CLINICAL APPLICATIONS OF A PARENT PERCEPTION INTERVIEW IN INFANT MENTAL HEALTH

Charles H. Zeanah, MD, and Diane Benoit, MD, FRCP(C)

The evocative power of infants has been widely recognized by both re-searchers and clinicians. How parents perceive, interpret, and experience their infant is of great importance for both the infant's development and adaptation. In this article we outline briefly the theoretic and empiric backgrounds of a semistructured interview designed to assess caregivers' representations of their infants. We also illustrate with excerpts individual differences in parents' narrative descriptions of their infants that we believe are clinically salient. We conclude by discussing considerations in using an interview derived from research in the clinical setting.

THEORETIC BACKGROUND

People enter new relationships with predispositions to behave in certain ways and with certain expectations of the reactions and behaviors of others. One of the most striking examples of this is when adults become parents for the first time and develop elaborate perceptions and expectations about their baby even before the baby is born.[19] Freud[11] suggested that these kinds of expectations are derived in part from an individual's early relationship experiences. A number of object relations theorists have extended Freud's observation by concerning themselves with the processes through which individuals' relationship experiences affect their internal worlds and vice versa. The closely related theoretic

Note: The interview and scoring system are available from the first author.

From the Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana (CHZ); and the Department of Psychiatry, The Hospital for Sick Children and University of Toronto, Toronto, Ontario, Canada (DB)

framework of Bowlby's[4-6] ethologic attachment theory provided the specific background for the work that we describe in this article.

Bowlby posited the construct of internal working models as dynamic internal representations that structure and order an individual's internal world. Internal working models refer to all of the processes involved with interpretation of social information, including selective attention to social information, perception of specific features of the information, affects elicited by the information, anticipation about behavior of an "other," and even various defensive processes that may be mobilized.

Thus an important component of caregivers' internal working models or representations of their infants is the array of expectations and perceptions that parents bring to their relationships with their infants. It is precisely this array that is among the major targets of change in clinical work with troubled infants and families.[10] Stern-Bruschweiler and Stern[16] pointed out that virtually all the major forms of psychotherapy with infants and their caregivers address the dynamic open system formed by ongoing interactive behaviors and representational processes between caregiver and infant. Given the central role internal working models are asserted to play in shaping an individual's subjective experience within relationships, as Bretherton[7] noted, it is surprising that so little empiric attention has been directed to parents' subjective experience of their children.

EMPIRIC BACKGROUND

One major impetus for study of parents' perceptions came from studies of infant temperament, which for a time tended to rely on parent report measures. When it became clear that these measures reflected at least as much about parents as about infants, temperament researchers began to develop observational measures of infant temperament. Another group of investigators began to explore parents' perceptions of their infants.[19] They showed that some aspects of parents' perceptions of infant characteristics are moderately stable from pregnancy through the first few months of life. [9, 13-15, 19] This suggests that parents' perceptions of their infants are present even before the infant is born and may be related to how parents interpret infants' characteristics and behaviors after birth. Nevertheless, these findings were limited to the *content* of parents' representations of their infants. They failed to capture and consider the importance of *formal* characteristics of parents' narrative descriptions of their infants, including emotional integration, clarity, and flexibility of the descriptions.

Another major impetus came from the work of Main and her coworkers[12] who suggested that various formal features of narrative discourse reflect important differences in the organization of an individual's representational world. Specifically, they demonstrated that how individuals described their own childhood relationship experiences was related to how they related to their children, an observation that has been replicated by investigators in several different countries.[17]

WORKING MODEL OF THE CHILD INTERVIEW

With all of this in mind, we developed the Working Model of the Child Interview (WMCI) as a means of assessing parents' perceptions and subjective experience of their infants and relationships with their infants. The WMCI is a

1-hour semistructured interview that includes inquiries about caregivers' perceptions and subjective experience of their infants' distinctive characteristics. We have interviewed parents, with only minor modifications, from as early as pregnancy to as late as when their child is 4 or 5 years old.

The WMCI begins with a developmental history of the infant and the parents' relationship with their infant. The emphasis is less on a compilation of facts and more on eliciting the story of the baby, beginning with conception and continuing up to the present. The effort is to understand the parents' experiences of and with their baby. Although this section of the interview is optional for those using the interview for research (classifying a representation), we recommend that it be included routinely in interviews used for clinical purposes. It is important for the clinician to take into account the match between parents' response and the age or developmental level of the child.

