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Finding Each Other

Using a Psychoanalytic-Developmental Perspective to Build Understanding and Strengthen Attachment Between Teenaged Mothers and Their Babies

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Pregnancy in adolescence and the developmental sequelae for both mother and child have been an ongoing concern in our society. Clearly, early intervention offers us a chance to enhance the teenager's opportunity to become a competent parent, as well as a chance to support the healthy development of the child. The therapeutic intervention we describe in this article is aimed at strengthening the emotional relationship and increasing the psychological understanding of high-risk, inner-city adolescent mothers for their babies, thereby improving the mothers' ability to provide responsible and growth-enhancing maternal care. Two clinical cases are presented to demonstrate the usefulness and effectiveness of our approach.

THE CHANCES FOR CHILDREN: TEEN PARENT–INFANT PROJECT WAS created through a collaboration between a psychoanalytic training institute, the Institute for Child, Adolescent, and Family Studies (ICAFS), and the Living for Young Families Through Education (LYFE) program of the New York City Department of Education. Our model was

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developed in response to the psychological needs of these teenaged mothers and their babies and informed by recent infant research as well as an understanding of contemporary psychoanalytic developmental theory. It demonstrates the relevance of this theory to the lives of what we call "real children in the real world."

The LYFE program runs approximately 46 day-care centers in New York City public high schools where teen mothers attend classes, and this program was implemented in selected inner-city high schools where on-site day care was provided for the babies of these teenagers. This enabled us to gain therapeutic access to both the mother and the baby.

Demographics

Teen pregnancy and early parenthood is a significant and extensive social problem that has been the focus of much debate and concern. The Children's Defense Fund (1998) estimates that a baby is born to a teenage mother every 21 minutes. Pregnant adolescents often lack adequate prenatal care and are more likely to have poor nutrition and inadequate living conditions. In addition, lack of support from the baby's father and negative responses from the teen mother's own family result in further psychological stress. These conditions have a profoundly negative impact on the social and emotional development of both the adolescent mother and her baby.

In addition, because interactions between a mother and her infant begin before birth, when a pregnant woman begins to imagine what her baby will be like, the parent–child bond is likely to be disrupted if a pregnancy is unexpected or unwanted, if health problems arise, or if the social relations of the pregnant mother with family, her peers, or the baby's father becomes strained (Rogel and Petersen, 1986). These stressful conditions are found much more frequently among pregnant teens than in older pregnant women, making this population more vulnerable to emotional disorder.

Furthermore, most of the mothers in our project come from African American and Latino families without many social or economic resources. Several years ago, the U.S. Surgeon General issued a report on the status of mental health treatment in minority populations in the United States. He found an urgent need for more access, more availability, and a higher quality of service, describing the existing situation as a "critical public health concern." In neighborhoods such as East Harlem and the South Bronx in New York City, almost one in five births is to a teenage mother (*New York Post,* August 10, 2003).

Self-report questionnaires of the mothers in our pilot project ($N = 85$) confirmed that these young mothers face extensive and intensive social and emotional pressures. Of our sample, 63 percent had a family member incarcerated, 43 percent reported having witnessed or experienced domestic violence in their homes, 20 percent had been the victims of sexual abuse, and 11 percent currently lived or had previously lived in foster care.

Rationale

The Chances for Children: Teen Parent–Infant Project emerged from our experiences trying to provide mental health services to children in inner-city public elementary schools over the last decades. We came to realize that many of these children would never have been helped had we not been available to them on-site. We also recognized, however, that whatever help we were giving was already "too little, too late." We began to think about developing an on-site program that would reach new mothers and their babies within the first years of the baby's life, an early intervention that might prevent the emotional and cognitive disturbances we were observing in so many school-aged children.

We developed a tripartite model of intervention, encompassing the mother, the baby, and the nursery staff. This model included treatment for both mother and child (dyadic and individual therapy as well as a weekly mothers' support group), an educative parenting curriculum for the mothers (Partners in Parenting Education [PIPE]; Butterfield et al., 1998), and ongoing case conferences that could provide a forum for the education and support of the nursery staff. Our goals were as follows:

- Increase the mothers' understanding of their babies' needs.
- Increase parenting skills.
- Strengthen the attachment between the mother and her baby.
- Increase their positive interactions and decrease their negative ones.
- Diagnose and provide early treatment for emotional illnesses in the mother (e.g., depression, posttraumatic stress, anxiety disorders).
- Assess and treat children for early signs of disturbed development.

In addition, we hoped to consult with, support, and educate the teachers and day-care staff who worked with the mothers and babies in these LYFE centers, improving the quality of care they were able to give to the babies while their mothers were attending school.

The Adolescent Parent

In normal development, adolescence is a time of significant emotional and cognitive maturation, a time when the capacity for intimacy deepens, and when the identity and character of the teenager begins to consolidate. It also is a time of intense egocentricity, with rapid changes in physical, social, and emotional circumstances that need to be processed and integrated, making life turbulent for many teens.

