

Speaking for the Baby: A Therapeutic Intervention with Adolescent Mothers and Their Infants

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ABSTRACT: Adolescent mothers frequently experience problems in mother-infant interaction. However, intervention can be very difficult, particularly when complicated by unresolved conflicts involving relationships in the young woman's past. This article describes a therapeutic intervention, based on the work of Fraiberg, which allows the young mother to learn to interpret her infant's cues while also encouraging her to express her own emotions in the context of the mother-infant relationship. Two case studies are discussed to illustrate the use of the technique as part of a program of mother-infant intervention.

RÉSUMÉ: Les mères adolescentes connaissent souvent des problèmes dans l'interaction mère-nourrisson. Cependant, l'intervention peut être très difficile, surtout lorsqu'elle est compliquée par des conflits non résolus impliquant des relations appartenant au passé de la jeune femme. Cet article décrit une intervention thérapeutique, basée sur le travail de Fraiberg (1975), qui permet à la jeune mère d'apprendre à interpréter les signaux de son enfant tout en l'encourageant aussi à exprimer ses propres émotions dans le contexte de la relation mère-nourrisson. Deux études de cas sont examinées pour illustrer l'utilisation de cette technique comme partie intégrante d'un programme d'intervention mère-nourrisson.

RESUMEN: Las madres adolescentes con frecuencia experimentan problemas en la interacción madre-infante. Sin embargo, la intervención puede ser muy difícil, particularmente cuando se complica debido a conflictos no resueltos que envuelven relaciones en el pasado de la joven madre. Este artículo describe una intervención terapéutica, basada en el trabajo de Fraiberg (1975), el cual permite a la joven madre aprender a interpretar las señales de su infante y al mismo tiempo la anima a expresar sus propias emociones en el contexto de la relación madre-infante. Se discuten dos casos para ilustrar el uso de la técnica como parte de un programa de intervención madre-infante.

抄録：思春期で母親になると、母-乳児交流の問題を体験する事が多い。そうした例への治療的介入は、非常に困難なことがあり、過去の関係にまつわる未解決な葛藤が絡んでくると、特に難しい。この論文は、Fraiberg(1975)の業績をもとにした治療的介入について記載する。その介入法は、自分の感情を母-乳児関係において表現するよう幼い母親を促すと共に、乳児の与えるヒントcuesの解釈法を体得できるようにするものである。母-乳児介入プログラムの一部であるテクニックの利用法を例示するため症例を2つあげた。

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Adolescent pregnancy continues to be a major social problem facing our country today. With about 480,000 babies born each year to young women under the age of 19, the need for both primary prevention to decrease these numbers and secondary prevention to work with the adolescent mothers and their infants is urgent. At least one third of the adolescents who become mothers have been parented by adolescent mothers themselves. Thus, important intergenerational transmission factors may be contributing to the pregnancy and may also be influencing the adolescent mother's attitude, style, and ability to parent her child effectively.

In our research and intervention work with adolescent mothers, we have become increasingly aware of the ways in which adverse experiences may influence the young mother's relationship with her baby. "In every nursery, there are ghosts," stated Fraiberg and her colleagues (Fraiberg, Adelson, & Shapiro, 1975) in their classic article discussing the "ghosts" resulting from pain and suffering in the past which can adversely influence a parent's ability to provide effective parenting. Because of unresolved conflicts especially those involving relationships from the past, these parents tend to make similar mistakes with their own children. The problems are complex, stemming from family structural issues as well as the risks related to adolescent pregnancy. In studying adolescent pregnancy, attention must be paid to the precursors in childhood, as well as the consequences of these early influences.