Other probes in the WMCI ask parents to describe impressions of their infant's personality and behavior in general and in specific situations. They are asked of whom their infant reminds them and how the infant is like and unlike each of the parents. Parents are also requested to describe their infant when upset or difficult, including their own reactions and responses to the infant's behavior. Finally, they are asked to describe their relationship with the infant, what pleases and displeases them about the relationship, and how they expect the relationship to change over time. In addition to past and current impressions about the infant, parents are also asked about anticipations about the infant's future development, providing a look at "future memories." Specific examples are frequently requested to augment and elaborate general impressions.

The interview may be audiorecorded and transcribed or videotaped. Video-taping may be especially useful for those using the WMCI as one aspect of a clinical assessment. For research, transcripts are rated using 15 separate Likert scales to assess qualitative, content, and affective features of the representation. Descriptors of three major classifications allow coders to assign an overall classification to the narrative description provided by the caregiver: *balanced, disengaged,* or *distorted,* as described below.

Classifications of Parents' Representations of Their Infants

Representations classified as *balanced* are characterized by narratives that convey, in a straightforward manner, a reasonably full and rich impression of who the baby is and what the caregiver's relationship with the baby is like. The perceptions of the baby are neither overly rigid nor resistant to new information. Prominent is a sense of the caregiver as engrossed in his or her relationship with the infant, valuing the relationship with the infant, and considering it to be important for the infant's behavior and development.

Disengaged representations are identified by the caregiver's prominent disengagement from the relationship with the infant in the form of emotional aloofness or even more pervasive distancing from or aversion to the infant. There is a lack of engrossment with the infant or an overly cognitive and somewhat emotionally impoverished involvement with the infant. Details about the infant are not particularly rich and may seem pat, generic, or unelaborated (e.g., "a regular baby"). There may seem to be little flexibility to accommodate changes in the representation and little sense of discovery about the baby.

Distorted representations convey narratives in which the caregiver is involved and may have a lot to say but one of several types of distortion is imposed on the representation of the infant. The narrative is not distorted in

comparison to some putative objective reality, but instead is internally inconsistent. For example, the caregiver may seem preoccupied by or distracted by other concerns, confused and anxiously overwhelmed by the infant, or self-involved and insensitive to the infant as an individual. Descriptions of the infant may be confused or contradictory. The caregiver may have difficulty remaining focused on the infant and the relationship with the infant during the interview. In general, these narratives convey the sense of an unsuccessful struggle to feel close to the infant.

These three types of classifications are thought to reflect major differences in how internal representations are organized. Essentially, we infer from parents' narrative descriptions of their infants and their relationship with their infants certain characteristics of parents' internal representations of their infants.

Parents' Representations and Infant Attachment

In a preliminary investigation with 45 middle-class American mothers and their 1-year-old infants, we found that mothers' WMCI classifications were systematically related (69%, 38% expected by chance, $\kappa = 0.50$) to their infants' concurrently assessed attachment classifications at age 12 months: balanced-secure (74%), disengaged-avoidant (73%), and distorted-resistant (55%).[20]

A second investigation replicated and extended these findings in a middle-class Canadian sample of 85 mothers and infants.[2] Mothers' representations of their infants and concurrently assessed infant attachment classifications were concordant 73% of the time (55% expected by chance, $\kappa = 0.40$). On the other hand, in this investigation the overall concordance was explained by the 88% concordance between mothers classified as balanced and their infants classified as secure. The hypothesized disengaged-avoidant (50%) and distorted-resistant (40%) concordances were not significant.

In addition, because the WMCI also had been administered during the third trimester of pregnancy, it was possible to examine the stability and predictive validity of WMCI classifications. Stability between pregnancy and 11-month WMCI classifications was substantial, with 80% of mothers (51% expected by chance, $\kappa = 0.59$) having the same classifications at both points in time. The greatest stability was for balanced (89%) and distorted (85%) classifications. On the other hand, only 12% of mothers whose narratives were classified as disengaged prenatally were still classified as disengaged at one year.

Finally, WMCIs completed in pregnancy correctly predicted infant Strange Situation classifications in 74% of cases (54% expected by chance, $\kappa = 0.49$). The concordance between pregnancy WMCI classifications and 12-month Strange Situation classifications was significant, although this concordance also was explained by the balanced-secure relationship ($\kappa = 0.67$). In fact, 91% of mothers classified as balanced had infants classified as secure in the Strange Situation. These findings provide remarkably clear evidence for the importance of the organization of parents' representations of their infants for later infant adaptive behavior. These findings also extend results from previous studies that had suggested that there was moderate stability in the content of parental perceptions of their infants before and after birth"[13-15,18,19] by suggesting that specific formal features of their representations may be even more stable and more strongly related to infant adaptation than content features.