An ordinary adolescent has five developmental tasks to master throughout these years (Siegler, 1997):

- Separation from old ties.
- Creating new attachments.
- Establishing a mature sexual identity and a mature sexual life.
- Formulating new ideas and new ideals.
- Consolidating character.

Pregnancy radically alters this developmental trajectory, requiring the teen to forsake her own adolescent developmental path for that of motherhood. Ironically, becoming a mother often causes the teen to become *more* dependent on her family at the very time when healthy development requires *less* dependency. Instead of the adolescent being at the hub of her own new universe, she must relinquish this place to her dependent infant and assume adult responsibilities for which she is ill prepared. When a teen mother cannot manage this transition (which is challenging even for more mature mothers), the baby can only be viewed as an extension of herself, rather than as an individual person. The mother may also hold on to distorted expectations of an *imagined* baby who will fulfill her own needs, and this expectation can block her ability to take care of a *real* baby with complicated needs of his own. When this happens, a vicious cycle of expectation, disappointment, and despair is set up, and the longer this cycle is fueled, the more compromised the development of both the infant and parent–infant relationship becomes, decreasing subsequent chances of repair.

In studies designed to examine the effects of adolescent parenting on infant outcome, adolescents have been found to be less verbally expressive and sensitive to their babies, to express less positive and more negative affect, and to endorse punitive child-rearing attitudes more frequently (Field et al., 1980; Culp et al., 1988).

Furthermore, several studies suggest that mother–child relationships affect, and in some cases predict, the cognitive-linguistic development of

children, with more disturbed mother–child pairs producing children that are less able to think, speak, and learn (Osofsky, Hann, and Peebles, 1993; Kelly et al., 1996).

Depression

It is also important to recognize that adolescent mothers display more instances of depression (Osofsky et al., 1993) than mothers generally, who, in turn, are reported to show more depression than women who are not mothers (Hart, Field, and Roitifarb, 1999). The prodigious research of the past 15 years on the effect of depression on mother–infant interactions has made it clear that maternal depression produces serious consequences for infants. Babies of clinically depressed mothers are empirically distinguished at two months of age from infants of nondepressed mothers in their diminished emotional and cognitive functioning (Whiffen and Gottlieb, 1989). Many studies confirm that interactions between depressed mothers and their babies are significantly more negative than those in a nondepressed population, and these infants appear more passive and helpless and less likely to attempt to assert themselves to control their environments, even with adults who are not depressed (Field et al., 1985; Field et al., 1988; Fleming, 1988; Cohn et al., 1990; Dodge, 1990; Rutter, 1990; Rosenblum et al., 1997).

Resilience

Although many adolescent parents live in conditions of chronic stress with few economic, social, familial, or educational supports, it is important to recognize that some teenagers are able to cope well, even under these conditions. In an attempt to understand why, Osofsky and colleagues (1993) reported on some of the *protective factors* that appear to increase resilience in this population. These factors include strong social supports, the ability to continue to pursue educational goals, a stable relationship with the infant's father, high self-esteem, good problem-solving skills, and an infant with an "easy" temperament who is able to easily draw positive attention from its environment. Crnic, Greenberg, and Slough (1986) reported that external support from the community correlated positively with positive parenting behavior and attachment security in samples of high-risk infants and also emphasized that both the adolescent parent and her child would benefit

from supportive, interactive treatments. We drew on these findings as we began to design an intervention project for a population of teen parents who lack many of these resources so essential to resiliency. This article highlights the mother–baby treatment component of our program.

Treatment of Mothers and Babies

The treatment model we developed for each mother–infant pair was determined on the basis of an individual clinical assessment of their needs. Our interventions were informed by the research and findings of a number of people and projects, particularly the Selma Fraiberg/Alicia Lieberman Parent–Infant Psychotherapy Project in San Francisco, the International Guidance Model of Susan McDonough at the University of Michigan, Michael Trout's Infant–Parent program in Illinois, the STEEP project (Steps Toward Effective, Enjoyable Parenting) from the University of Minnesota, Bertrand Cramer's work with mothers and infants in Geneva, and Beatrice Beebe's videotape feedback interventions at Columbia University. For all of our mothers and babies, we hypothesized that providing them with a relationship-based experience of nurturance (what we call "mothering the mother") would lead to more effective parental involvement on the part of the mothers, as they were able to absorb and incorporate this experience. We assumed, along with Schafer (1997) that this incorporation would be a "mediating and enabling process" and that the teenage mothers participating in our program would identify with our therapeutic stance, particularly two capacities we felt were crucial for good mothering: *empathy* and *reflective thinking*. We hoped that we would be "swallowed" and absorbed as useful intrapsychic objects and that this incorporation of us would then continue, independent of our presence. "Incorporation may culminate in the experience, conscious or otherwise, of an introject, or if carried further, in an identification whereby the subject takes on characteristics on his or her own" (p. 113).

