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# A Mother, A Baby, and Two Treatment Approaches: Discussing A Switch Case from CBT and Mentalization Perspectives

Jordan Bate, Ph.D., Ozlem Bekar, Ph.D., and Inga Blom, Ph.D.

**ABSTRACT**

As the literature on perinatal depression and anxiety grows, there is an increased need for dialogue among theoretical approaches for mother-infant mental health. This article describes a community mental health program incorporating a range of treatment models for pregnant and postpartum women experiencing issues during the transition to parenthood. Perinatal distress can affect parenting practices, from breastfeeding to health care access, creating the need for targeted, practical, and concrete interventions. Interventions that aim to foster secure attachment relationships and mentalization capacities can also help increase maternal sensitivity and attunement and joy in caregiving, and reduce withdrawn/hostile behaviors that may be associated with perinatal distress. The article describes psychotherapy with a mother and her newborn that began from a cognitive-behavioral approach and transitioned to a psychodynamic mentalization-focused treatment. Working principles and examples of two additional components of treatment, a group psychotherapy and research measures, are discussed. The case helps demonstrate how attachment theory can inform treatment and build a bridge between alternative approaches.

## Introduction

Pregnancy and postpartum are periods of risk and opportunity as a new mother undergoes a neurobiological and psychological reorganization that involves a shift from being an individual to a dyad, and from being a child herself to the parent of a child (George & Solomon, 2008; Stern, 1995; Von Mohr, Mayes, & Rutherford, 2017). This transition is one in which mother and infant, reality and fantasy, interact with each other, often changing the mother's conscious and unconscious representations of self and others (that may include projections) (Cattaruzza, 2014; Fraiberg, Adelson, & Shapiro, 1975; Lieberman, Padron, Van Horn, & Harris, 2005a; Markin, 2013; Raphael-Leff, 1990; Von Mohr et al., 2017).

An estimated 10–20 percent of perinatal women experience clinically significant depressive symptoms and/or notable anxiety symptoms, which have received less attention from researchers (O'Hara et al., 2012, Ross & McLean, 2006). One way new mothers are able to make meaning of the baby's experience and respond appropriately is by drawing on an internal representation of a good enough mother (Cattaruzza, 2014). Depression and anxiety can make this more difficult by leading to distorted patterns of thinking and inaccurate interpretations of the infant's needs. The transition to parenthood can awaken a parent's own early relational memories. Clinicians who work with

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perinatal women (and parents in general) often notice various defenses against negative feelings or relational trauma memories, some of which may be maladaptive (Porcerelli, Huth-Bocks, Huprich et al., 2015; Warshaw, 2000).

Relational trauma is a proximal risk factor for maternal depression and dissociation during caregiving (Alvarez-Segura et al., 2014; Cohen & Beebe, 2002; Markese, 2011). Furthermore, maternal depression increases the risk of reduced maternal sensitivity, withdrawn and hostile maternal behaviors, and is correlated with a host of developmental risks and difficulties as well as internalizing and externalizing problems in children (Ahun et al., 2017; Feldman et al., 2009; Field, 2010; Goodman et al., 2011; Grace, Evindar, & Stewart, 2003; Lovejoy, Graczyk, O'Hare, & Neuman, 2000; Madigan, Wade, Plamondon, Maguire, & Jenkins, 2017; Markese, 2011; Norcross, Leerkes, & Zhou, 2017; O'Connor, Monk, & Burke, 2016; Weinberg & Tronick, 1997). Given the impact that maternal distress can have on the baby and the developing mother-child relationship, our clinical stance is that any treatment that targets maternal distress is also preventative vis-a-vis the developing baby.

There is a long psychoanalytic tradition of working with parents and infants (including Anna Freud, Selma Fraiberg, Margaret Mahler, Daniel Stern, and Anni Bergman). Attachment research has provided an additional and related lens through which we understand this population and make interventions. Bowlby (1988) posited that early experiences with caregivers shape children's attachment-related behaviors to maximize survival, as well as the development of "internal working models," which are representations of the self, other, and relationships that guide expectations and behaviors. Assessment tools such as the Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978) and the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985), among others, have allowed us to empirically study the ways in which these representations unfold in parent-child relationships. Specifically, studies have linked maternal attachment security to how mothers relate and respond to their children, which then impacts their children's developing patterns of attachment (De Wolff & Van Ijzendoorn, 1997; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005a; Steele & Steele, 2008a; Steele, Steele, & Croft, 2008b).

The concept of mentalization came to be defined within the context of this literature as the ability to understand one's self and others in terms of internal mental states (thoughts, feelings, and intentions) that underlie behavior. It was not a new concept, but its definition and operationalization as reflective functioning facilitated research explaining its role in the development of attachment security (Fonagy et al., 1991). It is hypothesized that mothers who are able to freely explore and reflect on their own feelings, in light of past experiences, are better able to regulate their emotions and respond sensitively to their children, providing them with a similar platform to freely explore mental states and develop the capacities for affect regulation, flexibility, reflection, and a sense of self (Fonagy et al., 2002; Rutherford et al., 2013; Slade et al., 2005a; Suchman, DeCoste, Leigh, & Borelli, 2010). Thus, mentalization has been proposed as one mechanism that may explain the transmission gap in attachment patterns (Fonagy & Target, 2005).

There are various ways parents' relational patterns and mentalization skills may be transmitted to their children, and many factors influence attachment security and the ability to mentalize (George & Solomon, 2008; O'Connor et al., 2016). However, the attachment and mentalization constructs can offer a useful window through which we listen and work with families clinically, providing an entree into the therapeutic process for making sense of parental difficulties and children's developmental problems, engaging parents in treatment, working with treatment resistance, and facilitating a working alliance (Warshaw, 2000). As such, this article focuses on mentalization as a target for treatment of parents and their infants within a relational/interpersonal treatment approach, which can be used in conjunction or integrated with other orientations.

## Approaches to psychotherapy for postpartum women

A growing body of research examines the efficacy and effectiveness of psychotherapy for postpartum mood and anxiety disorders. Initially, the treatment for postpartum depression with a strong

research base was interpersonal psychotherapy (IPT; Miniati et al., 2014; Weissman, Markowitz, & Klerman, 2000). Given its popularity and effectiveness in treating depression and anxiety, practitioners and researchers have also looked to CBT as a treatment for perinatal mood and anxiety disturbances (Sockol, Epperson, & Barber, 2011; Wenzel, Haugen, Jackson, & Brendle, 2005). According to Kleiman and Wenzel (2014), a structured, time-limited, collaborative and active approach to reducing symptoms may be welcomed by perinatal women who are looking to feel like themselves again. However, a criticism of both IPT and CBT has been their primary focus on reducing acute mood symptoms in mothers, with questions remaining about the quality of parent-child relationship, the child's development, maternal satisfaction, and the recurrence of symptoms in the face of new challenges. Recently, the utility of these treatments in reducing even maternal depression has been called into question (Trivedi, 2014).

