating all by herself."

As the mother and the clinician talked, it was impressive to witness the insight that this mother with a third-grade education had into herself and her child. The pressure of her circumstances had misled Mrs. Sanchez into implementing an abrupt weaning process that disrupted the baby's age-appropriate association of well-being with her mother's milk and made her reject the food substitutes she was offered. Mrs. Sanchez had misinterpreted Amelia's responses of distress when she returned to work as an indication that the child was hungry and needed more solid food and ignored Amelia's urgent pleas—by hitting the breast, pulling the mother's blouse up, and refusing the bottle—to restore the lost intimacy of nursing as both a form of feeding and a strategy for soothing. In effect, Amelia had experienced a double loss: first, the uninterrupted maternal care that she had before Mrs. Sanchez returned to work, and then the weaning that followed soon afterward. Mrs. Sanchez had failed to recognize the meaning of both of these emotional stresses for the

child when they were happening, but the clinician's empathic naming of Amelia's sense of loss was sufficient to change the mother's inner stance from an authoritarian expectation of compliance to an understanding of the child's plight. She now felt wanted and missed rather than defied. This internal shift allowed Mrs. Sanchez to move rather quickly from denying that she cared about the power struggle with her daughter to a thoughtful acknowledgement that Amelia was angry at her. This inner shift allowed her to give Amelia the autonomy that the child now needed to feed herself.

From a psychoanalytic perspective, we can hypothesize that the failure of Mrs. Sanchez to recognize that Amelia's distress was a response to separation and to weaning, particularly in light of her extensive experience as a mother, might have been due to her ambivalent feelings toward this unplanned baby. We can also surmise that the mother's aggression found expression both in the forced feedings and in her perception of the baby as a "Yankee"—a term with distinct derogatory overtones in Latin America. The fact that the feeding perturbation was resolved without addressing its possible psychodynamic structure suggests that Mrs. Sanchez's loving commitment to Amelia significantly outweighed whatever anger she harbored toward her.

The cultural component of this intervention was an important element of its success. The clinician defused the tension created by the parents' feeling that the referral was unnecessary by openly affirming the parents' competence and authority. She then tried to make Amelia's striving for autonomy more acceptable to the parents by linking it to their perceptions of the child as "a little Yankee" who partook of the assertiveness and valuing of independence they attributed to this country. The clinician never took issue with the mother' feeding practices but suggested instead an alternative approach that incorporated what she had learned about the parents' values and point of view. This approach proved effective. In three sessions, the child's food refusal was largely resolved, as confirmed in follow-up telephone calls 1 month and 2 months later.

Expectable Anxieties of the Early Years

Along with the epigenetic development of progressively more advanced capacities to act, think, and feel, children also experience a parallel unfolding of developmentally expectable anxieties. As described in Chapter 1, the primordial anxieties consist of fear of abandonment, fear of losing the parents' love, fear of body damage, and fear of being bad (Freud, 1926/1959c). While emerging sequentially in the first 4 years of life, these four anxieties usually overlap. Each of them takes center

stage for a while before receding to the background as the child acquires adaptive coping mechanisms to manage it. All of these anxieties are also present forever, emerging throughout the person's lifetime in response to internally triggered vulnerabilities and external stresses and traumas.

Each of the anxieties signals a new stage in the child's ability to understand danger and to appreciate the role of emotions in governing human relationships. The transition from fear of abandonment (manifested in separation anxiety) to fear of losing the parent's love (manifested in fear of disapproval) indicates that the child is moving from concrete reliance on the parent's physical presence as the agent of protection and source of safety to an increased appreciation of psychological reciprocity. The child now knows that what he does and feels has an effect on what the parent feels and does, and an enormous amount of effort is deployed in trying to understand how this connection works. Toddlers have a rudimentary grasp of causality, and they consider themselves the prime movers of their universe, in a self-oriented cognitive frame of mind that Piaget famously described as "egocentric" (Piaget, 1959). Toddlers and preschoolers routinely attribute causality to juxtapositions of events that are not logically related but have meaning for them, and this meaning is often a reflection of their fears. For example, a 3-year-old boy who was the last child left in his day care center when his mother came to pick him up said to her: "I thought you forgot me." Another 3-year-old whose father was rushing around in a frenzy trying to get to work on time asked his mother: "Is daddy angry with me?" Parental behavior has such momentous import to small children that they cannot fathom its being influenced by any other reason than themselves.