We developed three therapeutic models for our specific population. First, for new mothers who, though teenagers, appeared to have had "good-enough" parenting themselves and present themselves as comfortable, committed mothers with "good-enough" outside support (Winnicott, 1950a), we offered ourselves as people with access to current research on infancy, brain development, and parenting whom they might find useful. This is an *educational and developmental guidance model,* and like all parent guidance,

this approach depends on sufficient ego strength in the parent for its effectiveness.

Secondly, for mothers whose families were *unable* to provide good outside support and were either resentful and subtly undermining, overinvolved and intrusive, or directly disparaging to the new mother–infant pair, we offered the dyad a *supportive treatment model,* a "safe haven" where the mother and baby could get to know each other and begin to build a healthy attachment free from outside interference and "impingement" (Winnicott, 1950a). This supportive model focused on encouraging the mother in her role as a parent and helping her to establish an independent, mutually responsive relationship with her baby.

Our third model offered *infant–parent psychotherapy* to those mothers whose own histories were riddled with trauma (e.g., emotional and medical illness, physical and sexual abuse, abandonment). These mothers participated in an intensive psychodynamic parent–infant treatment that linked the past to the present and began to banish some of the "ghosts" that lurked in their nursery (Fraiberg, 1987).

Our attempts to replace *reactive behavior* with *reflective thinking* governed all the interventions in all aspects of our program (including those not discussed in this article, such as the ongoing parenting groups and the psychological support for nursery staff). That is, for our young mothers, we hoped that a response such as "Bad girl! Get in your stroller this minute!" would be replaced by a consideration of what was in the baby's mind that was keeping her from immediately cooperating (e.g., the baby is in the middle of trying to learn how to stack some blocks; the baby is curious about a scratch on another child's leg).

To *transform reaction into reflection,* we acknowledge the mother's own feelings and experiences, and then we wonder and consider with them the meanings of these feelings (e.g., "What do you imagine your boyfriend was thinking when he didn't show up for the baby's birthday?" "I wonder why your mother said that the baby was spoiled?" "What do you think your baby might be thinking when he makes that face?"). These kinds of questions open the way for the development and expansion of empathy. It also emphasizes the reliance on thought as a way to modulate action. Fonagy and colleagues (2002) have called the "capacity to envision mental states in self and others" *reflective function* (p. 23), whereas Siegel (2000) refers to this capacity as "*mindsight,* the ability to perceive the mental state of another" (p. 140). These capacities are essential for healthy social and emotional development.

Program Structure

All mother–infant interventions began with us making a 10-minute free-play videotape, in which the mother was asked to play with her child as she might at home. In a subsequent session, the therapist and the mother watched the tape together and discussed it from a *nonjudgmental, strengths-based perspective*. This perspective, which was another important aspect of our program, emphasizes only *positive* aspects of the mother–child interaction. Instead of instructing, offering suggestions or criticism, and so forth, we used the mutual viewing experience to build an alliance with the teenage mother, to start a dialogue about what life is like for this particular mother and child, and to begin the process of modeling *reflection over reaction*.

Because the parent guidance model assumes a relatively intact mother–infant pair, this article illustrates only clinical interventions with the remaining two models: *supportive therapy* and *intensive infant–parent psychotherapy*.

Supportive Therapy: Latoya and Cherelle

Latoya's full figure and elegant hair weave made her appear considerably older than her 16 years. She and her feisty, 18-month-old daughter, Cherelle, lived with Latoya's mother, who suffered with lupus and was physically fragile and vulnerable. Latoya had had a difficult labor and delivery. Her blood pressure dropped dramatically during the birth, and the doctors had informed her mother that either Latoya or the baby was likely to die. Although both survived, Cherelle was born with a deformity that would make walking nearly impossible without subsequent surgery. Because Cherelle's problem did not interfere with Cherelle's life as an infant, Latoya was able to ignore her daughter's condition for almost a year, telling herself that the problem would "work itself out." But as Cherelle grew and began to crawl, Latoya was having a harder time trying not to notice the difficulties Cherelle was having in trying to move around.

When I first met Latoya and Cherelle, they were unable to separate from one another, and Cherelle would cry inconsolably for hours when Latoya left the nursery to go to class. Similarly, Latoya could not let Cherelle alone, despite reporting that she didn't like the way Cherelle clung to her. Latoya was also physically exhausted from carrying Cherelle everywhere and suffered with neck and back pain. I told Latoya I thought I might be able to help them sort out some of the difficulties she and Cherelle were having, and she

agreed to join the parent group, meet individually with me, and allow a play therapy assessment for Cherelle.