Psychodynamic treatment for postpartum depression and anxiety does not appear as frequently as these other modalities in meta-analytical reviews, despite its strong theoretical background and the prevalence of case studies. One study that did include psychodynamic therapy reported statistically significant gains compared to the control group (Cooper, Murray, Wilson, & Romaniuk, 2003). In contrast to IPT and CBT, which tend to treat the mother individually, psychodynamic treatments have often placed the parent-child relationship and/or the infant at the center of the treatment, with many of these interventions targeting mentalization as the mechanism of change. There is a well-established evidence base for parent-infant/toddler treatments, including Child Parent Psychotherapy (CPP; Cicchetti, Rogosch, & Toth, 2000; Lieberman, Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ippen, 2005b; Toth, Rogosch, Manly, & Cicchetti, 2006), Minding the Baby (Ordway et al., 2014; Sadler et al., 2013; Sadler, Slade, & Mayes, 2006; Slade et al., 2005b), Parent-Infant Psychotherapy (PIP; Fonagy, Sleed, & Baradon, 2016), and Parents First (Slade, 2007). These interventions have also shown support for holding reflective functioning at the core of attachment-based, perinatal interventions.

## An integrative treatment model

The perinatal mental health program at Northwell Health, Lenox Hill Hospital Outpatient Center for Mental Health (OCMH), an urban mental health clinic, was formally started in 2016 to provide specialized services to pregnant and postpartum women and their families. The program is integrative and psychotherapy-driven. In our experience, trainings/conferences sponsored by the hospital system and broader New York City initiatives related to perinatal mental health emphasize psychoeducation alongside symptom-focused interventions that prioritize maternal distress over attention to infant experience. In contrast, our staff and supervisors are primarily psychologists versed in a range of approaches, including psychodynamic psychotherapies and attachment theory, as well as cognitive, behavioral and third wave CBT treatments. As a teaching hospital, clinical psychology externs, interns, and postdoctoral fellows comprise the majority of the treatment providers.

### *Individual psychotherapy*

The treatment provided is based on trainee clinicians' assignment to one of two perinatal supervision groups: cognitive behavioral or psychodynamic. Both psychotherapy treatments consist of weekly 45-minute sessions with the mother, and she chooses whether to bring her infant. The cognitive behavioral approach emphasizes identifying automatic thoughts, behavioral activation, problem solving, coping skills, and interpersonal effectiveness. The psychodynamic approach can be further specified as contemporary object relational, with particular attention given to mentalization skills, attachment patterns, transference to the therapist, and maternal transference to the baby.

### Group psychotherapy

All mothers, regardless of the type of individual treatment modality they receive, are invited to a weekly, psychodynamically oriented group for new parents. Group therapy is considered an efficient treatment modality and often recommended during this period, as there is some evidence of its efficacy in reducing distress in women with young children (Bergman, Moskowitz, & Friedman, 2011; Goodman & Santangelo, 2011; Sossin, 2011). The group is described to new parents as a time to ask questions and make sense of the tremendous changes that come with parenthood. The group is open-ended, with no attendance requirements, and serves simultaneously as a community space and a clinical space.

Offering a holding environment for mothers and babies to be together that is nondirective but convened by "experts" has a long history in psychodynamic work and research on motherhood and early childhood development (e.g., Beebe & Markese, 2011; Mahler, Pine, & Bergman, 1975; Nachman, 1991). Our group's frame and aims are similar to groups established by these clinical-researcher "baby-watchers" and by more recent attachment-based group interventions (Bate et al., 2016; Murphy, Steele, Bate et al., 2015, Steele, Murphy, & Steele, 2010). Typically, one group-leader focuses on interactions among the mothers, and the co-leader focuses on what the babies are doing in relation to their parents and others in the room. The general approach is to engage parents in helping each other work out shared problems, reflecting on the experiences (minds) of their babies, and considering how their own histories may be influencing their present perspectives and behaviors.

### Research plans

A current part of services includes an ongoing, naturalistic longitudinal study, designed to examine the role of reflective functioning in the treatment of perinatal mood and anxiety disorders (PMADs). Consenting mothers complete research measures at intake and every three months. The full details of this program will be described in later publications, but one measure, the Five Minute Speech Sample (FMSS; Adkins & Fonagy, 2017), is administered by the clinician in session and is discussed in the case that follows. The FMSS asks a mother to talk freely in response to four prompts: describing her baby, her feelings about the baby, the baby's imagined feelings about her, and how she has handled a recent problem. Responses are coded using the Reflective Functioning Manual (Fonagy, Target, Steele, & Steele, 1998) and the Coding System for Mental State Talk (CSMST), developed by Bekar and colleagues to analyze speech through the lens of mental state words (Bekar, Steele, Shahmoon-Shanok, & Steele, 2018).

## Clinical material

The following case is presented to demonstrate how the therapy approaches outlined above are actually delivered in a community setting and to examine aspects of two different treatment approaches with the same patient. The clinician in this case is the first author, who was a trainee at the time of this treatment. For simplicity and clarity, the clinical material is written as the therapist's first-person narrative.

## Initial background

Maria was a multiethnic American woman in her early 30s who presented for treatment when her first-born child, Ashley, was about 8 weeks old. She was recently married to her child's father and had returned to work full time while he worked from home and cared for their daughter. At intake, Maria endorsed symptoms of generalized and social anxiety, and panic attacks. She reported fatigue, difficulties with attention and concentration, muscle tension, irritability, and insomnia. She reported

stress in her new marriage, feeling unsupported, several postpartum medical issues, and body dysphoria. In the face of these stressors, she felt invalidated by her environment and that the attention paid to her baby was at the expense of her psychological well-being. Maria's own mother was a teenager when she was born, and she had limited contact with her father after her parents divorced when she was young. Maria described her relationship with her own mother as good and elaborated very little. Maria had briefly received outpatient psychiatric treatment as an adolescent.

## Course of treatment

Maria's treatment was initially supervised in a CBT for perinatal mood and anxiety disorders approach (Kleiman & Wenzel, 2014) for one year, at which point therapy switched to a psychodynamic and mentalization-focused approach. The research program was initiated at the beginning of the second phase of treatment, and Maria consented to participate. Some of these research measures will be discussed as part of this vignette. Because Maria was employed full-time, she was not able to participate in the group therapy component.

## Cognitive behavioral therapy for perinatal distress

### *Starting treatment*

In the first session after intake, Maria reported poor sleep and was in the midst of a disagreement with her husband. Kleiman and Wenzel (2014) write that the clinician's flexibility is important in the early phase of treatment, and that treatment may not proceed within the same structure and organization that it typically does with nonperinatal patients. Instead, assessment, case conceptualization, orientation to treatment, and hearing the patient's story may all be done simultaneously. Thus, after listening to what happened, I (JB) provided some information about how we could work together on this and other sources of distress.

### *Framing the CBT conceptualization*

I explained my conceptualization, within a biopsychosocial framework and informed by a cognitive behavioral perspective. Maria's family and personal history suggested a possible biological vulnerability to mood symptoms. Furthermore, she was eight weeks postpartum and had medical problems immediately following the birth, which likely affected her on a physical and neurobiological level. Stresses in Maria's environment included lack of social support and the recent transition back to work. Psychologically she was struggling with anxiety, in relation to her husband and her daughter's well-being. Maria agreed with the conceptualization, so I described the cognitive model, drawing out how situations trigger automatic thoughts, and lead to feelings that are attached to behaviors or urges to act.

### *Using examples*

I suggested we use the situation with her husband as an example to begin mapping out the automatic thoughts associated with her anxiety. She identified automatic thoughts that her husband did not understand her feelings, which she feared would mean he did not love her. Based on that fear, we labeled Maria's core beliefs, which included that she was unlovable and would be abandoned by others, namely her husband. I explained that we all have positive and negative core beliefs, and in general, when things are going smoothly, our more positive core beliefs are activated. But in times of stress, even joyful stresses like having a baby, our negative core beliefs are more likely to get activated and our automatic thoughts get filtered through those lenses. We concluded by laying out goals in our treatment plan: 1) identifying and evaluating the automatic thoughts that lead to her painful feelings

and 2) improving communication patterns in her relationship with her husband. I also provided some information about breathing exercises and progressive muscle relaxation to help improve sleep.