Parents' Representations of Infants in Clinical Settings

As a further test of the validity of WMCI classifications, we administered the WMCI to mothers of 24 infants with failure to thrive, 17 infants with serious sleep disorders, and 13 infants with other clinical disorders .[3] We found that only 5 of 54 (7%) mothers of clinically disordered infants were classified as balanced. In contrast, 19 of 45 (42%) mothers of control group infants had interviews that classified them as balanced. Because these assessments were cross-sectional, we can make no statements about direction of effects. Nevertheless, taken together with results from the other studies, these results provide additional evidence that disengaged and distorted representations are associated with high-risk and clinically disordered infant status.

CLINICAL EXCERPTS OF PARENTS' NARRATIVES

We have found the WMCI to be useful in clinical settings because it provides a means for formally assessing parents' perceptions and subjective experience of their child and their relationship with the child. Because these are of immediate concern to most parents whose infants are seen in clinical settings, the detailed focus by the clinician on their perceptions of their infants makes intuitive sense to them. We therefore recommend that the clinician attend to whatever thematic content emerges, as well as to various aspects of the formal features of the descriptions.

A number of features may be striking about particular interviews, but we have found that a number of more formal characteristics are useful to consider. We use eight rating scales to help characterize caregivers' representations of their infants: richness of perceptions, openness to change, intensity of involvement, coherence, caregiving sensitivity, acceptance, infant difficulty, and fear for safety. These dimensions are not independent, as they are moderately to substantially intercorrelated [20]

Most of these WMCI rating scales require that the clinician attend to qualitative aspects of the narrative descriptions, that is, *how* the characteristics of the infant are described, as well as to the content, *what is* described. We believe that individual differences in a number of these dimensions may prove useful for clinicians wishing to understand caregivers' representations of their infants. We emphasize that patterns throughout the interview are always weighted more than isolated statements. Nevertheless, we provide below some illustrative examples to demonstrate important individual differences in parents' descriptions.

Richness of Perceptions

Richness of perceptions refers to the relative richness or poverty of the caregiver's descriptions of the infant as an individual and of the parent's relationship to the infant. Rather than merely a count of the number of words used, it is more specifically a sense of how much the words are used to elaborate a sense of "who" the infant is. Parents who succinctly but richly describe details about their infants as an individual are considered to have richer perceptions than parents who have a lot to say even though they convey little about the infant's personality, feelings, and behavior. When asked to describe her 1-yearold daughter's personality, one mother reported

> Her personality. She's like usually a happy kid, you know. You know, like she sings and dances, and she talks to herself, and she, you know, she talks on the phone, and um.

In order to have her elaborate on this response, the mother was asked to pick five adjectives to describe her daughter's personality. She chose "a smiling baby" and "inquisitive." She then illustrated each of these with examples. Then she struggled.

> And, ummm, I can't think of adjectives that describe . . . She's pretty. She's tall. She's thin. Do you want adjectives that describe her personality though? Rather than her looks? Um, I don't know. She's a regular baby.

In contrast to this example, consider how much more comfortable and how much clearer another mother was after being asked to describe her 1-year-old daughter's personality.

> She's a real smiley baby. I mean she loves people. The more people, the better. Um, aaahh, she's real, she's kind of got a real twinkle about her personality. Um, she seems real bright. I mean not, you know, not gifted or anything. But just real interested in learning and interested in everything in her environment, that is, um, she seems to enjoy life. She seems to enjoy her parents. She seems to enjoy her pets. She just seems to find enjoyment in just about every aspect of life now. She just seems to be a real happy, twinkly kind of child.

In contrast to the prior example, this mother seems to be attentive to her infant's preferences and characteristics, to have thought about her infant, to know her infant in some essential way, and to convey this in her descriptions.

Openness to Change

Openness to change refers to the flexibility of the representation to accommodate new information about the infant. Given the ambiguity of behavior in early infancy, and the rapid changes accompanying development, openness to change is an important reflection of the parental process of discovery. We emphasize that flexibility is not equivalent to uncertainty; descriptions may be sure but still open. Representations that are open to change seem potentially capable of accommodating new information about the infant. In contrast, representations that are rigid convey the impression that new information about the infant would be actively resisted in the service of maintaining a particular view of the infant. The following vignettes illustrate low scores on this scale.

