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A Model for Conceptualizing the Role of the Mother's Representational World in Various Mother-Infant Therapies

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ABSTRACT: A model of the mother-infant interaction/relationship is presented that permits systematic descriptions of different therapeutic approaches. The model consists of four interdependent elements in constant dynamic equilibrium. These elements are (1) the infant's overt interactive behavior; (2) the mother's overt interactive behavior (together these two constitute the interaction); (3) the infant's representation of the interaction; and (4) the mother's representation of the interaction (together the four constitute the relationship). Different therapeutic approaches, including a psychoanalytically oriented therapy, interactional coaching, a behavioral pediatric approach, a behaviorist approach, and a family therapy approach are each described in terms of (1) which element in the model provides the clinical information and (2) which element in the model is the direct focus of therapeutic action. Educational, clinical, and research implications of this perspective are discussed. In particular, the importance of changing the mother's representation of the interaction for therapeutic change is stressed. Further, it is argued that the mother's representation can be changed sufficiently by both direct and indirect approaches.

RÉSUMÉ: Un modèle de l'interaction/relation mère-nourrisson est présenté, modèle qui permet des descriptions systématiques de différentes approches thérapeutiques. Le modèle consiste en quatre éléments interdépendants en équilibre dynamique constant. Ces éléments sont: 1) le comportement interactif déclaré du nourrisson; 2) le comportement interactif déclaré de la mère (à eux deux, ces éléments constituent l'interaction); 3) la représentation que se fait le nourrisson de l'interaction; et 4) la représentation que se fait la mère de l'interaction, (à eux quatre, ces éléments constituent la relation.) Différentes approches thérapeutiques, y compris une thérapie orientée psychanalytiquement, une assistance interactionnelle, une approche pédiatrique comportementale, une approche behavioriste et une approche de thérapie familiale sont chacunes décrites en termes suivants: 1) quel est l'élément dans le modèle qui offre l'information clinique, et 2) quel est l'élément dans le modèle qui constitue le point de mire direct de l'action thérapeutique. Certaines implications pédagogiques, cliniques et certaines implications de cette perspective pour la recherche sont discutées. L'importance du changement de la représentation de l'interaction que se fait la mère pour le changement thérapeutique est particulièrement mise en évidence. Il est aussi noté que la représentation que se fait la mère peut être suffisamment modifiée par les approches à la fois directes et indirectes.

RESUMEN: Se presenta un modelo de la interacción/relación materno-infantil el cual permite descripciones sistemáticas de diferentes enfoques terapéuticos. El modelo está compuesto de cuatro elementos interdependientes en constante equilibrio dinámico. Estos elementos son: 1) la conducta interactiva visible del infante; 2) la conducta interactiva visible de la madre, (estos dos juntos constituyen la interacción); 3) la representación que el infante tiene de la interacción; y 4) la representación que la madre tiene de la interacción, (los cuatro juntos constituyen la relación.) Diferentes enfoques terapéuticos, incluyendo entre ellos una terapia sicoanalíticamente orientada, entrenamiento interactivo, un enfoque pediátrico de conducta, un enfoque de conducta y uno de terapia familiar, son descritos en términos de: 1) cuál es el elemento en el modelo que provee la información clínica; y 2) cuál elemento en el modelo es el punto de enfoque directo de la acción terapéutica. Se discuten algunas implicaciones pedagógicas, clínicas y de

investigación. En particular, se enfatiza la importancia de cambiar la representación que la madre tiene de la interacción como un cambio terapéutico. Además, se argumenta que la representación que la madre tiene puede ser modificada suficientemente a través de enfoques directos e indirectos.

抄録：母親・乳児交流／関係のモデルを示した。これは、いろいろな治療的アプローチの系統的な記載を可能にする。このモデルは、一定の力動平衡における、互いに依存しあう４つの要素からなっている。それらの要素とは、1)乳児の、外にあらわれた交流行動；2)母親の、外にあらわれた交流行動（この２つが一緒になって交流となる）；3)乳児の、交流の表象；4)母親の、交流の表象（この４つが一緒になって関係となる）。精神分析的治療、相互交流指導(interactional coaching)、行動小児科学的アプローチ、行動療法的アプローチ、家族療法アプローチなど、各種の治療的アプローチに関し、1)モデルの要素のうちどれが臨床的情報を与えるか、2)モデルの要素のうちどれが治療活動の直接の焦点となるか、について記載した。この考え方が、教育、臨床、研究において、どんな意義を持つか討論した。特に、治療的変化が起こるためには、交流の表象が母親の中で変化することが重要であることを強調した。さらに、母親の表象は、直接的なアプローチでも間接的なアプローチでも、十分に変えられると主張した。

POINT OF VIEW

Parents construct a mental picture of their infant. Equally they construct a mental picture of themselves in the role of the parent. This article presents a model to conceptualize the place of these mental pictures in the various therapies used to treat disturbed mother-infant relationships.