In the second session, Maria again discussed frustrations with her husband. After seeing on the "nanny cam" that her daughter awoke from a nap but he did not notice her, her automatic thought was "he is neglecting her" and "he does not care about her development." With some evaluation, Maria connected her current thoughts that her husband was neglectful and uncaring to her earlier experience of being abandoned by her father. She recognized that she interpreted much of his behavior through that lens, watching closely for signs that he would abandon both her and the baby.

### *Relationship expectations and roles*

In recent years, interpersonal models have been integrated into CBT because of the prevalence of interpersonal problems among those who are diagnosed with depression and/or generalized anxiety and the role that interpersonal problems play in exacerbating or maintaining symptoms (Newman et al., 2011; Schwartzman et al., 2012). Accordingly, my initial work with Maria focused on thoughts and feelings that arose in the context of her relationship with her husband, since this was the most overt source of distress. Shortly after an argument with her husband about household responsibilities, Maria exclaimed, "This is not how I pictured the relationship!" Expectations play an important role in relationships, and I asked more about how she was raised and what she saw growing up. After Maria's parents' early divorce, she lived with her grandparents for some time. Her retired grandfather took care of the household and "doted" on her working grandmother. Maria now had similar expectations of her husband, leaving her feeling entitled and disappointed.

Furthermore, during that time Maria's mother lived and worked in another town and visited her children on the weekends. Maria recalled worrying about her mother when they were apart, and her older relatives joked that she never "acted like a kid." We identified that Maria's role in her family had been the "worrier" and parentified child, and she was resuming these roles now.

### *Communication skills*

Although analysis and interpretation of transference and countertransference is not a central focus of CBT, the therapeutic alliance is seen as a critical element of treatment, and the therapeutic relationship is considered a source of data that can be useful to identify automatic thoughts and emotions related to interpersonal interactions and schemas (Prasko et al., 2010). Maria was pleasant and engaging but often talked about her distress with a sarcastic tone that, in one session, caused me to chuckle. She noted her husband often laughed too when she was upset, so she was curious about the impact her communication was having on others. Drawing on Jeremy Safran's early work on integrating CBT and interpersonal theory (1990a, 1990b), we mapped out Maria's interpersonal schemas and the cognitive interpersonal cycles she was trapped in. Core beliefs that she was unlovable shaped assumptions that her feelings would be ignored. Humor was a compensatory coping strategy, but it actually led her husband to dismiss her concerns, confirming her core beliefs. After going through cycles of this pattern, Maria would eventually resort to a more aggressive communication style, stating her demands and closing herself off to any negotiation.

Planning to return to cognitive restructuring, I decided assertiveness training might first help Maria express herself more effectively with her husband. As is often true, changes in the form of communication over content were the most beneficial, including shifts in tone, use of gesture, eye contact, and smiles. But when Maria's husband responded positively, she attributed the change in his behavior to his "just being nice because he is feeling guilty." She did not want to show appreciation, because she did not want him to forget that she had been upset.

### Cognitive restructuring

Maria's interpretation that her husband was "only being nice because he felt guilty" got in the way of her experiencing pleasure in her relationship. This is a common cognitive distortion, often referred to as discounting the positives. I urged Maria to think about other reasons he might be acting nicely (even lovingly) toward her, including the possibility he was appreciating her efforts to communicate differently. I suggested she try to think of their interactions as a dance where each partner's moves impact the other and recommended she try to notice her husband's "good moves," without requiring that she disregard his "bad" moves.

Another theme in our treatment was Maria's worry that something terrible would happen to her daughter due to carelessness by other adults, which caused tension with her in-laws, who perceived her as controlling. The primary distortion was overestimating a threat. While acknowledging some risk of injury to her daughter, we probed what was probable, Maria's worst fears, and how she would respond. Maria often underestimated her daughter's abilities to communicate if she was uncomfortable, so we looked at the evidence for how her daughter communicated and how others responded.

### Developing affective coping skills

Ultimately though, changing her cognitions did not reduce the immediate physiological responses that Maria often experienced. In supervision I sought help understanding Maria's behavior as ways of coping with those physiological reactions. Not only did Maria think something terrible was going to happen, but she also believed her worries helped to keep others safe and that taking action was the only way to stop her anxiety. These beliefs are common in anxiety disorders, particularly generalized anxiety disorder (GAD), and must be addressed.

As Maria began to talk more freely about her own negative childhood experiences and the emotional dysregulation she was exposed to, she noted that emotions were never discussed in her family. She had never learned adaptive ways to cope with distress. Instead, she learned to act as if everything was fine or to take immediate action in the form of control. Affective coping skills would offer a middle path. I reminded her of the mindfulness exercises taught earlier in our treatment and provided worksheets on distress tolerance skills from dialectical behavior therapy (DBT). When angry or afraid, she could calm herself by slowing her heart rate and breathing, and then evaluate her thoughts and problem solve.

As with many perinatal women, the stressors in Maria's life were real, and we were not questioning their validity. Our point of intervention was the intensity of her emotions. Their force took over, preventing her from thinking clearly and ultimately leaving her feeling enraged, unseen, and distant from her husband, and not able to be completely present with her baby. We also discussed behavioral changes that could reduce her vulnerability and help stabilize her mood, including sleep hygiene and getting more exercise, an important outlet she had not been using at all since the birth of their daughter.

### Exploring core beliefs

Throughout our work, we reflected on the multitude of ways Maria had not been protected by her own mother, how her internal experience had been disregarded, and she had been expected to be the responsible one—a role she now resented but at the time seemed the safest option. Maria had seen her father only a few times since her parents' divorce, and each time he dismissed or avoided her. Remembering this, she stated, "When the person who created you doesn't even want to know you, how are you supposed to feel about yourself?" She was on the verge of tears but said, "I don't want to cry. I don't want to get stuck wallowing." My supervisor pointed out that Maria experienced sadness as out of control and unacceptable, whereas her anger made her feel strong and more in control.

By the end of our first year of treatment, Maria's self-awareness had increased, and her mood and communication with her husband had improved. This was achieved through cognitive restructuring of automatic thoughts and core beliefs. Maria was also exercising, seeing her friends, and less obsessively checking the "nanny cam." And she was thinking ahead about what her needs were and how to get them met. Maria continued to have the most difficulty with emotion regulation and distress tolerance. I was also beginning the next year of my training, which meant moving from providing CBT to focusing on psychodynamic, mentalization, and attachment-based treatment.

## A psychodynamic mentalizing approach

### *No such thing as a mother (without a baby)*

A central feature of an attachment-based approach is curiosity and interest in (a) the baby's developing mind, (b) the parent-child relationship, and (c) the mother's own mind with respect to her attachment relationships. Though Maria had been bringing her daughter to most sessions as an infant and often spoke about her worries about her, we had focused primarily on Maria's thoughts, feelings, and behaviors and not on her relationship with her baby.