> **Interviewer:** How do you feel that your relationship with [28-monthold child referred for unmanageable behavior] has affected his personality, has made him the kind of little boy he is?
> Parent: No. I'm not going to take the blame for that. I don't think my, the way I'm raising him has, um, anything to do with his personality. It has nothing to do with it.
> **Interviewer:** Not necessarily causing a problem so much as maybe any kind of influence in the way that you raise him. How do you—**Parent:** No.
> **Interviewer:** You don't feel that the way that you raise him has any impact at all on his behavior?
> **Parent:** No.

The same parent at another point in interview:

> **Interviewer:** What is that like for you when he keeps whining like that?
>
> **Parent:** It's, it's stressful. 'cause I gotta think, oh actually I don't *have* to, *I do* think of what my neighbors are thinking. Are they thinking, I'm killing this kid, or what? Uh, I snap at him, say [child's name], you know you gotta stop. This is ridiculous. And he does it anyway. He just keeps on going, and going, and going.
>
> **Interviewer:** So what do you feel then?
>
> **Parent:** It just makes me mad cause I feel well, at that point I'm failing but I'm trying to figure out what the heck I'm failing at. You know, [child's name], did I do something to make you do this? But I've come to the conclusion that, no, it's neither one of us. It's just him. He does it, and it's not going to change.
>
> **Interviewer:** Not at all? Ever?
>
> **Parent:** No. Two years of it? He's not going to change! Not uh without uh complete guidance, I mean, and I can't guide him anymore

This parent, in addition to perceiving her child's behavior as extremely challenging, gives no evidence that new information about her child would modify her current negative perceptions. Later in the interview she anticipated that her son would become a juvenile delinquent and would "spend as much time behind bars as he is in his home." This kind of rigid and entrenched negative view of the baby is not uncommon in clinical settings. A major goal of infant-parent psychotherapy is to help parents like this one experience their infants differently.

Intensity of Involvement

Intensity of involvement is used to assess the amount of a parent's psycho-logical preoccupation with the infant and the parent's psychological immersion in the relationship to the infant. This is another feature that is difficult to convey in a succinct example because it more clearly emerges from a reading of the entire transcript. Nevertheless, the following two examples provide contrasting pictures. The first example is from a mother who was asked if she felt her relationship to her 12-month-old infant had changed much over the course of the first year.

> Has it changed? I think that you love your baby more as time goes on. I, I think that, you know, it takes a long time to get to know this little person. And people would say to me, "Oh, do you feel like a mother yet?" And I'd say, "No." I feel like I have this cute little person who lives with me, but I don't really feel like a mother. But more and more so as time goes on.

This response conveys a sense of the parent as somewhat estranged or detached from her infant. Interestingly, she had had little to say earlier when asked to describe her relationship with her 1-year-old. In contrast, the following mother conveyed an intense emotional involvement with her 12-month-old daughter when she was asked to describe their relationship.

> Ah, loving, just ah loving, a very deep, abiding love that just ah is more wonderful than I ever imagined or ever knew. You just don't

> know until you have a baby, it's just—there's nothing like it. It's very different from my relationship with my husband, but it's wonderful, it's . . . I love it! It makes me emotional just to speak about it. It's wonderful, yeah.

In contrast to the previous example, this mother is believably immersed in her relationship with her infant.

Coherence

Coherence of the parent's narrative descriptions is used to assess the integrity of the representation. As outlined by Main et al,[12] coherence refers to the overall organization and presentation of ideation and feelings, in this case in the parent's representation of his or her infant. Essentially, this means a well-organized and logical flow of ideas and feelings regarding the infant and the caregiver's relationship to the infant. Incoherence includes descriptions that are confused or difficult to understand, contradictory (especially when this is unnoticed and unintegrated), or irrelevant or bizarre in the form of non sequiturs. Compare the following two examples of mothers' descriptions of their infants' personalities.

> Let's see. Her personality. I think that, I know that a lot of, like if I could, if I walk up to someone and if I don't have a smile on my face, she won't smile. But if I walk up to someone that I know, and I, you know, "Hi, how are you," she smiles. Um, but I think that she's, I don't think she smiles as much as, I don't know, as much as say the next one that you compare her to, or whatever. Um, she's always happy. Most of the time, she's happy, sometimes. And she's always pretty content, and ummmm.

In addition to this mother's uncertainty, it is difficult to follow her halting description without considerable interpretive effort. Whether the baby is always happy, only sometimes happy, or generally content but sometimes reserved, is not clear from this description. As a result, it is difficult to get a clear picture of the infant's personality. The following mother's description of her 14-month-old is far clearer and more consistent.