The fear of losing the parent's love may be rooted in the young child's difficulty understanding that contradictory emotions can be experienced simultaneously. Toddlers are not aware of their love for the parents when angry at them, as reflected in the famous "I hate you!" that is sooner or later uttered by most toddlers and dreaded by all parents. It is only natural that toddlers assume their parent feels the same way when angry at them. The capacity for ambivalence, in the form of sustaining love while feeling hate, is a laborious undertaking that can be achieved only with practice and steady parental assistance.

Fear of body damage is represented most starkly in psychoanalytic theory by the much-maligned although persistently useful concept of castration anxiety, but it goes much beyond this circumscribed meaning. We can say that "at the beginning, there is the body" because all the affective experiences of the preverbal infant have a somatic basis. The body conveys to the emerging mind of the infant essential messages regarding its most urgent needs as well as its states of well-being.

Joyce McDougall (1992) refers to the "intimate interpenetration of psyche and soma through the bridge of affect" (p. 432). This affective bridge provides the substrate for what will become a symbolic structure to represent the somatic self. Psychosomatic integrity is based on the mother's recognition and responsiveness to the baby's body-based affective experience, a process that becomes gradually internalized by the child and is expressed in autonomous self-regulation. Conversely, psychosomatic pathology is the result of major failures and distortions in this recognition–response affective process. McDougall points out that language vividly reveals the somatic roots of emotion, particularly through metaphors such as "feeling crushed by events," "torn with sorrow," "stifled with rage," "heartsick with disappointment," and "stabbed" or "burned" by treachery. Feelings of strong emotion are very frightening to the young child, who experiences viscerally what adults later put at some distance by transforming it into metaphors.

The normative fear of body damage is likely to gain intensity from at least four sources, each of which might become particularly salient depending on the child's individual experience but all of which contribute to the child's body experience both in its pleasures and in its fears. The first source is the overpowering nature of body sensations, graphically described by Erik Erikson (1950) as "the rages of teething, the tantrums of muscular and anal impotence, the failures of falling" (p. 79) but including also the gratification of pleasurable skin, oral, anal, and genital sensations. The second source is the small child's inability to understand the nature of such diverse and highly charged bodily phenomena as urine and feces coming out of the body and hair and nails being cut. The third source is the awareness of pain in the self and others through falls, cuts, illnesses, accidents, and the myriad assaults to body integrity in the course of everyday life, including seeing children and adults with handicaps of one kind or another. The fourth source is infantile sexuality, which includes the child's absorption in bodily sensations as well as the child's effort to make sense of such mysteries as why boys and girls have different genitalia, why the genitals of mothers and fathers are different from the child's, how babies come out of the mother's body, who puts them there in the first place, and whether children of both sexes can get pregnant and give birth.

All of these areas are colored by the child's sense of self as being good or bad, loved or unloved, accepted or rejected. How parents respond to the child's curiosity about the body and sexuality affects how children think of themselves, their freedom to explore, and their guilt and shame about what they think and feel. Attitudes toward the body are shaped in part by the overlap of the primordial anxieties about abandonment, loss of love, body damage, and being bad which

lead to the formation of conflicted and conflict-free areas of functioning (Hartmann, 1939).