### *Integrating research measures into clinical work*

During the first session after the change in my training modality, Maria did the five-minute speech sample task, which involved talking freely when describing her baby, her feelings about the baby, the baby's imagined feelings about her, and how she had recently handled a problem. She began with saying:

> My baby is very sweet. She can be very loud. And she's very gentle. I don't know, she kind of varies, and then she can be very rough. But she listens, she understands "no," even if she doesn't follow what we're asking her to do… Sometimes I feel like she, well, she's wanting to be independent and exploring, so sometimes I feel like because we're still breast feeding that she just is like using me for food, and then she goes off and does the next thing.

When she reached the question about a recent problem, she had difficulty coming up with or acknowledging one. She was holding Ashley, who was 1 year old at the time and quite active. To see if she might be able to add anything further, I offered to take the baby from her arms, narrating, "I don't think you're going to like this, but I'm going to try to give this [paper with the questions] back to mommy so she can see if she has any more thoughts on any of these. And maybe we can try, I can hold you while she thinks about them." Almost immediately upon having her child out of her arms, Maria continued:

> Ok, yes, I can expand on this. So right after she turned one she became a true toddler and start screaming unexpectedly and being very assertive with what she wanted. And breastfeeding, she'll like scream in public… That is actually a problem.

Maria's narrative about her daughter was primarily in behavioral terms and lacked coherence. For example, she shifted from describing her baby as "sweet," "loud," "gentle," and "rough," without giving much acknowledgment to these contradictions and reflecting on her own thought process. This paralleled the lack of coherence that I had observed throughout our treatment, with regard to her upbringing, which she had initially described as "good" and "normal," before later acknowledging challenges. Furthermore, there was an avoidant quality to her inability to think of any problems. However, her capacity to mentalize herself was somewhat restored when I took the baby. She was less distracted, but it also seemed that without the baby in her arms Maria could allow herself to think about problems they had been having. I also gained important new information about the dyad, namely that Maria was viewing Ashley's frequent comfort nursing as a problem.

### Asking what, not why

Consistent with an MBT approach (Bateman & Fonagy, 2013), I aimed to explore her experience in detail, by asking "what" questions, rather than "why" questions that demand an explanation. Knowing about her experiences growing up, I could understand Maria's worries, but I remained curious about how Maria's ideas were "held" (Bateman & Fonagy, 2013), that is, the certainty she had about what her daughter would feel in the hypothetical situation.

I encouraged Maria to tell me more about what was happening around breastfeeding. She laughed uncomfortably while describing her baby's demands and spoke to the baby when she seemed to want to avoid speaking directly to me. When asked what she was feeling, she expressed embarrassment. Her psychiatrist had recently given her advice for feeding schedules and sleep training. I inquired about how she perceived that advice. She explained that she felt like the psychiatrist was telling her what to do, and she was in fact really torn because she had never wanted to put her baby on a schedule. "What do you think a schedule would be like for her?" I asked. Maria imagined that her baby would feel hungry and then neglected.

I did not then push any further on mentalizing her daughter. My initial step into this new approach needed to be exploring, clarifying, and relating to Maria's own mental state. Knowing that she was feeling anxious and judged about her parenting, I returned to mentalizing her experience, inquiring what this way of feeding has been like for Maria. "That's the other thing," Maria elaborated, "We never wanted her on a schedule, because we wanted to bring her everywhere to do everything with us. We never wanted to be those parents whose lives were dictated by her schedule. And it's great, we do take her everywhere with us and I love doing all of these things with her." Validating her enjoyment, I also normalized her reluctance to change. But then Maria moved back to how unmanageable it had become, "I mean, it's like she thinks she owns me, as if I belong to her." I asked Maria what she would like her daughter to think instead. And she responded, "That I'm not entirely hers. That I love her, and I don't want her to be hungry, but that she can't always get things exactly when she wants them."

I agreed with Maria that babies need to learn that their mothers are separate from them. But as she was convinced that her daughter would experience separateness as painful, I also explained some of the infant research about how the experience of manageable frustrations helps infants to develop the capacity for distress tolerance and self-efficacy (Bergman & Harpaz-Rotem, 2004; Mahler et al., 1975). I suggested she try to imagine a world where everything seemed to go well all the time, saying "it would probably be nice to have everything go so smoothly, and yet you might not feel you have much control." I contrasted this with experiencing something that "is a little unpleasant, but realizing that you can handle it, and maybe do something to restore the pleasant feeling." This is how we develop a sense of agency and self-efficacy.

### Modeling mentalization

As we were talking, Ashley toddled around, sometimes sticking her head into our conversation. Maria spoke to her with a mocking tone as if to say, "You little troublemaker, I see what you're doing." I wanted to model for her a different way of including the baby that would reflect what was happening on the inside. So, the next time Ashley approached us I said warmly, "I see you, Ashley. Maybe you're wondering what we are talking about, why we aren't playing with you. Mommy is just telling me it's hard when she can't give you what you want right away, but she's always here for you." In the moment, my modeling had little impact on Maria, who did not seem to note anything about my way of speaking, nor did I ask. My hope was that by hearing these alternative ways of speaking, Maria might gradually adapt some new scripts or even start to become more curious and thoughtful about how she used vocalization and language with her baby.

### Mentalizing the patient

It was often tempting to make links between Maria's own experiences of not being heard and her worries that her baby would not be heard, as well as tolerating her own disappointment of not getting what she wanted from other people and helping her baby delay gratification. But unlike other psychodynamic therapies or CBT, the MBT therapist "is focused on mental processes and is not engaged in cognitive restructuring, [she] is not working to provide insight and [she] does not attempt to alter behavior directly. The cognitive and behavioral changes that often take place… occur in MBT as consequences of the change in mentalizing, rather like positive side effects" (Midgley & Vrouva, 2012, p. 28).

In one session, Maria was furious with her husband and their friends for being rowdy while she was driving them home from a party. She experienced them as children she could not control and called her mother. I told her I could imagine her frustration but did not fully understand why she called her mother. "It sounds kind of childish," Maria acknowledged. I highlighted Maria's word choice, "When things feel out of control like that, I think you do feel similarly to how you did as a child. You want your mom to step in. You don't feel you are able to do it yourself."

Maria agreed and elaborated how frequently she felt powerless and scared of getting in trouble. For many women, the transition to motherhood is marked by a shift from seeing themselves as the child of their mother to seeing themselves as a mother to their child. Having a caregiver who responds to distress by labeling feelings and showing an interest in understanding what happened, along with helping to contain it, one internalizes that ability to regulate emotions. Maria's experiences had not been mentalized when she was young; therefore, she had not internalized the ability to regulate her emotions. Maria was looking for someone to help stop the problem altogether. Instead, I attempted what a "good enough mother" might do and empathized with her experience of what pests the others were being. Once she was calmer, we explored what about it made her so angry, and arrived at an understanding that she was jealous of the fun they were having. She was missing the days before she had children, when she and her husband could let loose together.

### Mentalizing the relationship

Sessions with Maria continued in much the same manner for some time. She would begin in an activated state, often about her relationship with her husband, and we would work together to mentalize her experience until her affect became more regulated. Sometimes Maria brought her daughter, and other times she did not. During one session, her daughter napped peacefully in the stroller, but toward the end of the session woke up, in a fit. Maria lifted her and held her, asking, "What happened?" I joined her in this exploration, adding, "Oh no, it seems like you woke up with a terrible feeling. Maybe it's being in this office, with all these lights, or seeing me. Perhaps you weren't ready for all of this?" I used a questioning tone, wondering what Ashley might be thinking and feeling, rather than telling her. Maria attempted to bounce her and soothe her, but with a facial expression that looked rather frantic. "Aww. There, there, Mommy's got you," I said to Ashley, before turning to Maria and commenting, "I see a sort of smile, but I can't quite tell, it looks like maybe a tense one, I don't know …"

Maria apologized, "I'm so sorry. I don't know what to do. Maybe we should just end the session. I don't know if she's going to stop." I used her apology as an opportunity to mentalize our relationship, asking what she imagined I was thinking. She expressed fear I would judge her because she "should be able to soothe her baby." Friends and family often jumped in during these moments with advice. I pointed out I was not a friend, but yet in her mind she had put me into that group.