> Her personality. She’s full of life, um, she's a very active child, she laughs a lot and she's a lot of fun. She's like extremes. She's, she makes you happy because she's so active and so full of life, but because of this she can also be a pain. She's very much like me, we're very similar, it will be interesting to see as she gets older, but I would say that her personality reflects me more than my husband. She's just uh, she's beginning to become shy of strangers, but when she was younger, people were amazed how easily she went to strangers. She likes people. She loves kids. She just goes crazy when she sees other kids. She's gotten a little more uh, she's difficult because she's not a quiet baby in some ways. She still doesn't sleep at night. But you see other babies who sort of just sit there. Well, she doesn't sit there. She's active in life, she's a participation and I really think it's worth the extra work to have that type of baby. If I were asked if I had my choice, I would definitely pick her. Of course, I guess I'm prejudiced, but . .

Importantly, the picture that we get of the infant in this description is consistent with descriptions at other points in the interview, adding to the sense that the mother's impressions of the infant are coherent.

Acceptance

Our experiences in high-risk and clinical samples of infants and parents indicate that parents may have feelings of rejection or even an aversion to their infant. The following WMCI excerpts illustrate low ratings on the "acceptance" scale. When asked why her 28-month-old child was behaving in particular way that the mother found difficult, she responded as follows.

> I could say he's frustrated, but I'm not gonna say he's frustrated! There is something wrong!
> **Interviewer:** Like what?
> **Parent:** It's, well, it's either hereditary or it's a personality disorder with the child. And it's pretty bad when you, you can't, you don't really want to face the morning or the afternoon with your own child. There's a problem! He's out to destroy you!

In this case the mother seems capable cognitively of considering other explanations for her son's behavior, but the intensity of her negative feelings and aversion is too strong and seems to dominate her experience of the infant. Similarly, in the next example, another mother describes her relationship with her 24-month-old infant in terms of the rejection that it elicits in her.

> Well, like I say, I'm not, I'm really not that fussy about kids. Umm, I love him, I like him, but I don't like him a hundred percent. I like him maybe about ninety percent of the time. The other ten percent of the time I would cheerfully give him to a babysitter. Eh, if we are together for 24 hours, I find that he gets on my nerves. If I can get rid of him for stretches during the day, then it's just fine.

Caregiving Sensitivity

Following the pioneering work of Ainsworth et al,[1] caregiving sensitivity has emerged as a vital dimension in caregivers' interactions with their infants. It is possible to ascertain sensitivity in caregivers' descriptions of their infants. By sensitivity, we mean that the caregivers' descriptions of the infant convey a recognition and a valuing of the infant's own needs and emotional experiences. Sensitive caregivers describe their infants and their own reactions to their infants in ways that convey the caregiver's respect for the infant as a separate but dependent individual. Consider the following response from a mother who was asked how she reacts when her infant is emotionally upset.

> Whenever she's emotionally upset, it goes right to my heart, and I'm emotionally upset. I just want to comfort her, my, I just want to take whatever it is that's bothering her away, and that's how I feel all the time whenever anything upsets her. But um, if something hurts her, you know, unexpectedly, that's just like, you know, you just wish it had happened to you instead kind of feeling, just wanting to take the pain away.

In contrast, consider the response of another mother who was asked how she felt when her 1-year-old was emotionally upset.

> **Mother:** I just figure babies are like that. You know, I don't get all nervous about it.
> **Interviewer:** And what do you actually do when she gets emotionally upset?
> **Mother:** Okay, it depends on the situation again. If it's something that she has a right to be, well it's up to me to decide if she has a right. If it's something that logical that she's upset about, I will hug her, you know, and sympathize with her, but if it's something else, I try to pass it off, you know.

Notice the emotional distance that this mother maintains from her infant's distress. Of course, parents must make innumerable evaluations and interpretations of the severity of their infant's distress each day. When asked about emotional upset in her infant, this mother first minimizes it by making it into a characteristic of all infants, and then questions its legitimacy. In addition to insensitivity, this example also illustrates low acceptance of the infant's dependency.

Fear for Safety

This dimension addresses specific fears about the infant's well-being and safety. At the low end of the continuum are parents who have fleeting, common fears about their infants. At the other end are parents who have an irrational fear of the infant dying which cuts across different contexts and which is inexplicable in terms of the parent's known experience. One mother was describing problems that had resulted from her 6-month-old infant's sleeping for only two hours at a time.