Adolescent parenthood is often problematic for both mother and child. Adolescent mothers, in general, talk less to their infants than do older mothers and frequently have difficulty understanding or articulating the feelings of their babies (Crockenberg, 1985; Culp, Appelbaum, Osofsky, & Levy, 1988; Culp, O'Brien, & Osofsky, 1989; Field, 1981; Garcia-Coll, Hoffman, & Oh, 1987; Osofsky & Osofsky, 1970). Because adolescent mothers are children themselves, they continue to experience their own developmental struggles which can interfere with their ability to understand and be sensitive to their children. In our research (Hann, Osofsky, Barnard, & Leonard, 1990; Osofsky & Eberhart-Wright, 1988, in press), we have observed less reciprocity and less affect sharing between adolescent mothers and their infants. It is often difficult for the mothers to read and respond to their infants' cues. In our recent work, we have observed infants of depressed adolescent mothers in the first year of life who show diminished affect themselves (Carter & Osofsky, 1991). We have concerns about what these early patterns may mean for later development.

Expectations of teenage mothers are often in conflict with the developmental needs of their children. For example, when the infants are extremely dependent in the first year of life, the young mothers may have difficulty accepting behaviors that communicate helplessness and neediness. The mothers often encourage their babies to hold their own bottles and feed themselves as if they are much older and more competent. In contrast, as the infants move into adulthood, the mothers may have difficulty understanding and being sensitive to their children's growing autonomy. As the children try to move away and explore their environment, the mothers have difficulty allowing appropriate independence and often experience a need to exercise excessive control.

Fraiberg (Fraiberg et al., 1975) proposed an intervention model in which the therapist "talked" for the baby and described how the baby might be feeling as the mother took care of or played with him or her. The therapist used "speaking for the

baby" as a way to help the mother understand her baby's feelings in response to her mother's behaviors or words. This method was used with very disturbed, confused, and angry mothers to help them relive negative experiences and feelings from the past that interfered with current parenting. Fraiberg hypothesized that by gaining a clearer understanding of the influence of past behaviors, the mothers might be better able to comprehend the impact of their behaviors on their infants or children. The purpose of this study was to adapt Fraiberg's model as an intervention technique to be used with adolescent mothers and their infants.

METHOD

Subjects

Subjects for the study were part of larger group of 90 adolescent mothers and infants who were enrolled in the Adolescent Mothers' Initiative Program (AMIP) of the National Council of Negro Women of Greater New Orleans. This intervention program provides education to obtain a GED, nutritional guidance, basic skills training, and parenting classes for the young mothers. In addition, 40 teenagers from the larger group participated in a more intensive intervention program for the first year of their infants' lives. This more intensive program included all components of the regular program plus parent-infant classes and an infant nursery. All of the participants from the AMIP program could not be included in the more intensive intervention group due to financial and personnel constraints of the project. Thus, we were able to compare outcomes for the more intensive and the regular intervention groups.

Objectives

A primary goal of the more intensive intervention project was to provide the mothers with increased understanding of the developmental needs of their infants and alternative ways of relating to them. Specifically, the intervention was designed to: (1) provide the young mothers with fundamental knowledge of infant development which would encourage realistic expectations of infant behavior and (2) improve patterns of interaction between mother and baby by helping mothers become more verbal and affectively in tune with their babies.

Another major goal of the intervention was to help the mothers become more empathic with their babies. In order to accomplish this objective, the mothers were asked to "speak for their babies" during small group sessions while the baby was being videotaped. "Speaking for the baby" involved providing a description and emotional rationale for the infant's physical gestures and emotional expressions. Mothers were encouraged always to use the first person to express the baby's thoughts (e.g., "Mama, I'm hungry and I want you to feed me" rather than "He looks hungry" or "He wants his bottle.") If the mothers had difficulty with the task, one of the instructors would model "speaking for the baby" for them.

The technique had almost immediate appeal even for young mothers who seldom participated verbally in class. The mothers appeared to enjoy "speaking" for their own babies as well as taking turns talking for each other's babies. The mothers were frequently more responsive to their babies when another person expressed the baby's feelings. Mothers, who on their own often seemed to ignore their babies' cues, smiled at their infants, offered kind words, or even sang to them when a speaker provided

the baby a "voice." Young women who ordinarily resisted suggestions for comforting their fussy babies responded easily to the suggestions offered when the baby "talked," as can be seen in the case studies presented later in this paper.