I pressed further, "If you think of me not as a friend, but as myself, your therapist, in this room with you, then what is it you imagine I am thinking?" A difficult question, but the answer was less important than the process of Maria experiencing our relationship in the here-and-now, separating me from her transference. She answered she did not know what I would be thinking. Not knowing is

especially useful in a mentalization-focused treatment because we often do not know what others are thinking or feeling, and this leaves us prone to misinterpretations. Maria also acknowledged she did not know what her baby needed, and it was so hard for her to tolerate not knowing.

A few sessions later, Maria again indicated a readiness to mentalize our relationship, spontaneously wondering about my personal life. Upon exploration, her curiosities were rooted in the question of whether I understood her. Maria's experience of me seemed to be shifting, from potentially judging her to possibly understanding her. Was she someone whose mind could be seen and understood by another person, with a different mind? This was the same question she was working so hard to answer with her husband — could he see and understand her needs, even as they were different from his own — and with her daughter, whom she was trying to understand.

### *Enactments*

A few months before the end of my fellowship, Maria asked whether she could do every other week treatment. She insisted this was because of time constraints due to her full-time job, taking care of her daughter, and an upcoming vacation. I asked whether she was avoiding something that could come up in our sessions (i.e., closeness with me, deeper feelings, our ending) and voiced concerns about how every-other-week often slows down and dilutes the work we do together. But Maria persisted, and I ultimately agreed to try it. I learned soon after that in arguments with her husband, Maria would threaten to leave the house, hoping he would stop her. This would mean he really cared. I immediately regretted I had not stopped her from leaving me by agreeing to every-other-week sessions.

Before raising it directly to Maria, I brought it to my supervision group where we discussed the possible meanings and outcomes of being more insistent on weekly treatment, versus letting her make the decision. I decided rather than interpreting to Maria that she was doing the same thing with me as she did with her husband, which she would likely disagree with, I would continue letting this arrangement play out while paying close attention to it. When sessions felt too full and we did not have time for everything, I would merely comment on how the time limited what we could do.

### *Mentalizing the child*

Three months into the switch to psychodynamic treatment, we administered the five-minute speech sample again. Ashley coincidentally was in this session, and Maria began the same way. But there were subtle differences in how she viewed Ashley's steps toward separation and independence:

> Umm, how do I feel? I love her. And I think she loves me too. And I think she's less reliant on me for nutrition, so that the bond that we have is changing. She still will comfort nurse, but not, I guess she's not needing me as much. So I'm seeing that like independent side of her. And it's actually kind of freeing. I thought I was going to be upset, and I'm not. I'm so happy.

She continued to experience Ashley as unpredictable, but her narrative around this was more coherent and less contradictory:

> And she is, I feel like I said this last time, a little unpredictable. She's very sweet and can be very gentle, and then out of nowhere, pow, she'll slap someone or something.

She also more readily identified this as a problem, and balanced the description with positive examples of joy:

> But she had her first trick or treating. And she ran into the crowds of people with her costume, she was very excited and was like a teenager…she just went, on her own. But she would turn back sometimes, so there's like that safe distance…she doesn't just run off and not care, but, so that was interesting to see. And she's I guess

> exhibiting some stranger anxiety. So instead of nursing so much she's kind of using me as a like a home base… and she's dancing a lot now. Which is a lot like I was. And it's really hilarious.

Maria's narrative remained heavily focused on her daughter's behavior, but she seemed to be honing her skills as an observer and recognizing her daughter's attachment needs.

Maria's five-minute speech samples were analyzed using the CSMST, which revealed dramatic changes in her mental state discourse over time. At Time 2, Maria used 41 mental state words compared to 29 mental state words at Time 1. Even more drastic were the differences in the distribution of her mental state words among the mental state categories. At Time 1, most of Maria's mental state words with regard to her baby referred to behaviors that imply mental states but are not actually internal (i.e., "trying," "crying," and "following") compared to Time 2, where she more frequently referred to her baby's internal mental states, such as emotions, cognitions, and perceptions. At Time 1, Maria referenced her baby's emotions only once ("love"), whereas at Time 2 she mentioned a total of nine words regarding her baby's emotional states (e.g., "love," "annoyed," "fearful," "excited"). Of note, there was no change in terms of Maria mentalizing her own emotions.

### *Parenting changes*

Maria began occasionally updating me on behavioral changes, such as moving Ashley to her own bed (from co-sleeping), getting her on a sleep schedule, and beginning to wean. These changes were never suggested by me or even directly spoken about. Through experiencing the nurturing, mentalizing presence of a therapist, Maria was developing a more coherent and contained sense of self that relied less on others to regulate her. These capacities were helping her to not only tolerate her child's distress but also to differentiate herself from her daughter and make herself available emotionally rather than physically.

Maria also started making new links between her experience and her daughter's, acknowledging their separateness. For example, she reflected, "I just don't want her to worry about her father the way I worried about my mother. She's getting older, and I don't want her to feel like she has to parent him, the way that I do." We have begun exploring what her daughter needs and what her daughter has that is different from what Maria had. Maria has also recommitted to weekly psychotherapy and noticed feelings of attachment to me, thinking about me outside of session, wanting to call when she needs help, and tearfulness at the thought of our termination.

### *Ending phase of treatment*

I anticipate this next phase in treatment will mean moving from anger to deeper emotions, such as sadness. In acknowledging that her daughter's experience is not only similar but also different than what she had, Maria will be faced with the task of mourning the losses of her childhood. Recall that preoccupied patterns of attachment develop because they are the best solution the child can come up with to maintain proximity with their parents. For all the pain and difficulty that her anger and anxiety caused Maria, it served an important function when she was young, that is, to keep her close with a mother who was unpredictably responsive and at times frightening, and perhaps even to a father who was physically absent but with whom there was always a hope of reconnecting. And these emotions continued to serve important functions in Maria's present. They protect her from the vulnerability involved in getting close and placing her trust in another person, a potentially new attachment figure, who can provide a corrective emotional experience but also risks hurting and abandoning her. Helping her overcome these barriers to intimacy and enjoy the relationships in her life is the goal of our ongoing treatment.

## Discussion

Bowlby (1951) wrote that "if a community values its children it must cherish their parents" (p. 84). The above case shows some of what cognitive behavioral and psychodynamic treatments can offer pregnant and postpartum women. Maria was representative of the mothers we typically see in that she came to treatment for anxiety and depression. She felt desperate and unsupported, unable to problem solve effectively due to exhaustion and stress, and as if she had lost touch with herself. She did not express concerns about the bond with her baby or dissatisfaction related to her parenting role, but anxiety and depression were robbing her of joy and keeping her from being fully present. Furthermore, what she imagined about her daughter's internal world was often a projection of her own childhood rather than her daughter's present.