Depending upon the theoretical point of departure, these mental pictures of the infant or of the parent-as-parent consist of "attributions," "distortions," "fantasies," other forms of constructions, and possibly even accurate perceptions of the "real" infant (whatever that may mean). We will call all of these constructions "representations."

Also, for the sake of clarity, we will include in the mother's representation both her representation of her infant as well as her representation of herself in the mothering role. These two representations, although separate, are almost always so complementary that any aspect of one implies an aspect of the other.

In most psychodynamically oriented mother-infant therapies the role of the mother's representations has been central in conceptualizing the pathogenesis of mother-infant relational disturbances and has been a determinant in selecting the nature and focus of the exact therapeutic interpretations (Cramer, 1982a, 1982b; Cramer & Stern, 1988; Fraiberg, Adelson, & Shapiro, 1975; Lebovici, 1983). In fact, an implicit tenet of dynamically oriented therapies is that meaningful and lasting therapeutic change will not be seen unless the mother's representations have been altered.

In the nonpsychodynamically oriented conceptualizations of pathogenesis and therapeutics in mother-infant relational disturbances (behavioral modification techniques providing an extreme example), the role of the mother's representations is either neglected or minimized, because the focus of attention is placed largely on the nature of and changes in the overt behavioral interactions between mother and infant, rather than on the mother's representations of those interactions. An explicit tenet is that changes in the relationship are based on changes in the overt interaction behaviors.

In general, the more psychodynamic the approach, the more overt interactive behaviors tend to be overlooked, both in theory and practice; and the more behavioral the approach, the more the mother's representational world tends to be overlooked. In spite of this theoretical dichotomy, our own clinical experience as well as observa-

tions of various therapeutic approaches suggest that "good" effective therapeutic interventions always involve both a change in the overt interactive behaviors and a change in the mother's representation of her infant and herself in the mothering role, no matter whether the intervention was directed exclusively at the mother's representations or at the overt interactive behaviors of mother and infant.

Although there are relatively "pure" psychodynamic approaches and relatively "pure" behavioral approaches (see below), the majority of approaches fall somewhere in between. To complicate matters further, experienced therapists often flexibly shift the focus of therapeutic action back and forth between representation and behavior on the basis of clinical intuition alone. Such flexibility, however, usually falls outside of the theoretical framework officially used and espoused, or else the theoretical framework guiding therapeutic action tends to get blurred and relegated to disuse.

One of the reasons for this relatively poor match between what our theories propose and what we see and do clinically is that we lack a comprehensive model which describes the relationships between representations (mother's or infant's) and overt behaviors (mother's and infant's). Such a model can systematically describe, according to different therapeutic approaches, where the therapeutic action is directed and, at the same time, explain how therapeutic changes can occur in several areas other than the one to which the therapeutic action was applied.

This article proposes a general model which can describe a spectrum of therapeutic approaches.[1] It is our hope that this tentative conceptualization may permit greater clarity in thinking about comparative approaches from the clinical and theoretical point of view. In addition, it is hoped that research strategies will be devised for examining those processes of change that are unique to each therapeutic approach and those that are common to all approaches.

THE BASIC MODEL: A DYNAMIC INTERACTION BETWEEN BEHAVIOR AND REPRESENTATION

We view the mother–infant relationship in terms of four main elements in dynamic interaction. These are (1) the infant's overt interaction behaviors, B_I, and (2) the mother's overt interactive behavior, B_M; although considered as separate elements these represent the two sides of a mutually influencing reciprocal interaction ($B_I \leftrightharpoons B_M$); (3) the mother's representation, R_M, of that interaction; and (4) the infant's representation, R_I, of that same interaction. The interplay of these four elements can be schematized as shown in Figure 1.

The first two elements, the infant's interactive behavior, B_I, and the mother's interactive behavior, B_M, are treated as separate elements because they belong to separate people and, perhaps more important for the model, because different therapeutic approaches can focus on one or the other separately; i.e., they represent different loci of potential therapeutic action. Nonetheless, it is understood that the B_I and B_M in the interaction are interdependent.

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[1]We do not mean to suggest that all theoretical approaches are equally valuable in all cases. There are certainly criteria that determine the optimal approach for each case as we suggest. The point is that all approaches, if successful, will effect changes in all domains.