Procedure

In the initial intervention classes, each mother was videotaped while interacting with her baby. In a subsequent session, each mother was asked to watch the play session that was videotaped earlier and say aloud what she thought the baby was feeling. Both the observations of mother–infant interaction during play and the mother's attributions while she was talking for her baby were used to determine the most urgent needs of the dyad. Their specific needs were targeted for classroom intervention and became a focus of further application of the baby talk technique.

After the initial observations of mother and baby, several steps were used for the intervention. First, during the play session, the mother was asked to continue playing with her baby while the intervenor "talked" for the baby. Next, the mother was asked to "speak" for her baby while the intervenor interacted with the baby. Immediately following these episodes, the mother and intervenor watched the replay on videotape and discussed the mother's successful attempts at both reading and following cues. The technique was useful in teaching the mother through modeling, controlled practice, and feedback. Variations included letting the adolescent mothers pair off and take turns reversing roles with each other. In addition, a doll was used to demonstrate other types of behaviors or situations that were difficult to show with a real baby.

CASE EXAMPLES

Keshana and Kareem

Keshana and Kareem entered the program when Kareem was almost 2 months old. On initial assessment, Kareem scored within the normal range developmentally, but some of his behaviors were of concern. He was a jumpy, easily stimulated baby, and startled frequently. He had a high-pitched screaming cry and a particularly low threshold for auditory stimulation. When he became overwhelmed, he was difficult to calm. His arms tremored with almost every move. He resisted physical comfort, became rigid, and turned his head away from his mother.

The infant's difficulties were compounded by the fact that Keshana was an energetic young woman who tended to be intrusive in interactions with her baby. Although she exhibited a number of positive maternal behaviors such as holding the baby close during feeding, talking to him, and displaying positive affect, she also tended to put her face too close to the baby's face, to talk too loudly, and to change activities too quickly. Intellectual and academic assessments confirmed the impressions of the staff that Keshana was functioning far below average.

We learned in working with Kareem that moving him to a very quiet room away from everyone and rocking him while holding him close to block out extraneous sensory stimuli was an effective method for calming him and we suggested to Keshana that she might try this technique. She could not accept this suggestion and continued having difficulty calming Kareem adequately during his outbursts. Keshana rejected the idea that Kareem might be a difficult baby and had only positive comments to

make about him. She continued to maintain this attitude throughout her participation in the program, even after it became apparent that the infant had feeding problems and rather severe gastroesophageal reflux. Keshana's typical response to Kareem's distress was to feed him, resulting most often in the entire contents of the bottle being regurgitated on her clothing. Keshana was never prepared for this outcome. She neglected to cover her shoulder, refused to bring extra clothing, and reacted to each incident with a startle and a demand for assistance. Further, she consistently neglected to follow the pediatrician's directions for preparation of the child's formula. When the bottles were prepared correctly by nursery staff, Kareem seldom vomited. Keshana, however, either left out the required cereal or added far too much, resulting in problems for the baby.

Keshana had poor personal hygiene, and both she and the baby frequently had body odor. Nursery workers were reluctant to care for Kareem until he was bathed each morning after he arrived. Personal hygiene improved temporarily during a period that Keshana spent with her grandmother.

Some of Keshana's difficulties in parenting were likely related to her unhappy early life. Keshana was an unwanted child of a mentally ill mother. She was shifted back and forth between relatives as an infant until her maternal grandmother took her in as a young child. When Keshana was 12, her mother wanted her back. She moved from what she describes as a "big house in a nice neighborhood" in the suburbs to live for the first time with a virtual stranger. She was 14 and in the seventh grade when she became pregnant. As both Keshana and her mother failed to recognize the pregnancy until the final month, she received no prenatal care until a few weeks before delivery. Following Kareem's birth, Keshana and the baby moved in with her grandmother because Keshana's mother was unable to provide adequately for them.