The individual psychotherapy approach was determined by the orientation of the supervision. Abrupt changes from one treatment modality to another can feel jarring to both training clinicians and patients. But as Anna Freud (1951) wrote, "the material which presents itself is seen and assessed not by an instrument, nor by a blank and therefore unprejudiced mind but on the basis of pre-existent knowledge, preformed ideas and personal attitudes" (p. 20). The therapeutic relationship served as the stable force underneath the change in approach. This was facilitated by the clinician's foundation in attachment theory, which became the thread that wove the treatment together.

One of the greatest achievements of Bowlby's theory is its applicability to both cognitive-behavioral and psychoanalytic orientations. Internal working models can be schemas or object relations. Links to the past can be made through core beliefs and thought distortions, or the pre-conscious and defense mechanisms. In *A Secure Base* (Bowlby, 1988) Bowlby laid out five tasks for the therapist:

- Provide a secure base from which the patient can explore the pleasant and unpleasant aspects of life with a "trusted companion."
- Help the patient to explore the ways he/she engages with other people, the expectations for self and other, and what he/she unconsciously brings to relationships.
- Focus on the therapeutic relationship to gain a deeper understanding of the patient's working models of attachment figures.
- Explore the patterns of thinking, feeling and behaving that emerged from early experiences while acknowledging often painful feelings toward parents and the therapist.
- Help the patient to see that early patterns may or may not be relevant/useful in the present.

With Maria, the first three steps were undertaken during the CBT phase, where Maria explored her ways of relating to and expectations of others. The psychodynamic treatment then focused on exploring the feelings that emerged and helping Maria to see her own patterns that were worth changing. In both orientations there were frequent shifts from present to past (and back again), and attending to internal experiences that were outside of awareness, implicit or automatic. The defining differences in approach were the role of affect/emotion, and how the patient's suffering was responded to or addressed. In the CBT model, thoughts were the primary focus, and tools were offered to actively reduce emotional suffering. The psychodynamic, mentalizing approach aimed to deepen the affective experience, using the therapeutic relationship as a container in which emotions could be explored, elaborated, and ultimately contained by the patient herself.

The baby's presence in the treatment was not a focus until the switch to a psychodynamic approach, though it is possible to address the parent-infant relationship in CBT since core beliefs and automatic thoughts surrounding the infant can be used similarly to other content. The five-minute speech sample facilitated the centrality of the baby in the therapeutic process. These same topics might have been addressed earlier in the CBT frame, had the mother been prompted to think about her baby during that period of treatment. However, the issues with feeding, for example, would have likely been responded to differently in CBT, with a more active approach to problem solving, change, and psychoeducation, compared to the psychodynamic approach of exploring affects and making meaning of the choices. The speech sample also

served as a clinical and research tool, providing a measure of change in psychotherapy and valuable feedback to the clinician that could further inform the treatment.

A limitation in the case of Maria was the lack of group participation. The group setting provides a useful window into the mother and child's functioning. Groups offer information about the mother's attention/cognition, problem solving, ability to elicit support/rejection, memory for recent and past experiences, and openness to new ideas and behaviors, and the baby's ways of relating to the parent and relative strangers (personal communication with Beatrice Beebe, 2017). For example, one highly successful professional woman expressed distress around her newborn's colicky behavior and feeding issues. Her group participation quickly revealed the ways that focusing on feeding/sleeping was a proxy for her feeling out of her depth in a situation where the rules, expectations, and pathways to "success" were unclear. Witnessing the change in her baby's distress, as he transformed from fussy and agitated to calm and interested when in the arms of a group leader, allowed the group to focus on helping her with her fears rather than coping with a problem baby.

Gaps remain in our understanding of what the perinatal population needs and the suitability of any particular model of therapy for a specific patient. Training and research programs necessarily differentiate among treatment modalities, but theoretical integration provides valuable flexibility in responding to patients' needs. The concept of meeting patients where they are is especially relevant for the pregnant and postpartum women. There are barriers to treatment related to having an infant, including transportation, childhood illness, multiple conflicting appointments, and parents' difficulties adjusting to new and unexpected demands. We tend to work more flexibly with pregnant and postpartum women because the presence of a baby carries with it a sense of urgency (Blom, 2018). Additionally, the developmental nature of the work means that as one problem is resolved, developmental changes give rise to new problems. As such, it is not uncommon for treatment with new parents to follow an episodic pattern, with periods of consistency followed by breaks and returns to treatment (Stern, 1995).

Within any orientation, an active stance toward intervention is called for, with a "theory that integrates parental goals with child outcome" (George & Solomon, 2008, p. 834). Dyadic treatment has the advantage of providing multiple points of access to the attachment system, and effective treatment may start from any of these points, including with the parent, the infant, or the relationship, and at the level of behavior or representation (Stern, 1995).

Several theorists and clinicians working with new parents highlight the immense representational shifts that occur in the transition to parenthood (George & Solomon, 2008; Stern, 1995). The activation of the caregiving system means a reorganization of systems hierarchies. For example, new parents shift from being the child/one seeking protection (by their attachment figures) to the protector of their child. Flexibility is required, as parents have to balance their own perceptions of threat or danger with their interpretation of the child's signals. Both the attachment and the caregiving systems are regulated by strong emotions, which activate fantasies, wishes, fears and recollections, either positive or negative (Fraiberg et al., 1975; Lieberman et al., 2005a). Attachment security provides a backdrop of the expectation of safety and security, the internalized "good enough mother," from which to explore the new world of parenthood.

Like the attachment system, the nature of the caregiving system is shaped by factors related to the parent (i.e., their personality and their childhood; Blom, 2018), the child (i.e., temperament, appearance), and the environment (i.e., social support, marital relationship). Thus, both systems offer multiple levels through which we intervene and effect experiences and outcomes, for mother, child, and the family system. Maria's treatment began with interventions around her environment, and moved over time toward interventions related to herself, and finally in relation to her child. The choice of treatment modality and the point of access can depend on the mother's chief complaint, her strengths, her cultural background, and what she is looking for (and what she does not want in therapy). There is still much to learn about the most effective approaches to engaging patients and beginning treatment. Just as the integration of CBT and psychodynamic principles may be necessary, so too is the ongoing dialogue between clinical practice and empirical research.

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## References

Adkins, T., & Fonagy, P. (2017). *Coding reflective functioning in parents using the five minute speech sample procedure: Version 2* (Unpublished Manuscript).

Ahun, M. N., Geoffroy, M. C., Herba, C. M., Brendgen, M., Séguin, J. R., Sutter-Dallay, A. L., … Côté, S. M. (2017). Timing and chronicity of maternal depression symptoms and children's verbal abilities. *The Journal of Pediatrics*, *190*, 251–257. doi:10.1016/j.jpeds.2017.07.007

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. N. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum.