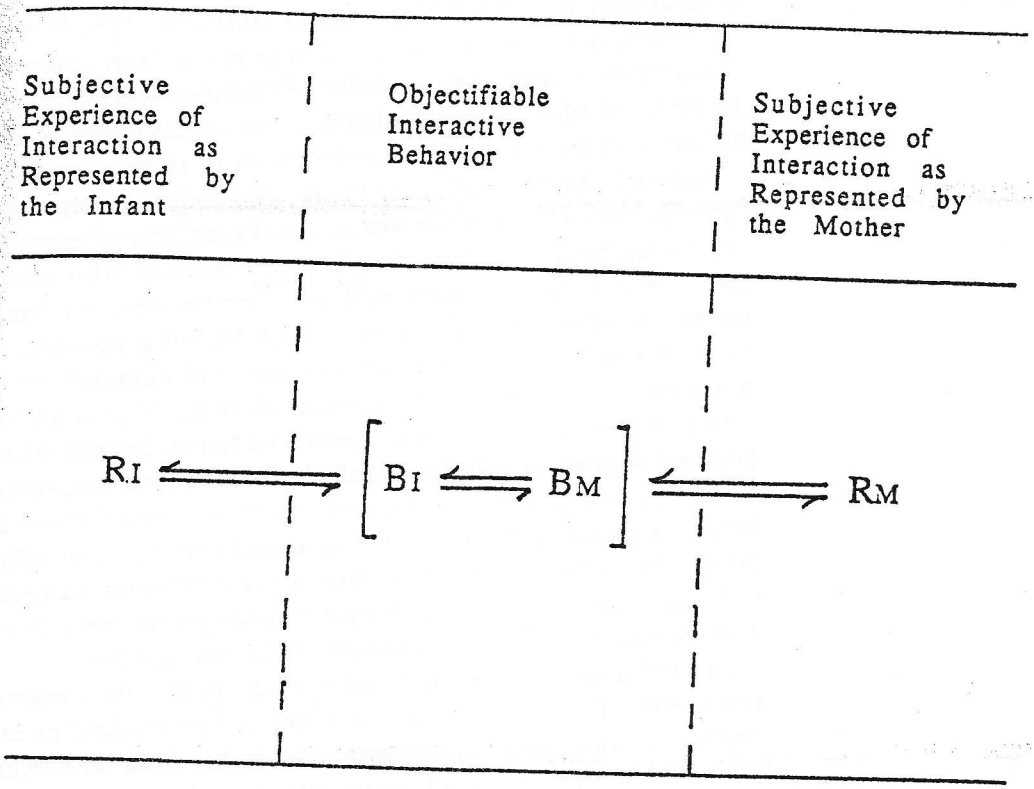

FIG. 1. The Elements of the Basic Model.

The interactive behaviors of mother and infant are in the domain of objectifiable events which can be described verbally or, even better, by videotaped recordings. These behavioral elements of the model thus offer a wider range of techniques for therapeutic approach.

The third element, the mother's representation, RM, of the behavioral interaction is a complex unit requiring some explanation. This representation concerns two people in an interaction. It does not concern how they may be represented outside of the interaction unless that influences how they are perceived, thought of, felt about, or acted toward in the interaction with each other. Accordingly, the mother's representation of herself as a mother in the interaction may be, or may not be, influenced by her representations such as those of herself as a person, of herself as a wife, of her husband, or of her own mother. Any of those related representations are only considered to fall into the category of RM if they directly influence how the actual behavioral interaction with the infant is experienced. (See Cramer & Stern, 1988.) This restriction allows us to bring together into one unit (RM) these "families" of related representations.

Similarly, the question could be posed why the unit RM is not actually two separate families of representations: one concerning how the infant is represented, and the other how the mother is represented in the mothering role. We have chosen to collapse these two families into one unit for several reasons. The dominant reason is that in dealing with the mother's representation of the interaction, one can rarely

focus exclusively on the mother in the mothering role without raising or activating the complementary representations of the infant as the other partner. Even when discussing the mother's own mother, one quickly introduces the mother as girl or child. In the domain of representations, it is technically hard and clinically not worth it to maintain the distinctions that would leave us with several subcategories of mother's representations of the interaction. Accordingly, we will work with a single complex representational unit.[2]

The fourth element, the infant's representation of the interaction, RI, also falls into the domain of subjective experience and can be inferred from an examination of the infant's expectations in the interaction, especially when they are violated. Here, too, the infant's representation of the interaction will include all of the representations (prototypic or generalized memories, scripts, models; see Stern, in press) that he or she has of him- or herself-with-the-mother which will influence how the infant represents (i.e., perceives, interprets, remembers, acts, and feels about) the interaction. In general, the same considerations that apply to the unit RM also apply to the unit RI.

The essential features of this model are that we view these four elements in constant dynamic interaction. Each is open to modification depending upon the input from the others—they form an interdependent system.