Our first goal was to address the separation issues that were so troubling to both Latoya and Cherelle. I felt that unwittingly, Latoya was consistently conveying to Cherelle that she would not be safe without her mother. Cherelle confirmed her mother's message to her by crying each morning when her mother left, and Latoya, at the end of each day when she returned to Cherelle, continued the message by asking, "Did you miss me?" Latoya needed to learn that avoiding saying good-bye to her baby and sneaking out of the center, only made Cherelle more anxious and increased the intensity with which she looked for her mother. It also decreased Cherelle's ability to trust her mother. I wondered if Latoya could tolerate her own sense of separation if Cherelle *didn't* cry for her when she left and *didn't* miss her.

Infant research and attachment theory suggest that babies learn through patterns of expectancies that are generalized. Secure attachments derive from consistent, reliable responses (Stern, 1985; Beebe, 2003). To help establish these responses, I encouraged Latoya to play peekaboo games and hide-and-seek with Cherelle, building Cherelle's confidence and helping her to predict her mother's comings and goings. I also helped Latoya to create narratives for Cherelle about their different school days in the same building to enable Cherelle to anticipate and sustain their separation.

After making our initial videotape and viewing it together, I began to meet weekly with Latoya. During our meetings, she reluctantly began to talk about her grief and guilt over Cherelle's physical handicap. She felt as though she must have done something to make this happen—that Cherelle's handicap was her fault. Furthermore, Cherelle's condition was experienced as a humiliation as well as a punishment for Latoya, and its visibility to others was difficult for Latoya to tolerate. Sometimes she almost seemed enraged with Cherelle for having this problem. The extent of her rage at Cherelle then fueled her fears that Cherelle would die during surgery. (Analytic theory tells us that every fear may contain a wish, revealing, in this case, the mother's ambivalence about the special burdens of caring for this handicapped child.) To contemplate the surgery that could help Cherelle, Latoya would need to acknowledge openly the extent of her daughter's problem, and she could not yet face that realization.

Nevertheless, with therapy, Latoya's anxiety seemed to be decreasing, and she reported being able to allow Cherelle to sleep in her own crib for the first time. Gradually, Cherelle also stopped crying in the nursery in the mornings when her mother separated from her. When she asked for mommy, she could be comforted by being told that mommy was okay

upstairs, and Cherelle was okay downstairs, and that mommy would come later to see her after nap time. Gradually, as Cherelle's experiences with her mother were becoming more predictable for Cherelle, and she could anticipate events more reliably, her anxiety over separation was decreasing, and she was becoming more confident and more competent.

After several weeks, Latoya gave me permission to begin play therapy with Cherelle. Whenever Cherelle spotted me in the nursery, she would lift her little arms and say, "Play! Play, Hirry"! At first she chose to work in the doll house, carrying the little toy figures in and out of the doors, over and over, as she tried to master coming and going. But beyond the separation difficulties she was having, Cherelle's developmental push to walk was now colliding with her obstructive physical handicap. Somehow she managed to balance herself on her damaged legs and to move around by hurtling and falling. Her determination to walk, no matter what, was on her mind during all of our therapy sessions. As she began to be able to walk 10 or 12 steps without falling, she started to build block structures and then knock them down, using this play activity to help her master her falls. In the nursery, she brought me her new favorite book, *The Tale of Duck* (Cooper, 1995), to read again and again. In this book, a boy has a wooden duck among his toys that wants to be the fastest toy of all. The duck will not heed the boy's warnings to slow down, but races about, finally falling down a flight of stairs and breaking into pieces. The boy then glues the pieces together and repairs the duck. Cherelle could not get enough of this book. Little did she know at the time how relevant it would be to her life because her operation would require the surgeons to break and then reset her legs.

In another play sequence, Cherelle became attached to two plastic mommy and daddy dolls and a school bus. She struggled over and over to cram these dolls into the school bus, but they would not fit unless one bent the legs, and Cherelle absolutely could not bear it if their legs were bent. Her pain at the dolls' bent legs enabled us to talk about how Cherelle, too, did not want bent legs; Cherelle wanted straight legs. She loved the long-legged toy giraffes and would crawl to the wall with them and make them climb up. We talked about how Cherelle wanted to get up like the giraffe; Cherelle wanted to be straight and tall. Both Cherelle's focus and determination as well as her capacity for symbolism now at 18 months old were remarkable to me. As her wishes were understood and verbalized, Cherelle finally began to allow the dolls to bend their legs to fit into the bus.

I made the decision to share the content of Cherelle's sessions with her mother to help Latoya see for herself the intensity of Cherelle's wish to walk normally and to enable her to face the necessity of an operation for

Cherelle. Finally, Layota's denial began to diminish, and through her tears, she made the decision to schedule surgery for Cherelle. Both of us prepared as best we could for the operation. Latoya rallied her support systems, we made lists of questions for the doctors, and a picture book for Cherelle with a story of what would happen to her legs, knowing that this was going to be one of the hardest things they would face together. Cherelle's operation was successful, but she came home in a lot of pain and discomfort. She had a great deal of trouble sleeping, and when she did, she had nightmares or would awaken in the morning crying.