Alvarez-Segura, M., Garcia-Esteve, L., Torres, A., Plaza, A., Imaz, M. L., Hermida-Barros, L., ... & Burtchen, N. (2014). Are women with a history of abuse more vulnerable to perinatal depressive symptoms? A systematic review. *Archives of Women's Mental Health*, *17*(5), 343–357. doi: 10.1007/s00737-014-0440-9

Bate, J., Nikitiades, A., Hoffman, S., Allman, B., Steele, M., Steele, H., & Murphy, A. (2016). Attachment-based group therapy for children and parents. In C. Haen & S. Aronson (Eds.), *Handbook of child and adolescent group therapy: A practitioner's reference* (pp. 97–109). New York, NY: Routledge. doi:10.4324/9781315666860

Bateman, A., & Fonagy, P. (2013). Mentalization-based treatment. *Psychoanalytic Inquiry*, *33*(6), 595–613. doi:10.1080/07351690.2013.835170

Beebe, B., & Markese, S. (2011). Theory and research that informed the clinical approach of the project for mothers, infants and young children of September 11, 2001. *Journal of Infant, Child and Adolescent Psychotherapy*, *10*, 170–186. doi:10.1080/15289168.2011.599725

Bekar, O., Steele, M., Shahmoon-Shanok, R., & Steele, H. (2018). Mothers' mental state talk and preschool children's social-behavioral functioning: A multidimensional account. *Journal of Infant, Child, and Adolescent Psychotherapy*, *17*(2), 119–133. doi:10.1080/15289168.2018.1456890

Bergman, A., & Harpaz-Rotem, I. (2004). Revisiting rapprochement in the light of contemporary developmental theories. *Journal of the American Psychoanalytic Association*, *52*(2), 555–570. doi:10.1177/00030651040520020301

Bergman, A., Moskowitz, S., & Friedman, D. D. (2011). Therapist view I: Creating a space for mothers and babies after September 11, 2001. *Journal of Infant, Child & Adolescent Psychotherapy*, *10*(2), 207–216. doi:10.1080/15289168.2011.599745

Blom, I. (2018). Observing development from infancy to parenthood: Separation-individuation, attachment and intersubjectivity in the clinical encounter. In M. H. Etezady, M. Davis, & I. Blom (Eds.), *Psychoanalytic trends in theory and practice: The second century of the talking cure* (pp. 43–70). New York, NY: Lexington Books.

Bowlby, J. (1951). *Maternal care and mental health* (Serial No. 2). Geneva, Switzerland: World Health Organization Monograph. doi: 10.1192/bjp.98.412.491

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.

Cattaruzza, A. (2014). Difficulties in the treatment of depression during pregnancy and postpartum depression. *Journal of Infant, Child, and Adolescent Psychotherapy*, *13*(1), 75–87. doi:10.1080/15289168.2014.880296

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Child Psychology*, *28*(2), 135–148. doi:10.1023/A:1005118713814

Cohen, P., & Beebe, B. (2002). Video feedback with a depressed mother and her infant: A collaborative individual psychoanalytic and mother-infant treatment. *Journal of Infant, Child, and Adolescent Psychotherapy*, *2*(3), 1–55. doi:10.1080/15289168.2002.10486404

Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short-and long-term effect of psychological treatment of post-partum depression. *The British Journal of Psychiatry*, *182*(5), 412–419. doi:10.1192/bjp.182.5.412

De Wolff, M. S., & Van Ijzendoorn, M. H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child Development*, *68*(4), 571–591. doi:10.1111/j.1467-8624.1997.tb04218.x

Feldman, R., Granat, A., Pariente, C., Kanety, H., Kuint, J., & Gilboa-Schechtman, E. (2009). Maternal depression and anxiety across the postpartum year and infant social engagement, fear regulation, and stress reactivity. *Journal of the American Academy of Child & Adolescent Psychiatry*, *48*(9), 919–927. doi:10.1097/CHI.0b013e3181b21651

Field, T. (2010). Postpartum depression effects on early interactions, parenting, and safety practices: A review. *Infant Behavior and Development*, *33*(1), 1–6. doi:10.1016/j.infbeh.2009.10.005

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fonagy, P., Sleed, M., & Baradon, T. (2016). Randomized controlled trial of parent–Infant psychotherapy for parents with mental health problems and young infants. *Infant Mental Health Journal*, *37*(2), 97–114. doi:10.1002/imhj.21553

Fonagy, P., Steele, H., Moran, G., Steele, M., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *13*, 200–217. doi:10.1002/1097-0355(199123)12:3<201::AID-IMHJ2280120307>3.0.CO;2-7

Fonagy, P., & Target, M. (2005). Bridging the transmission gap: An end to an important mystery of attachment research? *Attachment & Human Development*, *7*(3), 333–343. doi:10.1080/14616730500269278

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to Adult Attachment Interviews*. London, United Kingdom: University College London.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421. doi:10.1016/S0002-7138(09)61442-4

Freud, A. (1951). Observations on child development the phases of libido development reflected in the child's behavior. *Psychoanalytic Study of the Child*, *6*, 18–30.

George, C., & Solomon, J. (2008). The caregiving system: A behavioral systems approach to parenting. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment theory: Theory, research and clinical application* (2nd ed., pp. 833–856). New York, NY: Guilford Press.

Goodman, J. H., & Santangelo, G. (2011). Group treatment for postpartum depression: A systematic review. *Archives of Women's Mental Health*, *14*(4), 277–293. doi:10.1007/s00737-011-0225-3

Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analytic review. *Clinical Child and Family Psychology Review*, *14*(1), 1–27. doi:10.1007/s10567-010-0080-1

Grace, S. L., Evindar, A., & Stewart, D. E. (2003). The effect of postpartum depression on child cognitive development and behavior: A review and critical analysis of the literature. *Archives of Women's Mental Health*, *6*(4), 263–274. doi:10.1007/s00737-003-0024-6

Kleiman, K., & Wenzel, A. (2014). *Cognitive behavioral therapy for perinatal distress*. New York, NY: Routledge.

Lieberman, A. F., Ippen, C. G., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(8), 913–918. doi:10.1097/01.chi.0000222784.03735.92

Lieberman, A. F., Padron, E., Van Horn, P., & Harris, W. W. (2005a). Angels in the nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal*, *26*(6), 504–520. doi:10.1002/imhj.20071

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005b). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry*, *44*(12), 1241–1248. doi:10.1097/01.chi.0000181047.59702.58

Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review*, *20*(5), 561–592. doi:10.1016/S0272-7358(98)00100-7

Madigan, S., Wade, M., Plamondon, A., Maguire, J. L., & Jenkins, J. M. (2017). Maternal adverse childhood experience and infant health: Biomedical and psychosocial risks as intermediary mechanisms. *The Journal of Pediatrics*, *187*, 282–289. doi:10.1016/j.jpeds.2017.04.052

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York, NY: Basic Books.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development*, *50*(1–2), 66–104. doi:10.2307/3333827

Markese, S. (2011). Dyadic trauma in infancy and early childhood: Review of the literature. *Journal of Infant, Child, and Adolescent Psychotherapy*, *10*(2–3), 341–378. doi:10.1080/15289168.2011.600214

Markin, R. D. (2013). Mentalization-based psychotherapy interventions with mothers-to-be. *Psychotherapy*, *50*(3), 360–365. doi:10.1037/a0031993

Midgley, N., & Vrouva, I. (Eds.). (2012). *Minding the child: Mentalization-based interventions with children, young people and their families*. New York, NY: Routledge.