The representations, either RM or RI, are constructions that use new information given the behavioral interaction (BI⇋BM) to adjust their configuration. The adjustments in the representation caused by changes in the behavioral interaction can be large and dramatic or on the order of fine tuning. But in either case, each new occurrence of or experience of participating in the behavioral interaction is measured against the existing representation of the interaction. If differences between what is expected (the representation) in the interaction and what currently happens in the interaction are detectable, the representation can be modified or updated (i.e., changed to account for this new occurrence). In this sense the representation is always open to modification based on current experience—except when it becomes pathologically rigid.[3]

Similarly, any enduring change in the representation of the interaction will necessarily change the actual behavioral interaction. This is so because any alteration in the representation will involve how the self or partner's interactive behavior is perceived, or interpreted, and such change will inevitably result in altered overt behavior in order to adjust. Representations and behaviors are thus in a relationship of constant assimilation/accommodation with one another.

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[2]Note that in the domain of overt interactive behavior we have made the opposite decision. In the behavioral world of interaction you could also argue that each member's behavior is almost totally determined and contextualized by the other's, such that conceptually a separate focus on one person's behavior without consideration of the other is meaningless, i.e., there is only one unit (BI⇋BM) not two (BI and BM). We have chosen two units in this domain because technically (with the aid of visual recording and the fact that each person's behavior emanates from only one person) it is possible to focus a therapeutic approach on one person's overt behavior alone and in fact this is done here.

[3]It is an empirical question whether "pathological rigidity" in this model refers to the difficulty of changing any one element, or to difficulty in the expected causal sequence of changes, once an element has been altered. This important clinical and theoretical issue deserves much further thought, but is beyond the scope of this article.

From this perspective, the interdependence between the four elements of the system is so great that an impact anywhere in the equation, i.e., on any one of the elements, will necessarily have some impact on the other elements. From the therapeutic point of view, then, one can theoretically change the whole system, i.e., have an effect anywhere or everywhere regardless of where one initially acted upon the system. Accordingly, therapeutic efforts directed at the mother's representation, if successful, can for example be expected to alter the mother's and then infant's interactive behavior, and vice versa. The point of entry into the system may prove nonspecific with regard to therapeutic results. However, specific clinical criteria may best determine the approach of choice, and each approach will have its specific technique despite the fact that the ultimate results may be nonspecific across many domains. The application of the general model is based on the work of Stern-Bruschweiler (1988).

APPLICATION OF THE GENERAL MODEL TO VARIOUS THERAPEUTIC APPROACHES

Each therapeutic approach will be described in terms of (1) which of the four elements of the model provides the *source of clinical information* (S); (2) which of the four elements acts as the *locus for therapeutic action* (A), i.e., where the therapeutic efforts are directed; and (3) which are the modalities of treatment used in the therapeutic action. The different modalities are Interpretation, Clarification, Modeling, Reinforcement, Education, Support, Advice, and Transference. Each description, for the sake of brevity, will necessarily only emphasize the broadest outlines of the approach.

Psychoanalytic Approach

The approach viewed schematically. The description of this approach is based on the psychoanalytically oriented brief therapies practiced by Lebovici (1983) and by Cramer (1982a, 1982b). It can be schematized as in Figure 2.

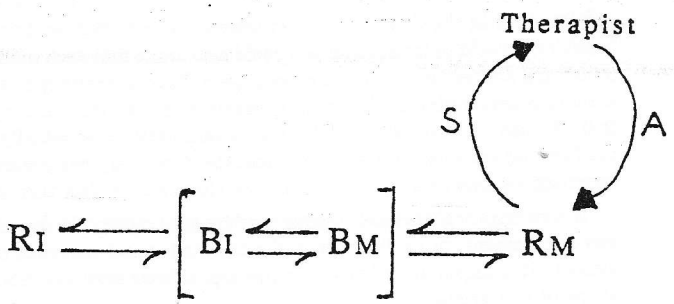

FIG. 2. The Psychoanalytic Approach Viewed Schematically.

Source of clinical information. Even though the infant is present during the sessions with the mother and is periodically interacting with the mother or the therapist, the source of clinical information (S, in Figure 2) is almost exclusively the mother's discourse about the problems as she perceives, describes, and interprets them, in comparison to the observed interaction between mother and infant. The interview with mother and infant present is directed toward eliciting information that will permit the therapist to construct in his or her own mind the nature of the mother's representation of the interaction. The clinical information sought consists largely of the mother's past, particularly as it may influence the current relationships with her infant, and her interpretations and fantasies about who her infant is and why he or she does what he or she does. The therapist also searches the mother's past and present life to discover the origins of her mental constructions about her infant.

During this search for the mother's representations, the therapist may comment upon the infant's or mother's interactive behavior occurring during the interview. However, such utilization of direct observation of the behavioral interaction is used mainly to highlight or exemplify points of clinical information that are being discussed in the domain of the mother's representational world (e.g., "Is what Johnny did just then—when he threw the block—an example of what you mean when you tell me that he wants to get back at you and hurt you?").