Within several weeks, Cherelle and Latoya came back to school. Cherelle's legs were cast to the hip. Once again in the playroom, she insisted the dolls have straight legs. She rolled the mother and father dolls around in a car calling it their buggy (the word she used for her stroller on which she was now dependent). As she threw the mother, father, and doctor dolls around the room and bit every toy she could get her hands on, she demonstrated the rage of a toddler who realized that she had had her newfound ability to walk (however ineffectually) snatched away from her, and she was once again immobilized. Her mother was overwhelmed by her own traumatic reactions to the operation and could not bear to play with this angry, overwhelmed Cherelle or to watch her attempts to use play to master her hospital experience. Both Cherelle and Latoya desperately needed some separation from each other for relief from each other's distress, but they clung together in their pain. This dyad needed both time apart from one another to address issues that could not be managed with the others present and time together to work on a relationship that was not fraught with rage and frustration. To address these different needs, I offered each of them individual sessions as well as dyadic sessions in the playroom, which became a safe haven in my presence.

Unfortunately, Latoya was graduating from high school in June, and my relationship with them was coming to an end. Cherelle at this point was still recovering from her operation and would need to spend a long, hot summer in her casts, confined to her stroller. We had tried hard to make sense of her anger at her operation and hospitalization through play, and Latoya had been able to share some of her overwhelming feelings of anxiety and grief with the other mothers in her support group; however, both Latoya and Cherelle had a distance to go to repair their relationship and to recover from the trauma of the operation. It was with great sadness that I parted from them in June with a referral for more treatment. I hoped that the work we had done together had been internalized and would now help to sustain them as they moved on in their lives together.

Psychodynamic Infant–Parent Psychotherapy: Luz and Oscar

When I met Luz, a stunning 17-year-old with jet black hair and eyes and a breezy, brisk manner and her sturdy, serious 18-month-old son Oscar, Oscar was having a hard time with aggressive impulses, and Luz seemed unable to stop him from hitting other children. The mothers of the other children in the nursery were angry at Luz because she didn't seem able to follow any plan to diminish Oscar's aggression, despite suggestions offered by the nursery staff. I told Luz I might be able to help her with the "stage" Oscar seemed to be going through, and she agreed to become a part of our Teen Parent–Infant Project.

Luz was an extremely efficient mother and kept Oscar immaculately clean (always bundled up neatly, his bottles and food always ready), but all of their interactions lacked a sense of emotional attunement. Diapering was rapid and mechanical, with little interaction between mother and child; feeding was quickly executed, with Oscar returned to a mat for play like a book stowed neatly on a shelf. Occasionally, as though suddenly remembering something she had forgotten to do, Luz would tickle Oscar somewhat aggressively, wiggle a toy intrusively in his face, unexpectedly attack him with kisses, or abruptly set him down and rapidly disappear to return to class. Oscar would then be left overexcited, confused, and alone. Although Oscar's nursery caregiver was at hand to soothe and console him after his mother left, we all wondered what it must be like at home for Oscar when these events occurred and no one was there for him. Was Oscar left to cry alone, was he chastised for crying, or did Luz come back to comfort him? Luz, we noticed, had little patience with crying.

Attachment theory tells us that children need a secure, consistent base from which to explore the world. Securely attached children count on their mothers to provide a more or less constant, reliable response that is generally comforting. Insecurely attached children learn different lessons. Many learn that mother is consistently unavailable and so they must rely totally on themselves; others learn that mother is overly anxious and they must cling to her at all costs to feel safe. Some children, like Oscar, can find no strategy at all, because their mother's behavior is changeable, sometimes creating an apparently secure base and sometimes a frightening threat. When an attachment figure is both the source of survival and the source of threat, a child can become incapacitated. These children display a kind of approach–avoidance behavior that looks confusing and disorganized, as Oscar's behavior did, particularly during reunions at the end of the day, as the following example illustrates.

One afternoon Luz came through the door, and Oscar, on seeing her and hearing her voice, began crawling toward her. Midcrawl he stopped, laid his head down on the floor, and began to cry. When Luz saw him lie down, she frowned, shrugged, and, ignoring him, began to collect his bottles and outdoor clothes, leaving him lying there, weeping on the rug. It was as though Oscar could not figure out what to do when he saw his mother, and Luz, too, could not figure out what to do when she saw her son. What was keeping Luz from understanding Oscar's needs and emotionally connecting to him?

While she was initially hesitant about making the videotape that is the first part of our program, Luz was convinced by her friends that "it could be fun." Not surprisingly, her tape displayed the same disconnected interactions with Oscar that we had seen in the nursery. She remained attentive to Oscar's physical state, making sure his clothing stayed neat, his nose clean, his hair just so, but she seemed completely oblivious to his emotional needs. Much of the tape recorded Luz relentlessly trying to teach Oscar to put block shapes into a container through the proper-shaped holes. This was punctuated by comments to him such as, "Aye, Oscar, no! You're so dumb!" or to us, "See how spoiled he is? He wants all the toys for himself." No matter what he tried, Oscar couldn't do anything right for his mother. When Luz wasn't teaching or fixing or criticizing him, she was tickling or teasing him. Finally, Oscar gave up altogether, stopped playing, and just sat motionless.