> **Interviewer:** It sounds as if you had thought about moving him into his own room at some point.
> **Mother:** I wanted to put him in his own room when he was 2 months old, and I was all set to do it, but then he got a bad cold, and I wanted him near me then because I just had this sense that he was going to suffocate. After his cold went away, I knew I shouldn't have still been so worried but I was. I got hooked or something, I guess.
> **Interviewer:** How much did you worry about the suffocating?
> **Mother:** I still think about it all the time.
> **Interviewer:** Do you know why that's such a big worry for you?
> **Mother:** No. I don't. It's just that you hear about these babies . . . who go to sleep . . . they never . . . it's just scary sometimes.

Although it is not uncommon for parents of young infants to fear that their infant may stop breathing, the intensity and pervasiveness of this mother's concern and her inability to identify a reason for the intensity of her fear contribute to the impression that the fear is irrational. Because the fear is specific, it may be distinguished from more generalized anxiety

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Infant Difficulty

A sizeable body of research and no small amount of controversy have addressed the concept of infant difficulty. Much of the controversy has centered around the degree to which infant difficulty is a subjective construction in the mind of the parent versus an objectifiable "reality" in the infant. Also, those features of infant behavior that comprise difficulty and how they are to be measured are not uniformly agreed upon.[21] Our perspective assumes that parents' perceptions are constructions forged from both generally agreed upon (objective) and more uniquely determined (subjective) characteristics of the infant. Considering infant difficulty as a feature of parents' representations means that objective assessment of the difficulty and the behaviors comprising them are largely irrelevant. What is of concern is how the parent subjectively experiences and responds to the behavior perceived as difficult.

As an example of a caregiver who perceives her infant to be quite difficult, consider the following response of a mother who is asked how she feels when her 11-month-old baby is emotionally upset.

> Ah, in the morning, I feel sympathetic. At night, I can't stand it. At night, sometimes, I feel like taking him and screaming, "What the hell is wrong with you?" or "Shut up!" or something. You know, after listening to him all day long sometimes I do. I just want to say, "Will you please shut up?" which is ridiculous because he doesn't understand it. But I do say it sometimes because I can't take it. In the morning, I'm more peppy and I'm more, you know, I try to say, "What's the matter?" and all that, and at night, I'm like ahhh.

In this description, there is an understandable irritation with the infant's behavior, but the irritation is neither contained nor modulated and the infant is not protected from the parent's anger. In addition, there is an implicit pleading with the infant to be reasonable and to straighten out because the parent feels overwhelmed. Later, after describing her son's most difficult behavior, the mother was asked how she reacts.

> Um, put him in a cage. That's what I always say. And then my other son will say that when I'm in the store and he's acting up. Get him a cage. And I get embarrassed because people think I'm crazy. That's all I can think of, getting him inside a cage and locking him in it.

Another mother, in describing her reaction with her infant's temper, seems to lose perspective and to become frustrated in the telling.

> **Interviewer:** Could you give me a typical example of what happens when [28 month old child] throws a tantrum?
> **Parent:** Well, we'll start in the morning. Like I say he'll start, he'll wake up and he's, whines, cries. I guess he expects me to run and give him a bottle. But he's beyond the stage now for bottles. I don't want him to get into the habit of using a bottle as a comforter. Um, I'll leave him in the crib and I'll wait until I hear this giggling sound. Then I'll take him out.
> **Interviewer:** How long would that be?
> **Parent:** Ah probab—, probably a half hour and sometimes a little longer. If it goes beyond the half hour then it's, I figure, oh god! Here we go! Dig him out of the crib and just let him go at it.

> Eventually you're gonna have to calm him down. He doesn't wanna come. If you get him at the wrong time it's uh .. . it's hell. The whine oh! the whining! God almighty I could cry!
> **Interviewer:** Can you give me an example of the whining?
> **Parent:** Oh he just, he'll stand up against the wall and for no—like I say this is right from the morning. If I take him directly out of the crib without letting him get into a good mood, you bring him out, he's you know, whining, want, want, want. He doesn't know what he wants. He really doesn't know. I say well, [child's name], do you wanna go back to bed for a little while? No, no. And then when you say that it's the head banging and he'll bang it against the wall or and if that doesn't inflict enough pain out of him he'll smack it on the concrete floor. So, at that point you have to restrain him, and it's right back to the crib cause he's gonna do more harm to himself than anything.
> **Interviewer:** Does he leave marks on himself?
> **Parent:** Oh yeah! I mean you keep constantly banging your head against the cement floor, you know, and you're gonna have a red mark right down the middle of your head .. .