Locus of therapeutic action. In the psychoanalytically oriented approach the therapeutic action is directed almost exclusively at the maternal representations, R_M, (i.e., at all aspects of the mother's representational world that are activated and operating in the interaction). There is no attempt to alter the mother's behavior directly (B_M) in the actual interaction. No advice, behavioral recommendations, direct reinforcement, or educational material is offered. Instead, the aim is to change her representation with the expectation that this will result in altered maternal behavior in the interaction (see arrows in Figure 2), which in turn will alter the infant's behavior and ultimately his or her representation of the interaction.

To change the R_M the therapist tries to identify and bring to light the conflictual themes from the mother's past that are reactivated and enacted in the current mother–infant interaction. The historical links between past events and current functioning are drawn via interpretations and clarifications.

Therapeutic modalities employed. Interpretation and clarification are the main modalities used to explicate the mother's present mental state in terms of past and ongoing events and needs. In actual practice, because the infant is present during the sessions, interactions between infant and therapist or infant and mother are inevitable. Such interactions or responses to such interactions may inadvertently involve modeling (by the therapist) or reinforcements of maternal behaviors or their support. However, these modalities are considered incidental to the main modalities planned.

The presence of transference is ubiquitous in all "patient"–therapist interactions. Because of the brevity of these analytically oriented brief psychotherapies, the transference is generally not actively used as a treatment modality—especially when it is "positive" in the sense of furthering the goals of therapy. In this sense the element of a "transference cure" is always present in this approach.

"Interactional Coaching" as a Form of Psychoeducation and Psychotherapy

The approach viewed schematically. The description of this approach is based mainly on the clinical work of McDonough (1988) and to a lesser extent on techniques described by Field (1978, 1982) and by Clark and Seifer (1983). It can be schematized as in Figure 3.

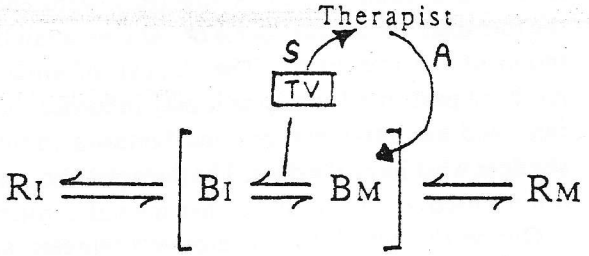

FIG. 3. The Interactional Coaching Approach Viewed Schematically.

Source of clinical information. Most of the needed clinical information of the therapy comes from watching the interaction. Videotaping is used to aid in this process, as indicated in the schematized model. In practice, the mother is asked to interact with her infant—usually a free-play interaction—and the episode is videotaped. Immediately afterward, mother and therapist review the tape. The therapist stops the tape whenever an interactive event of therapeutic potential occurs. This event can then be reviewed many times. The videotaped interactional behavior becomes the source or subject for the ensuing therapeutic exchange.

In addition, there are other sources of general information, coming both from home visits which are often made at the initiation of the treatment, and from the history the mother gives, which may include much of her representational life. Nonetheless, it is the videotaped interaction that serves as the initial and main source of clinical material to be identified and worked with in the process.

Locus of therapeutic action. The therapeutic action is initially directed at the mother's behavior as seen in the televised recording of the interaction. The therapist tries to alter what the mother does, i.e., her interactive behavior, BM. This is accomplished by seeking out those maternal acts (successful or not) which can be interpreted, positively reinforced, and then expanded upon and elaborated with information, advice, and clarification. (For example, if the mother of a slightly delayed child does nothing but watch her child finish playing with one toy and then, after searching around for several long moments, re-engaging with a new toy, the therapist will positively reinforce the fact that the mother did nothing and let the child take his or her own time in making the transition in attention and engagement from one toy to the next.) The therapist will follow up this reinforcement (which often comes as a surprise to the mother that she was doing something well without being aware of it) by providing information about the slower rhythm of attentional shifts present in a delayed child and how important it is to respect the child's own rhythm in order

not to overstimulate the child. The therapist can then suggest other situations where the same principles apply, and the mother is now more open to listening because she has just been complimented for utilizing the ability in question.

In the technique as practiced in interactional coaching, the therapist may always attend to mother's self-esteem-as-a-mother (which falls into the category of RM and not BM). The therapist will attempt to raise the mother's self-esteem, through their work on the mother's interactional behavior. If the mother can be made to feel that she is acting competently she will experience greater self-esteem. The situation is essentially the opposite of the psychoanalytic approach in which one tries to change the RM in order to secondarily alter the BM. In interactional coaching one tries to change the BM in order to alter her RM (self-esteem in this terminology).