Miniati, M., Callari, A., Calugi, S., Rucci, P., Savino, M., Mauri, M., & Dell'Osso, L. (2014). Interpersonal psychotherapy for postpartum depression: A systematic review. *Archives of Women's Mental Health*, *17*(4), 257–268. doi:10.1007/s00737-014-0442-7

Murphy, A., Steele, H., Bate, J., Nikitiades, A., Allman, B., Bonuck, K., … Steele, M. (2015). Group attachment-based intervention. *Family & Community Health*, *38*(3), 268–279. doi:10.1097/FCH.0000000000000074

Nachman, P. (1991). The maternal representation: A comparison of caregiver- and mother reared toddlers. *The Psychoanalytic Study of the Child*, *46*(1), 69–90. doi:10.1080/00797308.1991.11822358

Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., Boswell, J. F., Szkodny, L. E., & Nordberg, S. S. (2011). A randomized controlled trial of cognitive-behavioral therapy for generalized anxiety disorder with integrated techniques from emotion-focused and interpersonal therapies. *Journal of Consulting and Clinical Psychology*, *79*(2), 171–181. doi:10.1037/a0022489

Norcross, P. L., Leerkes, E. M., & Zhou, N. (2017). Examining pathways linking maternal depressive symptoms in infancy to children's behavior problems: The role of maternal unresponsiveness and negative behaviors. *Infant Behavior and Development*, *49*, 238–247. doi:10.1016/j.infbeh.2017.09.009

O'Connor, T. G., Monk, C., & Burke, A. S. (2016). Maternal affective illness in the perinatal period and child development: Findings on developmental timing, mechanisms, and intervention. *Current Psychiatry Reports*, *18*(3), 24. doi:10.1007/s11920-016-0660-y

O'Hara, M. W., Stuart, S., Watson, D., Dietz, P. M., Farr, S. L., & D'angelo, D. (2012). Brief scales to detect postpartum depression and anxiety symptoms. *Journal of Women's Health*, *21*(12), 1237–1243. doi:10.1089/jwh.2012.3612

Ordway, M. R., Sadler, L. S., Dixon, J., Close, N., Mayes, L., & Slade, A. (2014). Lasting effects of an interdisciplinary home visiting program on child behavior: Preliminary follow-up results of a randomized trial. *Journal of Pediatric Nursing*, *29*(1), 3–13. doi:10.1016/j.pedn.2013.04.006

Porcerelli, J. H., Huth-Bocks, A., Huprich, S. K., & Richardson, L. (2015). Defense mechanisms of pregnant mothers predict attachment security, social-emotional competence, and behavior problems in their toddlers. *American Journal of Psychiatry*, *173*(2), 138-146. doi: 10.1176/appi.ajp.2015.15020173

Prasko, J., Diveky, T., Grambal, A., Kamaradova, D., Mozny, P., Sigmundova, Z., … Vyskocilova, J. (2010). Transference and countertransference in cognitive behavioral therapy. *Biomedical Papers*, *154*(3), 189–198. doi:10.5507/bp.2010.029

Raphael-Leff, J. (1990). Psychotherapy and pregnancy. *Journal of Reproductive and Infant Psychology*, *8*, 119–135. doi:10.1080/02646839008403617

Ross, L. E., & McLean, L. M. (2006). Anxiety disorders during pregnancy and the postpartum period: A systematic review. *Journal of Clinical Psychiatry*, *6*(9), 1–14. doi:10.4088/JCP.v67n0818

Rutherford, H. J., Goldberg, B., Luyten, P., Bridgett, D. J., & Mayes, L. C. (2013). Parental reflective functioning is associated with tolerance of infant distress but not general distress: evidence for a specific relationship using a simulated baby paradigm. *Infant Behavior and Development*, *36*(4), 635–641. doi: 10.1016/j.infbeh.2013.06.008

Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. C. (2013). Minding the baby: Enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant Mental Health Journal*, *34*(5), 391–405. doi:10.1002/imhj.21406

Sadler, L. S., Slade, A., & Mayes, L. C. (2006). Minding the baby: A mentalization-based parenting program. In J. Allen & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 271–288). Chichester, England & Hoboken, NJ: Wiley. doi:10.1002/9780470712986.ch14

Safran, J. D. (1990a). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review*, *10*(1), 87–105. doi:10.1016/0272-7358(90)90108-M

Safran, J. D. (1990b). Towards a refinement of cognitive therapy in light of interpersonal theory: II. Practice. *Clinical Psychology Review*, *10*(1), 107–121. doi:10.1016/0272-7358(90)90109-N

Schwartzman, D., Stamoulos, C., D'iuso, D., Thompson, K., Dobson, K. S., Kramer, U., & Drapeau, M. (2012). The relationship between cognitive errors and interpersonal patterns in depressed women. *Psychotherapy*, *49*(4), 528–535. doi:10.1037/a0029583

Slade, A. (2007). Reflective parenting programs: Theory and development. *Psychoanalytic Inquiry*, *26*(4), 640–657. doi:10.1080/07351690701310698

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005a). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Development*, *7*(3), 283–298. doi:10.1080/14616730500245880

Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., & Mayes, L. (2005b). Minding the baby: A reflective parenting program. *The Psychoanalytic Study of the Child*, *60*(1), 74–100. doi:10.1080/00797308.2005.11800747

Sockol, L. E., Epperson, C. N., & Barber, J. P. (2011). A meta-analysis of treatments for perinatal depression. *Clinical Psychology Review*, *31*(5), 839–849. doi:10.1016/j.cpr.2011.03.009

Sossin, K. (2011). Support group II: An evolving approach: Reflections on group process in the early years. *Journal of Infant Child & Adolescent Psychotherapy*, *10*(2), 217–223. doi:10.1080/15289168.2011.599747

Steele, H., & Steele, M. (2008a). On the origins of reflective functioning. In F. Busch (Ed.), *Mentalization: Theoretical considerations, research findings, and clinical implications*. Psychoanalytic Inquiry Book Series (Vol. 29, pp. 133–158). New York, NY: Analytic Books.

Steele, H., Steele, M., & Croft, C. (2008b). Early attachment predicts emotion recognition at 6 and 11 years. *Attachment & Human Development*, *10*, 379–393. doi:10.1080/14616730802461409

Steele, M., Murphy, A., & Steele, H. (2010). Identifying therapeutic action in an attachment-centered intervention with high risk families. *Clinical Social Work Journal*, *38*(1), 61–72. doi:10.1007/s10615-009-0257-6

Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy*. New York, NY: Basic Books.

Suchman, N. E., DeCoste, C., Leigh, D., & Borelli, J. (2010). Reflective functioning in mothers with drug use disorders: Implications for dyadic interactions with infants and toddlers. *Attachment & Human Development*, *12*(6), 567–585. doi:10.1080/14616734.2010.501988

Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology*, *74*(6), 1006. doi:10.1037/0022-006X.74.6.1006

Trivedi, D. (2014). Cochrane Review Summary: Psychosocial and psychological interventions for preventing post-partum depression. *Primary Health Care Research & Development*, *15*(3), 231. doi:10.1017/S1463423614000206

Von Mohr, M., Mayes, L. C., & Rutherford, H. J. (2017). The transition to motherhood: Psychoanalysis and neuroscience perspectives. *The Psychoanalytic Study of the Child*, *70*(1), 154–173. doi:10.1080/00797308.2016.1277905

Warshaw, S. C. (2000). The contribution of attachment research to my clinical work with parents of school-aged children. *Journal of Infant, Child, and Adolescent Psychotherapy*, *1*(1), 3–17. doi:10.1080/15289168.2000.10486330

Weinberg, M. K., & Tronick, E. Z. (1997). Depressed mothers and infants: Failure to form dyadic states of consciousness. *Postpartum Depression and Child Development*, 54–81. doi:10.1002/imhj.20193

Weissman, M. M., Markowitz, J. C., & Klerman, G. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York, NY: Basic Books.

Wenzel, A., Haugen, E. N., Jackson, L. C., & Brendle, J. R. (2005). Anxiety symptoms and disorders at eight weeks postpartum. *Journal of Anxiety Disorders*, *19*(3), 295–311. doi:10.1016/j.janxdis.2004.04.001