The fear of being bad is also known as fear of losing self-esteem or fear of superego condemnation, and it signals the young child's progressive internalization of social standards of right and wrong in the form of an emerging moral conscience. Jerome Kagan (1981) has shown that 2-year-olds cry or become upset when they are unable to perform a difficult task if they believe that they are not meeting the expectations of an adult observer. Conversely, the same children show spontaneous joy when they meet a self-imposed standard, such as solving a difficult puzzle or building a six-block tower. Forming and maintaining a moral conscience is a protracted process, with many inconsistencies between self-image, expectations, and actual behavior. It is common to observe toddlers telling themselves "no!" or "bad!" while performing the very same action they are reproaching themselves for. Between 3 and 4 years of age, children begin to feel remorse not only for their actions but also for their feelings of aggression, which they believe make bad things happen. Children of this age blame themselves for events over which they have no control, including marital quarrels and parents' bad moods, illnesses, and even death. The magical quality of their reasoning leads them to attribute to their thoughts, feelings, and fantasies the power to become reality. This might be the origin of the fear of monsters, witches, and wild animals lurking in the dark of the child's room that is so prevalent during this developmental stage.

The anxieties of infancy and early childhood cannot be articulated in words but are enacted in behavior that may seem incomprehensible and irrational from the adults' point of view. The parents may misinterpret expressions of fear as manipulation, disobedience, or bad manners, and they may respond punitively in ways that perpetuate the unwanted behavior. The role of treatment providers is to translate the child's behavioral language into words so that the parent can understand the child's inner life and there can be better emotional communication between the child and the parents. The example that follows illustrates the treatment of a perturbation that originated in the overlap between the child's fear of body damage, fear of being bad, and maternal angry response to the child's behavior.

Example: Maysha and the Tiger

Maysha, age 3 years, 4 months, was brought to treatment by her parents at her day care teacher's suggestion because she had been waking up screaming several times during the night, insisting that there was a tiger

under her bed. Maysha had also become intensely afraid of the dark and was irritable, prone to crying, and aggressive with peers during the day. This behavior had started approximately 2 months earlier and it showed no signs of abating, although some days and nights were calmer than others. Maysha's mother and father were exhausted from lack of sleep, worried about their daughter's condition, and eager for help.

The Parents' Perception of the Problem

The initial session took place with the parents alone in order to learn about the parents' perception of the situation, Maysha's developmental history, the parents' functioning and background, and the family's circumstances. Mr. and Mrs. Lester were a middle-class, college-educated African American couple in their late 20s. Both of them worked in white-collar occupations and were reasonably satisfied with their jobs, their financial situation, and their marriage. They had been married for 5 years and had fallen in love "at first sight" when they met at a church function. Mrs. Lester reported laughingly that their grandmothers had known each other since childhood and had always wanted them to meet, but they had wanted to find their own soulmates without family interference and declined their respective grandmothers' urgings to go on a blind date together. Both parents were clearly pleased by the unexpected success of their grandmothers' plans. The pregnancy had been planned and welcomed. Maysha was the first grandchild on both sides of the family, and the Lesters reported feeling blessed by the amount of support that they had in raising their child. Maysha had been attending the same neighborhood day care center since she was 6 months old and the mother had returned to work. They reported no developmental or behavioral difficulties until the problem that had brought them in for treatment.

When asked about their perceptions of Maysha's behavior, the tone of the exchanges became noticeably awkward, and each parent urged the other to take the lead. Sensing their discomfort, the clinician sought to reassure them by explaining that preschoolers often show the kind of behavior that Maysha was displaying, and added lightly that parents seldom found this reassuring because it is so hard to live with a child who woke up at night, was afraid of wild animals that did not exist, and was aggressive at school. The parents looked relieved, and the clinician went on to ask how they had already tried to change Maysha's behavior. They reported the usual range of behaviors that well-meaning parents usually employ in similar circumstances: saying a prayer before going to bed, asking Jesus to protect her, looking under Maysha's bed and in her closet to show her that there was no tiger lurking in her room, leaving

a night light on in the hallway next to her room, and talking to her reassuringly from their bedroom when she woke up during the night. When none of this helped, one of the parents came into her room for a few minutes, spoke reassuringly while patting her, and told her to go back to sleep. They then let her cry herself to sleep.