During one of our early meetings together, Luz explained that she had been raised primarily by her grandmother's sister, whom she called "Tiamama," though there were periods she spent in New York with her mother when she was nine and again after Tiamama died when Luz was 14. Luz's mother had left for the United States when Luz was only two years old and did not send for Luz to come and live in New York with her until Luz turned nine. "I didn't want to go," Luz told me. "I didn't really know my mother, and when I got here, it was so cold! I cried every night, but I had to be quiet, because Mama wasn't having no crying kids in her house. I cried as soft as I could, but I guess it wasn't quiet enough. Her boyfriend started coming to my room and then, well, you know. . . . I didn't care really cause when my mother found out he was at me, I got to go home. . . . She sent me right back to Tiamama. I guess she liked the old slimeball better than she liked me. Not me. Men suck."

Throughout this conversation Oscar was playing quietly on the floor with a fire truck. Watching him pushing the truck back and forth, I wondered whether things might have been different for this pair had Oscar been a girl. Was the problem that this little baby boy was already a despised man in his mother's eyes? Did the problem lie in the traumatic separation

between Luz and her mother or Luz and Tiamama? Or was Luz still denying her own painful feelings and requiring of Oscar that he, too, deny his?

I asked about Oscar's father and discovered that he also played a role in Luz's feelings about men. "Oh, you know, at first I thought he was different," said Luz, "but he wasn't. Pretty soon he started with the shit—you know I shouldn't wear pants, my skirts was too tight, I couldn't go outside alone. Then he started listening to my phone calls and hitting me. . . . They're all the same, assholes." (Oscar, playing alone, has now begun throwing blocks around the floor.) Luz looked at Oscar irritably. "Why you always doing that? Makes such a mess, clean up, clean up." Oscar's burst of angry activity at that moment seemed a clear reflection of his mother's increasingly hostile tone.

"I guess it's hard to imagine there might be men out there who aren't like those two," I said. Luz rolled her eyes. Clearly the ghosts of these two men were contributing to the erosion of Luz's relationship with her baby son. Her rage and helplessness at these men extended to all men, even to her son, a little baby who needed her love and protection. In addition, Luz, herself, had not had the love and protection she needed from her own mother, so how could she be ready to be a mother for Oscar?

The next week Oscar was sick with pink eye and an ear infection so he and Luz were not in school. When I called to see how they were doing, Luz sounded angry and depressed. I hoped that my commiserating with her about the difficulties of being cooped up at home with a cranky child would support her enough to find patience with Oscar, but at this early point, I was not optimistic.

When Luz returned to school a few days later, I tried to focus my attention on *her*—how she could take care of herself, what mothers need for themselves, and what she remembered of being cared for as a child. When we talked about Tiamama and, for the first time, about Tiamama's husband, Raul, it became clear that here, perhaps, was a man who did not fit into the ideas of men as controlling abusers that Luz held so tenaciously in her mind. I asked about Raul, his relationship with her and with Tiamama, and remarked that her experience with him seemed unlike her other experiences with men. Luz continued softly, "When I was sick, he used to sit and tell me stories." She stared at Oscar and tears welled up in her eyes. Oscar crawled over to Luz and pulled himself up on her knee. She covered her face with her hands, and Oscar started to wail. "Oh, shut up," sobbed Luz, unable to connect to Oscar. "What are you crying about?" "Maybe he is keeping you company, Luz." I said. Luz dropped her hands from her eyes and looked at Oscar. Then she picked him up, burying her face in his chest. Oscar rested his little

head on her head and gently patted her back. For Luz, the idea that her son had a capacity to read and respond to her emotions was completely new, and this incident marked the beginning of a shift in her own capacity for "mindsight." In a dramatic reversal of the expected, Oscar had shown his mother compassion.

After a while Luz stopped crying. Feeling that she was calmer, Oscar made a move toward the toys on the floor and I followed him. Encouraging Luz to join us, I said, "What are you going to find, Oscar?" Oscar had spotted a ball and so began a game of rolling the ball among the three of us, which left us all laughing. This was the first play Luz and Oscar had shared together on the floor of the playroom. Even more unusual, it was child-led, reciprocal, and joyful. I felt that Luz and Oscar were taking the first steps toward a more mutually responsive mother–infant relationship.

"Does Oscar remind you of Raul at all?" I asked Luz, hoping to find a connection that might forge a link in her mind between her son and a man for whom she had affection in her childhood. This led us to a discussion of likes, dislikes, and temperaments. Little by little, over the weeks, as we talked about Luz's life, she began to think of Oscar as a child with his own interests and abilities and with needs that went beyond the physical attentions she had been giving him.