Once the mother's behavior has been altered, that will influence both her representation and the infant's interactive behaviors; the dyad will then have to adjust to the changes the mother has made. These changes will then exert an influence to change the infant's representations. (See arrows in Figure 2.)

The therapeutic modalities used. Positive reinforcement, information, and advice are the main modalities that are used when working on the mother's behavior. Modeling is avoided in order to support the mother's expertise in caring for her own child. Interpretation is never used. Transference is always present and is actively used in the treatment to support the therapeutic alliance. Creation of a positive therapeutic alliance is the first step in this intervention and is sought so that the therapeutic maneuvers will have more force for change.

The "Behavioral Pediatric" Approach

The approach viewed schematically. For the purpose of this article, we will define the behavioral-pediatric approach narrowly in terms of the source of clinical information, locus of therapeutic action, and treatment modalities used, as we have with the other approaches. The clinical work of T. B. Brazelton and his group (Brazelton, 1982; Brazelton, Yogman, & Tronick, 1979) provides an excellent illustration of this approach. It can be schematized as in Figure 4.

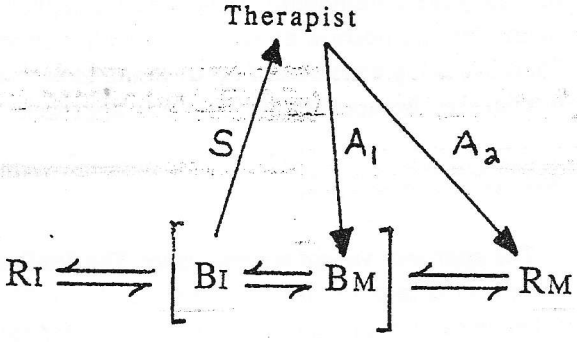

FIG. 4. The Behavioral Pediatric Approach Viewed Schematically.

Source of clinical information. Most of the significant clinical information comes from the baby's medical history and his or her behavior with the mother. This information is initially gathered from the maternal report. It is then tested, when possible, in an observed interaction between the mother and infant or the therapist and infant. In either case, the focus is on what the baby can and cannot do. Videotape is usually not used, and live observations are made.

The use of the Neonatal Assessment Scale (Brazelton, 1973) as an intervention to augment the mother's attachment or investment in her newborn is an excellent example of this approach. In this situation, the interventionist interacts with the baby to show the mother all of the extraordinary behavioral capacities her neonate already has and of which she may have been unaware.

Focus of therapeutic action. Although the source of information comes from the baby's spontaneous or elicited behavior, the focus of the therapeutic action is on the mother's behavior (BM) in response to the baby's behavior, and also on the mother's representation of the baby (RM) in light of what the therapist reveals to the mother about the baby's capabilities or limitations; i.e., the mother's expectation of the baby is changed and thereby her attributions and projections become altered. (For instance, if the baby had been premature or "small for gestational age," in many interactions he or she may become overstimulated, distressed, and disorganized. In the situation of the premature or SGA infant, the therapist would describe or demonstrate the type of responses required to deal with a hyperexcitable baby. He or she might advise or show that such babies cannot tolerate stimulation in more than one sensory channel at a time and that they will calm down and tolerate the interaction if it is conducted with only one channel—touching, or talking, or rocking, but not all three.)

The aim is to adjust the mother's overt behavior and representations to fit better the real and current interactive capacities of her infant. Once her interactive behavior and representations have been changed, the sequences of expected change in the entire system will result as described above. Using this focus, the therapist is also in an excellent position to address the mother's representation directly, especially as it must adjust to new information revealed about the infant's past, present, or future. With this approach, the therapist addresses the therapeutic action at both the mother's behavior and her representation, simultaneously.

Modalities employed. Education-information, advice, positive reinforcement, and modeling are paramount. Transference is implicitly encouraged because the therapist maintains the posture of the expert with concrete knowledge to offer, rather than "only" offering a method of exploration. However, the transference does not become crucial for therapeutic action in this approach.

Behaviorist Approaches

The approach viewed schematically. The details of this approach depend upon which symptom is targeted for intervention. As an illustration of the general features of a behaviorist approach, a case of nonorganic failure to thrive with food avoidance will be used (D. Benoit, personal communication, 1988). This approach can be schematized in three steps.