Keshana was keenly aware that her mother had never wanted her and believed that she only attempted to keep her to increase her welfare check. Undoubtedly, she also sensed that her grandmother felt overburdened by her and took care of her out of feelings of obligation. While living with her mother, Keshana learned that the little she had been told about her father was unsubstantiated. Thus, this young woman had few consistent people in her early life to guide her in finding her own identity.

Continuous effort was needed to convince Keshana to attend class, and, even then, participation was minimal. After 2 months of attendance, Keshana was still sullen and walked out if verbal participation was encouraged. She refused to participate in class discussions or to share her feelings. Often Keshana would leave the room rather than listen to others share their feelings, and she refused to answer the most innocuous questions regarding herself or her family.

Keshana's first response to the speaking for baby technique was remarkably positive. She had been attending class regularly for 11 weeks when the activity was introduced. When the class was offered an opportunity to participate, Keshana volunteered to try first. The instructions were to place her baby in any position she liked and to talk into the microphone as the baby was videotaped so that it would look on video as if he was talking. Keshana chose to place the baby alone in a crib and her remarks revealed themes of loneliness and maternal incompetence. The "incompetent mother" theme recurred and set the stage for intensive work with Keshana in an attempt to build her confidence as a mother.

Initially, Keshana and another student took turns speaking for each other's babies during mother-baby play. Keshana's ability to respond to the cues of the other students speaking for Kareem was remarkable. If the "baby" said, "Can't you see I'm hungry?" Keshana immediately picked up a bottle and gave it to her baby. When the "baby" said a position was uncomfortable, she promptly changed the baby's position. In no case did Keshana ignore a cue given when another student talked for her baby. To Keshana's surprise, her fussy baby became more settled and content as she relaxed and followed the suggestions offered when the intervenor spoke for the baby.

Because the young mothers sometimes used a negative, critical tone when speaking for another mother's baby, in future efforts, a teacher spoke for the baby resulting in an equally good response from the young mothers. The key to the success of the technique seemed to be in using the first person and attributing the thoughts expressed to the infant. For example, the mother responded much more readily to the teacher saying for the baby, "Mama, I need a hug" rather than simply pointing out, "your baby wants to be held."

This technique was continued as part of our intensive intervention with Keshana to build her sense of competence as a mother. Either Keshana or a teacher played with the baby while the other talked for the baby. When a teacher spoke for the baby, the "baby" not only clearly requested action from the mother, but also provided immediate verbal feedback on the consequences of her actions. Positive reinforcement for her efforts was a crucial element. So, the "baby" would say, "Oh, Mommy, I love it when you talk to me like this"; "I feel so much better when you rock me"; "Thanks, Mom, you knew just what I wanted." Reversing roles and allowing Keshana to speak for Kareem helped sensitize her to her baby's needs. Allowing Keshana a turn as the "voice" gave her experience in reading the cues for herself and watching as her suggestions were carried out and brought successful results. Dividing the complicated task of responding to infant cues into reading cues and providing a response allowed Keshana to build the skills necessary to become a more responsive mother. Concurrently, her confidence in herself as a person began improving as well.

For Keshana, the speaking for the baby class marked the first time that she was able to talk about her feelings. It also was the first time that she openly admitted, through the baby's "voice," her feelings of inadequacy. Since that time, Keshana's self-confidence and maternal caregiving have improved. This improvement has been evident from Kareem's frequent smiles, his initiative in interaction, and his clear preference for his mother. The speaking for the baby sessions were a significant factor in influencing the successes that Keshana and Kareem have experienced.

Carolyn and Joanna

Carolyn, 13, was approached about participating in our program as she waited for prenatal care. She was a scared 13-year-old sitting alone in the crowded waiting area. When asked if she was interested in joining the program for young women and their infants, she gazed down at the floor and silently nodded her head.