This set of strategies seemed like a textbook description of how to intervene, and when the clinician commented on this, the mother reported that she was an avid reader of childrearing books and had "done her homework" in trying to help Maysha during this difficult period. Nothing seemed to work, however, and the parents felt they needed outside help because they were beginning to worry that there was something really wrong with their child.

When the clinician asked what "really wrong" might mean, the earlier awkwardness returned. There was a long silence. The clinician asked if they worried that someone had hurt Maysha. The mother said, reluctantly: "Well, you hear so much about children being sexually abused in day care. There is a male teacher, and although he seems really nice, you never know." The clinician asked if they had seen anything inappropriate in the teacher's behavior, and both parents said they had not. The children at the day care center seemed to like him and the parents could detect no difference in the ways Maysha spoke about him and about the female teacher when she came home from school.

Maysha's Concerns

The next session involved Maysha and both parents and took place in the office playroom. Maysha was a dainty little girl, dressed in a velvety pink sweater with hearts and wearing glittery pink shoes. The clinician had provided a range of age-appropriate toys that included African American mother, father, and daughter dolls; a baby doll with a bottle; a furnished doll house; a kitchen set; and a set of farm animals and wild animals. She told Maysha that her mom and dad had brought her because the clinician was a lady who helped children when they were scared and angry, and Maysha's parents had told her that Maysha was afraid of a tiger under her bed, could not sleep at night, and was angry with her friends at day care.

While seeming to ignore the clinician's explanation, Maysha was busy examining each of the toys and then carefully putting them back in their place before examining the next one. She then sat on the floor, sighed, and looked at her mother as if asking: "What next?" The same question seemed to be in everyone's mind, because the parents looked at the clinician in a silent search for guidance. The clinician sat on the floor facing Maysha and said: "You can do whatever you want here. All these things are here for you."

Without saying a word (she had not spoken since she had first come in), Maysha looked around and then, without hesitation, went to the baby doll, looked at it, and started undressing it. When she got to the underwear, she struggled with it briefly and then gave it to her mother, saying: "Take it off." Mrs. Lester complied. Maysha looked intently at the doll's genital area, which was indistinctive, and after some hesitation fingered it gingerly. She then said to her mother, very seriously: "Put her clothes on." She had clearly thought of the doll as female, but it was unclear whether this was because she attributed her own sex to the doll or because of the absence of male genitals. Maysha watched soberly as her mother dressed the doll, went to the family of dolls, and systematically undressed each of them, looking intently in their genital area. The clinician said: "I think you are trying to see the difference between girls and boys." Maysha nodded in agreement without looking up and continued manipulating the dolls. The clinician continued: "Maybe you saw boys and girls peeing and pooping in your school." Maysha nodded again, this time looking at the clinician, who said: "They are very different, aren't they? Boys and girls don't look the same where they pee."

The parents were listening attentively and exchanging glances with each other. The clinician said: "Your mom and dad did not know that you want to find out about boys and girls." Taking this cue, the mother said a little awkwardly but with much clarity: "These dolls are just pretend. They are not made like boys and girls. Boys have penises and girls have vaginas." Perking up, Maysha asked: "Do I have a penis?" The mother answered that she did not have a penis because she was not a boy, but she had a vagina because she was a girl. Maysha hit the mother's arm and said grumpily: "But I want a penis!"

This response took everyone by surprise. Mrs. Lester later told the clinician that, on the basis of her reading, she had expected questions about sex differences to emerge at some point. She had been preparing herself to answer questions about who had a penis and who had a vagina, but she was totally taken aback by Maysha's circumventing of this plan with her plaintive disagreement with how things were. In the silence that followed, Maysha looked around the room, took the giraffe from among the wild animal set, and put it between her legs. "I have a penis!," she announced.