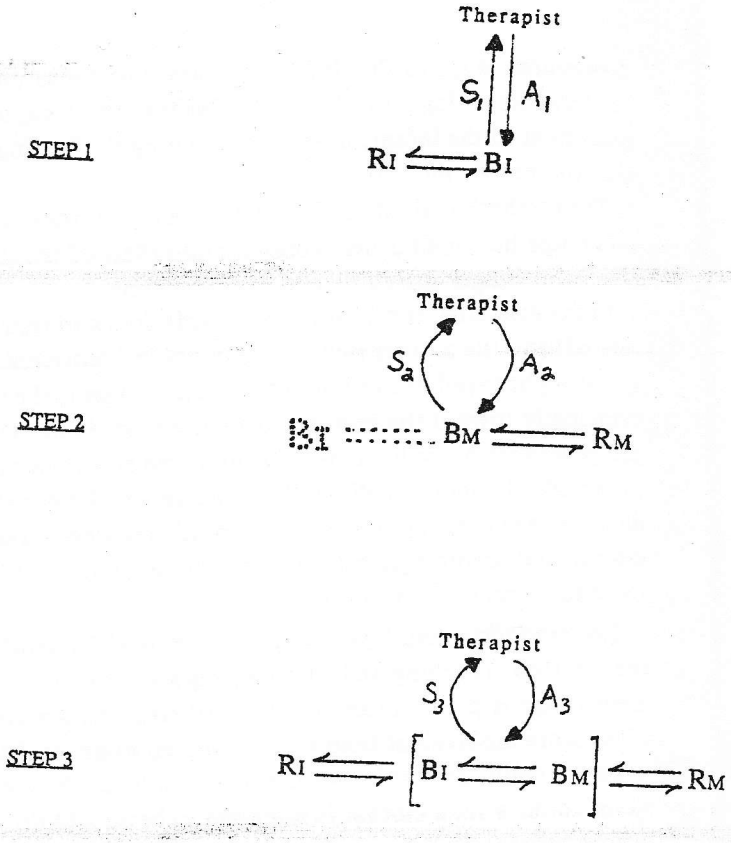

FIG. 5. The Behaviorist Approach Viewed Schematically.

In step 1, the therapist works with the baby alone, shaping his or her behavior.

In step 2, the therapist teaches the mother how to do the shaping.

In step 3, the mother interacts with the baby and the therapist comments upon and coaches the mother in that interaction.

Source of clinical information. In step 1, the source of information comes from what the baby does during a (feeding) interaction with the therapist as the feeder. In step 2, the therapist uses the interaction between him- or herself and the baby (often recorded) to teach the mother. In the final step, the interactive behavior (during feeding) between mother and infant becomes the source.

Locus of therapeutic action. In step 1, the therapist shapes the baby's behavior. In the chosen example this is done by negatively reinforcing all food aversion behaviors and positively reinforcing all food approach or intake behaviors (A, in Figure 5). This is strictly a shaping procedure, but with the expectation that once the infant's behavior has been shaped, feeding will be more gratifying and the infant's representation (RI) will alter accordingly (as indicated by the arrows in the diagram) with positive feedback on the feeding behavior after the RI has been altered.

In step 2, the therapist teaches the mother the behavioral guidelines she must adopt in the interaction to get the infant to eat. The therapist may also model these shaping

procedures (e.g., in the illustrative case, this focus on the mother's behavior, BM, concerns imposing strict hours for feeding; the composition of meals; the physical placement of the infant, face-to-face, during the feeding; how to introduce the spoon into the baby's mouth).

The mother's realization that these techniques work (at least in the therapist's hand) influences her to alter her representation (RM) of the infant and herself—the problem is no longer insoluble and overwhelming.

In the final step, the infant (whose behaviors and representation have already been altered) and the mother (whose behaviors and representation have also been altered) are brought together to try it out. At that moment, the therapeutic action is directed principally toward the mother's behavior to maintain the shaping so that the infant can generalize his or her new behaviors (and accommodate his or her representation) to include the mother. When this is achieved, the mother is extremely relieved and happy to see that she too can successfully feed her infant (a basic task for her self-esteem) and accordingly will alter her representation of herself as a mother. A positive feedback circuit is established.

The modalities employed. Negative and positive reinforcement are paramount in the first step. Teaching and advice giving are foremost in the second. And, reinforcement is again predominant in the third step. As always, transference is present—often more ambivalent than in the other approaches. Mothers are grateful that the therapist could get the interaction back on track, but jealous that it took a professional to do what a mother is supposed to be able to do. If well timed, both feelings can be helpful.

Family Therapy Approach

The approach viewed schematically. Often a family therapy approach is chosen or indicated. This is especially so when a marital problem becomes enacted in the interaction with the infant, either by the mother, father, or both, or when a family problem is transmitted via the couple to be enacted in the interactions with the infant. The use of group therapy in this context can be schematized as in Figure 6.

Source of clinical information. The source of clinical information will come from all of the interactions, i.e., BI ⇋ BM, as well as BI ⇋ BF, and certainly BM ⇋ BF. In addition, the mother's representation and the father's representation of themselves as parents and their representation of the role that their infant plays in the family system are essential sources.