Carolyn first attended the mother-baby class on a special incentive day. She and other young women in the intervention program were invited to our observational laboratory to watch a video solely for entertainment purposes. During this visit Carolyn's close-to-the-surface hostility and tough demeanor contrasted with that of the frightened little girl we had observed earlier.

For the next several classes, Carolyn showed up at the end of the class and refused to enter the classroom. She continued to arrive late, but she began to sit just outside the classroom door. Gradually, she began to arrive earlier, but ventured inside for the entire class only three times during her prenatal period. In those early classes, Carolyn exhibited oppositional behavior and rarely spoke. Typically, she responded with a shrug of the shoulders to direct questions and avoided eye contact.

Carolyn appeared to be particularly uncomfortable with infants. She was occasionally asked to hold another young mother's baby and, although she always balked at this request, did not refuse. Gradually, she began to smile while holding an infant.

Carolyn's class attendance stopped just prior to her delivery date. Her phone number was changed to an unpublished number, and letters to her were returned with no forwarding address. A home visit to her mother revealed that Carolyn had left home and that her parents did not know where she was staying. Contact was re-established with Carolyn when her baby, Joanna, was born. When Carolyn and Joanna (age 2 weeks) came in for an infant assessment, Joanna appeared healthy and scored within the normal range on the Hawaiian Early Intervention Profile (Furuno et al., 1988). Carolyn was cross and defiant. She was exceptionally rough with the newborn and spoke to her harshly. On arrival for the assessment, she made no attempt to soothe, comfort, or feed her hungry, crying infant. Instead, she sharply reprimanded the infant, "Shut up, girl, you know you ain't getting nothing yet!", as she helped herself to snacks.

After the infant assessment, Carolyn did not attend the mother-baby class and was not seen again until the 6-month assessment. She seemed happier and more energetic, but her interaction with her baby still showed difficulties. She avoided holding Joanna and did not pick her up to comfort her. Carolyn appeared to enjoy the free-play session, but she had a tendency to become more involved with the toys herself than play with them with her baby. She expressed interest in returning to school and attended class that same week.

Although Carolyn no longer appeared depressed, her behavior with the baby was disturbing. She handled Joanna roughly and teased her to get attention or laughs from others. Joanna's motor development appeared normal but she displayed little positive affect and took no initiative in social play.

Over the next 3 months, Carolyn attended intervention classes sporadically and twice attempted to return to regular school. Carolyn moved back and forth between her parents' and aunt's homes with such frequency that it was difficult to keep track of her. During the holiday week before Christmas, Carolyn brought 8-month-old Joanna with her to school seeking assistance from staff. She described a fight with her parents and said she had no place to go. Temporary shelter was found for Carolyn, and she began attending classes more regularly.

During the following weeks, the project staff made troubling observations concerning Carolyn's behavior with Joanna. Her merciless teasing of the baby was increasing. A particularly upsetting pattern of behavior involved Carolyn's slipping out of class several times each morning to exploit the baby's recently heightened separation anxiety. She would run to the door, call Joanna, and leave laughing as soon as the baby burst into tears or tried to crawl toward her. She avoided spending time with her baby and, when she was with her, the interactions with Joanna were alarming.

She was extremely rough when playing with her and seemed unable to anticipate or prevent the child's many falls and accidents. Joanna's behavior also caused concern. The baby's affect was generally flat, and, since her return to the nursery, she did not approach others for social stimulation, preferring to sit and play alone.