We spent the next month observing, discussing, and playing with Oscar together. Despite considerable progress, I felt that Luz still needed me present to hold them both together. She had not yet internalized our work. My presence seemed necessary to fill the space Tiamama might have occupied, had she been alive. I hoped our continued discussion about Tiamama and Raul would strengthen her positive memories so that she could begin to use them as emotional resources for herself and Oscar in the future. In mothering this mother, I was hoping to pull for the positive transferential feelings that would strengthen the link between Tiamama and me, increasing Luz's attachment to me and thus allowing her to increase her attachment to Oscar.

For several months things seemed to be steadily improving between Luz and Oscar, with more empathy and pleasure in their encounters, but then, suddenly and unexpectedly, Luz reverted to her old attitudes and behaviors. She became sullen, easily riled up, and seemed to be looking for a fight with everyone. Once again, she began treating Oscar like an inanimate, neatly wrapped package that she just dropped off at the nursery. It was clear something had happened to produce this regression, but what?

After some therapeutic exploration in which I highlighted the changes in her and asked Luz to reflect on their meaning, Luz was able to tell me that

the anniversary of Tiamama's death was imminent and that it reminded her of all the painful losses and separations she had had in her life and was propelling her into a rage. She now felt furious at having been abandoned, first by her mother at two years old and then by Tiamama when she agreed to send Luz to New York, a vulnerable nine-year-old who was unprotected and ultimately sexually and emotionally abused. She also felt furious at Tiamama for dying and again causing her to submit to the vicissitudes of her mother's life in New York. As these feelings surfaced, Luz was able, for the first time, to work hard in her sessions, describing her feelings of pain and loss. Her anger began to subside, and she was able to mourn and grieve for herself as a child. Just as talking about her abuse at the hands of her mother's boyfriend and her resentment of her baby's father had helped Luz to stop infecting her relationship with Oscar with her bad memories, so, too, as she allowed her feelings of hurt at the hands of Tiamama and her mother to emerge, she could also begin to identify with her son's feelings of hurt at her hands.

It is beyond the scope of this article to describe in detail Luz's participation in the mothers' support group that met weekly over lunch. In brief, through the group she was able to alter her previous belief that hitting Oscar was the only way to "control him" and "make him tough." She took deeply to heart the comments of another mother who said one day, "I been through it all. I been beaten, dragged across the floor by my hair, and slashed, and I *hate* my father. I'd do anything before I make my baby hate me like that." This helped Luz to recognize her own capacity to hate, and she realized that she had the power to make her own son hate her. She became attached to a book I gave her, *Mama, Listen! Raising a Child Without Violence* (Beaglehole, 1999), written for teen mothers from the perspective of a toddler. She carried this book with her in her book bag, as both a talisman and a reminder of help in times of distress.

In the final videotape that Luz and Oscar made after participating in our Teen Parent–Infant Project for nine months, the two of them played under some big pillows. Both the mother and baby were thoroughly disheveled, and the room was something of a shambles, a far cry from the perfect grooming and neatly stacked toys of their first video, but their joy and vitality shone through. At one point, Oscar, catching a glimpse of himself in a mirror, grabbed his mother's hand and pulled her over to it. "You want me to see the mirror," said Luz. Together they peered into the glass. "Mama," he said pointing to her in the mirror, grinning. "Oscar," she said smiling back, and hugging him gently. Oscar and Luz had found each other.

Discussion

Videotapes can be particularly useful in the treatment of adolescent mothers because they capture a vivid here-and-now experience and because they enable us to begin to rouse an observing, reflective, compassionate stance in the mother, one of the goals of our intervention.

The initial sharing of the videotape by the therapist and the mother set the reflective tone for the therapeutic intervention. Adolescents, and especially adolescent mothers, are acutely vulnerable to narcissistic injury, as the sense of self is still in the process of formation. In addition, they are often uncertain and defensive about their maternal competence and resistant and rebellious toward adult authority. Nonjudgmental reflection enables us as clinicians to avoid injuring the delicate ego of the new mother and to sidestep any power struggles about "who decides what" in relation to her child. (This is a frequently fought battle between teen mothers and their own mothers or mothers-in-law.) By searching for small moments of positive mutual interaction in the videotapes, the therapist underscores her interest in the details of her child's life, displays a willingness to wonder about the child and the mother's behavior rather than judging it, and expresses a deep regard for the power of the mother–infant exchange. As we think about the mother, we hope she, in turn, will also begin to think about her child.

Together, we imagine what the baby might have had in mind as she looks a certain way or performs a particular action. This requires developing a capacity for thought and reflection, and once this is in place, the mother's initial reaction can be modulated and reorganized. For example, when Luz exclaimed, "Aye, Oscar, no! You're so dumb!" or "He doesn't want to play with me," she was attributing qualities and motives to her baby that, on reflection, can be given new, more neutral meanings. Watching the tapes together, we began the process of encouraging *reflection* instead of *reaction*. As a reflective position develops, the mother begins to speculate about both the infant's feelings and her own. This leads her to recognize her child more clearly as an intentional being, with thoughts and feelings separate from her own. Fonagy and colleagues (2002) wrote, "A fundamental need of every infant is to find his own mind, or intentional state, in the mind of the object" (p. 474). They went on to argue that "this capacity to mentalize is a key determinant of self-organization and affect regulation" (p. 23).