The parents looked pained and worried. The clinician said: "You can play that you have a penis. Penises don't come off like that giraffe. Girls never have real penises and boys never have real vaginas, but they can pretend that they do." Maysha jumped all around the room holding the giraffe in place and saying: "I have a penis, I have a penis!" She then stopped in front of her father and said: "Do you have a penis?" Mr. Lester answered "Uh-uh." Maysha said: "Can I see it?" Mrs. Lester

came to her husband's rescue, saying: "No, sweetie, that is private." Maysha put the giraffe down, sat on the floor, and started trying to dress the dolls, asking her mother for help. At the end of the session, on saying goodbye, the clinician said to Maysha: "You learned something really important today. You can ask your mom and dad for help to remember it." She then suggested that the parents call her to discuss over the phone what had transpired.

During the telephone conversation, the mother expressed amazement at Maysha's clear distress over not having a penis. She said that the parents had tried to pursue the topic of sex differences on the way home, but Maysha was not interested. The clinician suggested that Maysha might have had enough of the topic for the time being, and that she might bring it up again spontaneously when she was ready. In the meantime, the parents could observe her behavior to see what they could learn from it.

Before the following session, Mrs. Lester called to inform the clinician that in the intervening week Maysha had insisted on watching when her father went to the bathroom, something that was against the parents' values and he refused to allow. The clinician supported this stance, explaining that there were different ways of teaching children about sex differences and that it was important to do it in a way that felt right to the parents. The mother also reported that Maysha had continued to place small objects between her legs and declaring that she had a penis. At school, she had asked her friend Joshua if she could look at his penis when he peed, causing much embarrassment to Joshua and some hilarity in the children who heard her request. The teacher took this opportunity to tell the class matter-of-factly about the differences between boys and girls, an explanation that was followed by the expectable series of questions about who had a penis and who had a vagina. Maysha did not participate but listened silently to this exchange.

For the next session, the clinician provided two anatomically correct dolls, a boy and a girl. When Maysha arrived, she went immediately to them and proceeded to undress them. She put the two naked dolls side by side, and looked systematically from one to the other. She said to her mother: "Why doesn't she have a penis?," pointing to the female doll. "Because she is a girl," said the mother. "Girls have vaginas so that babies can grow inside them when they are ready to be mommies." Maysha answered decisively: "Boys can have babies too growing inside them." The mother answered: "No, they can't. If they have a penis, they can't have babies inside them because they don't have room." Maysha asked: "Will I have room?" The mother answered: "Yes, you will. You are made inside so that there will be room for a baby when you grow up." The mother then spontaneously took a pen from her purse, asked

the clinician for some paper, and drew a boy and girl with the appropriate genitals. She then sang Fred Rogers's song about "girls are fancy on the inside, boys are fancy on the outside," which she had learned while growing up.

The Outcome

After this session, Maysha's behavior took a dramatic turn for the better. Her fear of the tiger diminished to the point that a cursory look under the bed was now enough to satisfy her that it wasn't there. She continued waking up once or twice during the night but went back to sleep by herself with minimal parental intervention. Her aggression in school declined markedly. She continued showing interest in pregnancy and in sex differences, but she no longer tried to go into the bathroom with her father and did not ask Joshua to watch him when he went to the bathroom. In follow-up telephone calls the next week and in the following 2 months, the mother reported that Maysha often had her hands on her genitals and looked dreamy while riding in the car, watching TV, or being told a story, and she liked to soap herself thoroughly between her legs when taking a bath. Occasionally she put a small object next to her vulva and tried to urinate standing up, but disliked having urine running down her leg and quickly sat down again. A few times she hid a doll under her shirt and said to her mother: "I am having a baby." These behaviors were taken in stride by the parents as a manifestation of Maysha's ongoing effort to learn about the sensations and possibilities associated with being a girl.