Focus of therapeutic action. Potentially the therapist can act directly upon each member's interactive behavior, or upon their representations, or both. The balance will depend upon the therapist's school of preference and the clinical opportunities offered.

Modalities employed. Potentially all modalities may be used depending upon the locus of therapeutic action at the moment, the therapist's biases, and the clinical situation.

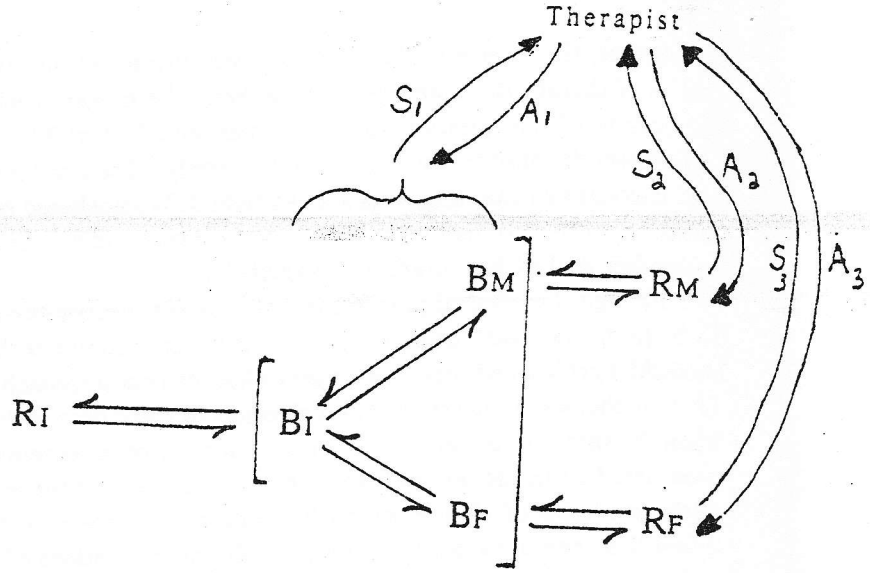

FIG. 6. The Family Therapy Approach Viewed Schematically.

Other Approaches

Supportive therapies are widely indicated and used. However, we will not consider them because, strictly speaking, these approaches consist of any and/or all of the above approaches, designed to maintain a mother–infant system under stress rather than to alter it. Supportive therapy, in this sense, is more a therapeutic aim than an approach.

Social therapies are also widely used in mother–infant mental health. The environmental manipulations involved are relatively nonspecific and are usually coupled with one of the above approaches.

DISCUSSION

We have presented a model of the relationships between representations (mother's and infant's) and overt interactive behavior (mother's and infant's). In that model, we have systematically described different therapeutic approaches in terms of where the crucial source of clinical information for therapy comes from and where the therapeutic action is directed. The value of such a model will depend on its clinical research, practice, and educational utility.

With regard to research, a basic assumption of the model relates to the interdependence of overt interactive behaviors and representations. This assumption leads to several predictions about the processes of change set in motion after a therapeutic intervention. For instance, it predicts that an intervention directed mainly at the mother's behavior (e.g., interactional coaching) may change the mother's representations, as much and as rapidly as an intervention directed mainly at the mother's representations (e.g., a psychoanalytically oriented approach)—and, most

important, the reverse is also predicted. An important question involving the processes of therapeutic change is at stake. With the model in mind to aid the conceptualization of this question, Stern, Cramer, and Robert-Tissot (1989) report on an experiment designed to test the prediction directly. (The two therapies, psychodynamic and interactional coaching, were applied "blindly" to a selected population, and change measures of the mother's overt interactive behavior and her representations of herself as mother and of her infant are evaluated.)

With regard to clinical practice, the various approaches currently used often seem to be so diverse, each using a separate theory and unique technique, that the commonalities get lost and practitioners get locked into one approach. The model presented is comprehensive in the sense that it attempts to show how each approach is working upon the same system and is related to—in fact, complementary to—the other approaches. In this model, each specific approach and its theory becomes secondary to the processes of change established within the system by any intervention. We believe that there are at least two practical clinical implications of this shift in emphasis.

First, as described earlier, in the new field of infant mental health, the majority of clinicians—even "doctrinaire" ones—do not, in practice, adhere purely to any one approach as it is theorized, either in different cases or during the same case. Given this reality, we need a more comprehensive model that permits clinicians to conceptualize better what they actually do—and to be eclectic when clinically indicated, while remaining within one coherent treatment model.

Second, a most pressing clinical question concerns not which intervention approach works best—they all work—but, Which approach is most indicated in which subset of cases? What are the treatment criteria for each approach? We believe that the present model will aid in practically defining the various approaches so that these questions can be better addressed.

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