Affect regulation is vital to good functioning in adolescence as well as infancy, and it is difficult to maintain at both life stages. As the teen mother finds her mind in the mind of the therapist, we found that she was better

able to regulate herself and her child. Together the teen and therapist muse over what happened during an argument the teenager had with her teacher, or they wonder together what might be happening with the baby when she starts to scream on the bus. As the teen mother reflects on what happens when she feels angry and what might be happening when her child is upset, she is more likely to offer her child a sensible, sensitive response than a smack.

The structure of our program encourages the caregiving staff and therapists to work together as partners in the regulation and support of the teen mother and her baby. In the case of Latoya and Cherelle, this was particularly important, because they were a dyad that evoked difficult reactions and complicated countertransferences in all of us. Cherelle's incessant crying during separations, the poignancy of her damaged legs and her wishes to walk, and Latoya's persistent denial that her child needed an operation wore out everyone's patience. It was difficult to contain our feelings and not let them spill out onto this young mother who was so terrified about her child that she kept the two of them locked in a constant state of intense preoccupation with one another. Open discussion with the staff that acknowledged the sadness, frustration, and anger the situation evoked, helped us to support each other, to support Latoya, to support Cherelle, and eventually to find opportunities to foster independence in both of them.

Indeed, we hoped that not only the mothers but the nursery caregivers and therapists as well would engage in a process of deeper reflection that would lead to more thoughtful decision-making and behavior. We hoped for a therapeutic trickle-down effect—as we, therapists and caregiving staff, held each other in mind, it helped us hold the mothers in mind, so they, in turn, could hold their children's needs in mind and act on them with sensitivity.

Special Challenges Working in a School Setting

Psychotherapy outside of a clinic or consulting room offers both opportunities and challenges to more traditional treatment techniques. On one hand, we had enormous opportunities for extensive and ongoing intervention. On the other, we faced enormous challenges in trying to offer help to young women who had no idea that they might need it and were often ambivalent about accepting it.

In addition, clinical parameters must be adjusted in a school setting. As familiar faces around the school, we were present at wakes, christenings,

and appointments with doctors. We were invited to school celebrations and birthday parties. We were drawn into the role of disciplinarians, asked for educational help with homework, or pressed to respond to real-life situations through requests to use the phone, for a Tylenol for menstrual cramps, or for money for breakfast. In other words, as clinicians in a school setting, we also took on the roles of advocate, coach, tutor, referee, and mother. Despite this necessary expansion of our role, we always tried to make our treatment decisions from a clinical and developmental perspective and to reflect on the altered parameters of our work. Who we were at exactly any moment to our mothers and their babies was a complex question that required persistent attention and analysis.

We have given a great deal of thought to the racial, cultural, and socioeconomic difference between the primarily white middle-class clinicians and the largely Latino and African American student population. It is interesting that this difference appears to have been less of a stumbling block than we had anticipated. It is possible that because our program is voluntary, the mothers had already taken this difference into account and accepted it as part of their participation. It is also possible that together, we were able to surmount these difficulties as the teen mothers realized that we were consistent, nonjudgmental, welcoming, and useful. (Sadly, consistency is rare in the lives of many of our mothers, and its very presence contributes a great deal to the creation of a therapeutic alliance.) Third, throughout our work, we tried to be sensitive and informed about culturally diverse parenting practices, and, to the best of our capacities, we approached cultural and racial issues from the same standpoint as everything else in our work, *emphasizing reflection over reaction*. This position seemed to allow the mothers to accept and trust us despite the fact that we did not share their racial, cultural, or socioeconomic background.

Conclusion

The Chances for Children: Teen Parent–Infant Project emerged from our experiences of trying to offer treatment to troubled elementary school children whose lives were already awash in violence, trauma, and school failure and our belief that a program informed by psychoanalytic-developmental theory would enable us to offer deeply useful help to these young families. We believe that on-site school programs for adolescent mothers and their babies can make a substantial contribution to the healthy development of both the infant and the adolescent, addressing their needs by creating a kind

of Winnicottian "transitional space" (Winnicott, 1958, 1971) in which the mother–infant pair can begin to play alone together in the presence of a supportive therapist. This experience, which offers a "holding environment" (Winnicott, 1960) for the mother–infant dyad while it encourages empathic and reflective responses, can then be internalized by allowing the teenage mother to take on as her own the therapeutic stance we have demonstrated (Schafer, 1997). In this way, we believe it is possible to undo the cycle of despair and failure that destroys so many of these young lives.

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