The parents' support during this process was pivotal in the resolution of the child's perturbation. The anticipatory reading that the mother had done about children's discovery of sex differences had helped her to answer Maysha's questions appropriately during the initial session. It was particularly noteworthy that she was able to use the adult words for the male and female genitals rather than resorting to colloquialisms, something that she attributed to the books that she read. In spite of this excellent preparation, the mother needed some help in retaining her flexibility and emotional balance to cope with the child's unexpected initial rejection of her gender status. Maysha's disappointment about not having a penis could well have become more persistent with a less supportive response from her parents and her teacher. The father's firm stance in preserving his privacy according to his values conveyed to Maysha a clear message about what was appropriate and was not appropriate in her family. The mother's drawing of a boy and a girl gave the child an appropriate channel to symbolize her curiosity without overstimula-

tion, so that Maysha no longer showed interest in watching her father or other boys in her day care center. The quick resolution of what had been a protracted behavior problem indicates how important it is to identify accurately the source of a child's difficulties and to respond with a combination of developmental guidance and emotional support.

The cultural differences in background between these African American parents and the Asian-born clinician did not interfere with their smooth communication. The parents asked casually about the origin of the clinician's accent in the second session. The clinician answered factually and asked whether their different backgrounds might make it more difficult for them to talk with her about their concerns. The mother replied that their pediatrician was Asian and that they were used to people of different backgrounds. The clinician invited the parents to let her know if they found that she did not understand their point of view for whatever reason, including having a different cultural perspective, and they agreed to do so. The topic did not come up again. This exchange illustrates the usefulness of addressing cultural differences as an integral component of all interventions, without waiting until the issue raises a communication problem but without making it a central topic unless this is clinically indicated.

The Role of External Events in Perturbations

Children respond to environmental events with a range of responses that are influenced by the nature and magnitude of the event, the child's individual characteristics and developmental stage, and the supports available from the parents and other significant people. Responses to environmental changes run the gamut of children's behavioral, social, and emotional problems. Temporary regressions in developmental milestones are frequent responses to environmental changes, and they include reverting to baby talk in children who were speaking at age-appropriate levels, wanting to nurse in children who had been successfully weaned, and regressions in toilet training. Mood changes and changes in biological rhythms are also a common response, with the child becoming subdued and withdrawn, losing appetite, or developing sleep problems. Other manifestations are temper tantrums, increased aggression, and oppositional behavior.

DC:0–3R includes a diagnostic category labeled adjustment disorder for mild, transient situational disturbances that last no longer than 4 months and are clearly tied to environmental changes or events, such as a family move, a change of caregiver, the mother's return to work, an illness in the family, or the birth of a sibling (Zero to Three: National

Center for Infants, Toddlers, and Families, 2005). Events that from the adult's point of view seem quite ordinary may represent a major source of worry or distress for a child. For this reason, it is imperative to ask very specific questions about any changes in the child's or the family's life when a child is referred. Seemingly minor changes might affect the meaning that the child attributes to people and routines and lead to major disruptions in the child's sense of safety and predictability.

The intensity and duration of the perturbation usually increase when the environmental change coincides with a developmental touchpoint that makes the child particularly vulnerable to additional stress. When the child is undergoing such a transition, it is preferable if at all possible to postpone changes that will disrupt the child's daily routine. For example, if the child is at the height of separation anxiety it is better to wait until it subsides to institute a change in caregiving routines. Toilet training is best postponed if the child is in the midst of an intensely negativistic period. The time spent waiting for a more propitious timing will be recouped by a faster and smoother child adjustment to the new situation.

Interventions that target perturbations caused by environmental changes need to be tailored to the specific characteristics of the event, but their intent is similar to interventions for perturbations resulting from maturational changes. Both situations involve efforts to improve the child's self-regulation and developmental progress. Children can be helped to negotiate transitions by (1) familiarizing them gradually with the new environment and new caregivers before a major change takes place, (2) giving them transitional objects that will create a bridge between the familiar setting and the new situation, and (3) incorporating familiar routines into the new situation. For children who are beginning to use language and symbolic play, speaking to them about the changes, giving them a chance to express their reactions through play, and helping them to put their feelings into words are time-tested methods of helping children navigate challenging transitions.