In contrast to these reactions, consider the following description of another baby who is perceived as difficult. After describing her initially "colicky" baby who then developed a series of ear infections that left him chronically irritable, a mother talked about how she felt when she saw her 1-year-old upset.

> Very frustrated. I feel, I feel bad for him that he feels that way. Um, I don't get angry at him, and I think maybe if he just started now, I might get angry because he's been this way since the day he was born, it doesn't you know, still . . . He's been a baby who, from the time he was like, a month old, you'd pick him up and he'd try to turn, he likes to sit on my hip facing out. If anyone sees me holding him, they'll think I'm not holding him right, but you can't hold him facing you. He just never, he just wants to be out looking. My brother picked him up once and he's like, holding this rigid thing who's trying to get away and he said something to the effect that it wasn't exactly the cuddliest baby he'd ever seen, you know.

Notice that despite a long history of challenging and ungratifying behavior in the infant, there is no expectation that the infant is responsible for improving the situation. In addition, the mother "protects" the infant from her own frustration and irritation and even feels badly for his unhappiness. She seems to have worked out compromises that attempt to make the best of it. The sensitivity score of the mother in this example would be much higher than the two previous mothers' scores.

Affective Tones of the Representation

Another source of individual differences in caregivers' descriptions of their infants is the affective tone of the representation conveyed in the interview. Many different emotional tones may characterize interviews, including joy, pride, anger, disappointment, anxiety, guilt, or indifference. Negative affective tones dominate WMCIs administered to parents of clinically referred infants.[3] After an initial example of joy, we concentrate on a few examples illustrating

more negative affective tones. Again, we emphasize that the entire interview is important to help in distinguishing a feeling that is apparent in a specific incident or context from the overall feeling or tone of the interview. The examples below were selected because they do reflect the overall tone of the entire interview rather than only effects that are direct but isolated expressions.

Joy

Not surprisingly, low scores on joy are characteristic of parents of infants who are clinically referred.

> **Interviewer:** Could you tell me a favorite story about [12-month-old infant]?
> **Mother:** Um, a real favorite situation is in the pool. She's pointing and talking to everybody that goes by and smiling and um, and I know there must be a million of them. All these people will come over and say "such a nice baby" and "does she always smile?" And them, um, and like, and I love it. I just, you know, I like these people being attracted to us. And I just, I mean when we're in the pool, and she's doing that, I just like to kiss her and hug her.

The joyful tone associated with descriptions of the baby also was characteristic of the entire interview.

Anger

In contrast, the anger and frustration in the following example also typified descriptions of the infant and the mother's relationship to the infant throughout the interview. This mother was asked to elaborate on her description of her 1-year-old infant as stressful.

> Because of all the crying he does, I have looked at him some nights, even when he was a small baby and thought, "Ooh, I can't stand you." And then after, I feel terrible but I used to get up in the daytime and say, "Now I see how people can really, you know, abuse a child"—not that I'd do that, but sometimes you get the feeling when he's looking at you in the middle of the night and screaming, and screaming, and screaming, you feel like you can't believe this little person is ruling over your entire emotional chaos, which is what you're feeling like when he's screaming like that. And he won't take a bottle and he won't go to sleep, and you keep picking . . . you can really resent the little kid. Believe me. You know and I, then you feel guilty afterward for even, oh God, what am I saying? What am I, crazy? You know you think of all, you know, it's kind of tearing you know because when they're good, they're great, but when they're bad, they're horrid. And you can't you know, screaming like that. And you do, and then live with all this guilty feeling like how could I even have thought something like that, but you do . . .

Her descriptions of the infant throughout the interview were similar, so that anger was a thematic pattern in the interview.

Guilt

The passage below concerns a feeling of guilt at a particular time in the infant's life, although it tended to be present throughout other sections of the interview, as well.

> **Interviewer:** What's your worst memory of her first—almost 2 years of life?
> **Parent:** When she was first born, she cried all the time. That really upset me because I didn't know how to fix it and nobody else seemed to know either and here was my beautiful little baby and she was so unhappy, I thought, I went through all this work to make this a healthy ba—I mean I did everything. I mean I counted my proteins. I didn't eat sugar, I didn't eat caffeine, and I worked so hard to make her perfect and I felt really guilty like I made her wrong. Like I made her and she wasn't healthy. I . . . I didn't do it right and so she was sick. . . . That's silly of me. She was born with allergies and there's nothing I can do about that, but still .. .