Joanna was typically irritable with Carolyn and had developed a habit of jerking herself backward from her mother's lap with little or no warning. Carolyn made no attempt to predict these maneuvers nor to shield Joanna's fall to the floor. Carolyn not only directed a lot of anger toward her baby, but also made no attempt to respond to Joanna's cues. Several staff members commented that Carolyn made no effort to be responsive. However, there was uncertainty as to whether or not she would be capable of contingent responding even if she understood the baby's cues. The speaking for the baby activity clarified these issues for us. Carolyn first participated in a speaking for the baby session when Joanna was almost 9 months old. During the first session Joanna was irritable and would not settle. Carolyn appeared to make little effort to calm or satisfy the baby and blamed each failed effort on Joanna. Several times Carolyn looked helplessly at staff and commented that this was typical of Joanna's behavior. The situation abruptly changed when the teacher began speaking for the baby. Carolyn complied with each "request" from the "baby." Initially, the teacher guessed at various reasons for the baby's discomfort and suggested Joanna was too tired to hold her bottle as her mother rocked her. The teacher said, "Mama, I may seem to be big sometimes, but I'm really still little. I need you to help me hold my bottle so that I can get to sleep." Carolyn held the baby close and steadied the heavy bottle with her hand. After a few more suggestions through speaking for the baby to talk softly and rock gently, Joanna quickly fell asleep. Later when she awoke, the teacher took the baby and let Carolyn speak. Carolyn was able to pick up on a few of Joanna's cues and verbalize them. Carolyn began to smile as she caught on to the task.

Carolyn and the staff were encouraged by the results of the initial speaking for the baby sessions. It was possible to observe through using this approach that the mother was capable of responding to the baby's cues when they were interpreted for her, but that she could not read the baby's cues alone. The meetings were continued twice weekly over the next 2 months with increasing success. The nursery staff began to report less teasing and rough play from Carolyn, and videotaped play sessions revealed that she was beginning to reach out to protect Joanna from falls. Both mother and infant began showing more positive affect during their sessions together. The sessions were interrupted when Carolyn once again disappeared a few weeks before Joanna's first birthday. Carolyn returned for Joanna's 13-month assessment.

The results of this assessment indicated that the gains experienced over the course of the preceding 4 months were significant and lasting. Both mother and child showed positive affect frequently throughout the assessment and demonstrated the ability to sustain reciprocal interaction. During the evaluation, Carolyn responded to Joanna's verbal and physical cues, which contrasted with her earlier behavior. Although Carolyn initially gave the baby the bottle to drink on her own, during the course of the feeding, she picked up Joanna and held her closely. During play, Carolyn seldom initiated talking to Joanna; however, she was responsive to Joanna's frequent vocalizations. Overall, Carolyn and Joanna's interaction at 13 months showed much improvement over previous observations.

DISCUSSION

Therapeutic interventions with adolescent mothers and their infants may be problematic for a variety of reasons. First, adolescence is a period of development during which teenagers may not readily accept advice or instruction. This issue is of particular concern when working with adolescent mothers, as the pregnancy may represent a mistake, a rebellious acting out, or a way to resolve a struggle for independence from authority figures. It is important to recognize that the intervenor may be perceived by the mother as yet another authority figure and become a target for her rebellion. Second, adolescents tend to be preoccupied with their own concerns and may have difficulty responding to the needs of others. Third, it may be even more difficult for a teenager who is struggling with autonomy and independence to acknowledge problems or feelings of inadequacy. Issues of self-esteem are very important during adolescence, in general, and play a crucial role related to outcomes for adolescent mothers. Therefore, the success of the intervention will depend upon the intervenor's ability to capture the attention of the adolescent mother and to engage her in an intervention process while supporting her self-esteem.

The speaking for baby technique appears to overcome these problems to some extent in that it provides the adolescent mother the opportunity to identify needs of her own as well as those of her baby. The intervenor then gently guides the mother in recognizing the links between her needs and those of her baby. The technique enables the intervenor to determine the factors that may be interfering with mother-infant interaction without requiring the mother to verbalize her inadequacies directly. In this way, her self-esteem is supported while she is helped to become sensitive to her baby. Further, the use of videotaping and role playing allows for indirect instruction for mothers who have difficulty accepting direct suggestions from authority figures. The gamelike atmosphere created by the novelty of the video equipment, turn taking, and a good selection of interesting toys encourages the mothers to relax and enjoy the process.

In addition to being useful in overcoming major barriers in working with adolescent mothers, the technique is particularly well-suited for bringing about therapeutic changes in these mothers. Because many adolescent mothers have been parented by adolescent mothers themselves, some of the difficulties they experience in interaction with their infants may be directly linked to difficulties they experienced with their own mothers. Role playing with their infants allows the young women an opportunity to uncover their own "ghosts" and may also facilitate identification with the infant.

Fraiberg et al. (1975) described parents who were abused as very young children, and then identified with their abusive parents. They postulated that this defensive behavior may provide the motive and energy for perpetuating the abusive cycle. Further, Fraiberg et al. suggest that the key component of this ability to identify with the aggressor lies in the repression or forgetting of their own affective experience associated with the early abuse. The mother's ability to recognize and understand this repressed negative affect becomes a powerful deterrent against repeating parental abusive behavior. In the case studies presented in "Ghosts in the Nursery," the parents were enabled as protectors of their children against further abuse when therapeutic intervention helped the parents to remember and re-experience the negative emotions of their childhood.

Although most adolescent mothers do not abuse their children, infants of adolescent mothers are at higher risk for a number of psychosocial problems associated with poor mother–infant interaction, including abuse and neglect. The speaking for the baby technique may be useful in helping the mother to resolve some of her own conflicts and, thus, free her to learn and use more effective parenting skills. It encourages the mother to recognize and label the infant’s emotional experiences, which may facilitate her remembering her own repressed affect while promoting identification with the infant.

While we have been encouraged by the success of this technique with the young women in the current project, the principles involved may also be applicable to work with other mothers struggling with relationship issues. The mothers in our sample are all young, economically impoverished, and educationally disadvantaged. For the two mothers described in this paper, we observed clear positive changes; however, they were also among those at highest risk in terms of academic placement, social support, and interpersonal skills. Whether or not similar success would be achieved with lower risk mothers remains to be demonstrated.

Empirical evidence is still needed to validate the speaking for the baby technique. Although we have subjectively concluded that there were clear improvements in mother–infant interaction over the first few sessions for a number of young women, including the two described here, formal assessment of the technique is required. However, such evaluation may be difficult for a number of reasons. The collection of baseline data is especially problematic. As observational measures of infant–mother interaction require careful coding, videotaping is required. The novelty of the video equipment lessens with each use, and young mothers lose interest in “playing” with their babies on camera after a few sessions. The collection of adequate baseline data requires a *minimum* of three data points before beginning the therapeutic intervention in order to establish a baseline. For some young mothers, who are at particularly high risk and in need of immediate intervention, collecting the baseline data may not be appropriate because it may mean delaying much needed intervention. At the same time, crisis periods are often the periods in which young mothers respond better to such a therapeutic strategy. These ethical considerations need to be taken into consideration in attempting to assess the baby talk technique formally.

In addition, while a few sessions of speaking for the baby may be clinically important, the technique’s function as a controlling factor in any improvement that takes place would require an extended number of sessions to allow the researcher to show a return to (or a fall toward) baseline on a single targeted behavior during periods of no intervention. The situation is further complicated by the fact that, as in most clinical work, one would hope not to find substantial loss of the gains resulting from the intervention following temporary withdrawal of treatment.

We are currently in the process of analyzing data for a single subject in a reversal design with the speaking for the baby intervention as an independent variable introduced after an initial and second baseline period (ABAB). Dependent variables include an observational measure of mother–infant interaction during feeding and a measure of maternal emotional availability and dyadic affect interaction.

The speaking for the baby technique, based on Fraiberg’s earlier method, represents a creative and appealing approach for intervening with adolescent mothers and may

also be therapeutically useful with other hard-to-reach mothers. It not only allows the mother to give voice to her own feelings, but also to legitimize them through labeling. Through attribution of her own feelings to the infant, the mother may experience a state of developmentally appropriate intersubjectivity that can lead to dynamic change and facilitate therapeutic intervention. Fraiberg provided the inspiration for us to continue to search for ways to reach young mothers and their babies in order to promote healthy development in both of these children—mother and child.

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