Indifference

Indifference is often strongly related to insensitivity and a lack of appreciation of the infant's experience. It may be tied to a particular moment in which one anticipates another emotional response or it may be more subtly but pervasively conveyed. A characteristic comment of the mother of a 10-month-old was her response to how she felt when her son was emotionally upset.

> Well, that doesn't bother me too much. You know, I don't dwell on stuff like that. You know, I get dressed and say, well, I still might be able to get to work on time.

At other times, a feeling of indifference emanates from descriptions of moments that ought to be powerful, important, or emotionally charged, but instead seem to be experienced by the individual as something less. One mother was asked how she decided on her child's name.

> I just, I was at a blank. And I was reading the newspaper and there was a dog in, on the front page or something and they called this dog [child's name]. That, I liked that name. So it was, I debated whether it was gonna be [another child's name] or [dog's name]. And [dog's name] sounded better. So that's what we called him .. .

PERSPECTIVES AND CONCLUSIONS

The WMCI provides a way of systematically assessing parents' perceptions and subjective experience of their infant and their relationship with their infant. Appreciating individual differences in interview responses can inform efforts to understand qualitative aspects of infant-parent relationships. Specifically, this semistructured interview has both a specific theoretic foundation and growing empiric support for its validity. We re-emphasize that the WMCI should be considered only one possible component of an assessment. We have found it useful to administer the WMCI in conjunction with a structured interactional

observation and other informal observations to describe the internal (represented) and external (behavioral) aspects of the infant-parent relationship.

Some may question whether an instrument developed for purposes of investigating groups can ever tell us anything meaningful about individual infants and families. Others may object to the structure imposed by the WMCI as stifling or constricting. We discuss each of these concerns briefly.

When the interview is used by clinicians as a way of understanding a particular infant and parent, classification of the parent's representation of the infant may be less useful than thinking about major themes that arise, qualitative features of the parent's narrative, or major affective tones of the descriptions, such as those described earlier. But is there a place for a procedure derived from developmental research in clinical work? Crowell and Fleishmann[8] thoughtfully reviewed the use of structured research procedures in clinical infant mental health and have concluded that they do have a place, assuming certain conditions are met. Those that are relevant to the WMCI are that it should be 1) applicable across a range of ages of infants, 2) attentive to the match between the parent's responses and age or developmental level of the child, 3) efficient in terms of time, 4) understandable, sensible, and feasible for use by clinicians, and 5) allowing some opportunity for natural and spontaneous behavior by parents. We believe that all of these conditions are met by use of the WMCI in clinical work.

As for objectives that even a semistructured interview is too limiting, we have several responses. First, the sacrifice of some spontaneity is made in exchange for having a relatively thorough overview of the caregiver's perceptions of the infant. We have been impressed by the power of story-telling for parents whose infants are symptomatic. Often, no one has ever really heard the story of this baby and this relationship in its entirety, and use of the WMCI may encourage both listening by the clinician and perspective-taking by the caregiver. Second, we recommend that the interview be administered in as conversational a style as possible in order to limit any sense of artificiality. Third, when used for clinical purposes, we encourage potentially useful digressions into topics that seem especially meaningful in particular cases. Finally, we do not object to those who wish to use only certain probes or sections rather than the entire WMCI in their clinical work.

Although developmental researchers are interested in continuities over time, clinicians are interested in change. An important question is the degree to which selective features or overall patterns (classifications) of the WMCI change as a result of various interventions. The model of Stern-Bruschweiler and Stern[16] predicts that changes in one area, either interactional behavior or representations, will be associated with changes in the other because of their ongoing, dynamic relation. Treatment outcome studies addressing these questions about parental representations would be a significant contribution to the field.

Ultimately, the measure of the clinical usefulness of the interview ought to be how well it helps us to understand a particular disturbed infant-parent relationship and to develop an appropriate intervention. The approach to a parent whose responses to the WMCI suggest low acceptance of and high indifference towards an infant likely will be different from an intervention developed for a parent whose responses suggested high intensity of involvement, high anxiety, and the presence of unrealistic expectations.

Addressing the complexities of infant-parent relationship disturbances will require the ongoing collaboration of clinicians and theoreticians. We hope that this collaboration will be facilitated by the development of measures with salience for both areas of inquiry.

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Address reprint requests to
Charles H. Zeanah, MD
Department of Psychiatry
Louisiana State University School of Medicine
1542 Tulane Avenue
New Orleans, LA 70112-2822