

## DISCHARGE PLANNING FOR THE HIGH-RISK NEONATE: A Consultation-Liaison Role for the Infant Mental Health Specialist

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*Frequent difficulties in discharge planning for the high-risk neonate are discussed, and case material is used to illustrate brief, focused psychiatric consultation-liaison intervention on behalf of an infant and its parents at high medical and psychosocial risk, respectively. Familial and hospital team dynamics, particularly issues of affective bonding, are examined, and the role of the infant mental health specialist is delineated. Principals of consultation in the neonatal services unit are outlined.*

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In recent years the infant mental health specialist has played an increasing role in the care and management of the high-risk infant.<sup>14, 17</sup> Infant psychiatry sits squarely at the interface between pediatrics and child psychiatry. It is therefore a natural component of a pediatric consultation-liaison program. This paper addresses the situation that arises when there is significant divided concern on the part of the medical-nursing teams about parental capacities to provide adequate post-discharge care. The problem is made more keen where extraordinary post-discharge medical care (e.g., home respiration monitor) is required of the parent.

The problem arises when the infant has achieved a degree of medical stability that raises the confidence and expectations of the medical staff to a level where, if one can only depend on parental capacities and willingness to comply with prescribed routines and precautions, a favorable outcome is predictable. When this precondition is at risk there frequently arises considerable, often heated, debate over whether or not the infant should be discharged into the parents' care. The child protection team or its equivalent may be alerted and brought into the deliberations. Despite the hospital staff's encouragement of parental visits to the

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hospital unit and despite the parents' general but not always consistent pattern of visits over the course of what may have been a long hospitalization, it becomes apparent that there is considerable latent concern amongst the staff: The baby is ready to go home, the staff is not ready to have it go.

High risk is determined by a combination of medical and social factors immediate to the infant's continuing viability or well-being. Many types of high-risk situations lend themselves to infant psychiatric intervention.<sup>5, 7, 8, 15</sup> They divide roughly into three categories: 1) difficulties imposed by the high-risk infant on ordinary caregiving circumstances; 2) difficulties imposed by the high-risk parent on the ordinary infant; and 3) difficulties created by the combination of a high-risk infant with high-risk caregiving circumstances.

The case to be presented here falls into the third category. It entails the familiar situation of discharging the infant at risk for respiratory crisis into parental care with a home cardiac-respiratory monitor. Since the parents posed serious possibilities of not being able or willing to comply with this prescribed post-discharge care, concerns were aroused. We will first describe the case and the brief evaluative consultation that was made. The case will be considered from several standpoints, ranging from theory to technique.

#### CASE PRESENTATION

Bobby L was 13 weeks old when he came to the attention of the Psychiatric Consultation-Liaison Program. His birth had been premature (GA=30 weeks, BW=6.46 kg; Apgars=3,5) by spontaneous vaginal delivery which re-

sulted in no physical complications for the mother. He was the first child of the mother (age 17) and the father (age 25). Consistent with his extremely premature status, Bobby developed several complications including respiratory distress requiring intubation and ventilation (3 weeks) and resulting in many instances of pneumothorax, physiological bilirubinemia, primary ductus arteriosus (surgically corrected), intracranial hemorrhage, bradycardia and apnea, impaired nutritional status and gastroesophageal reflux. Gradual and consistent clearing of these problems had allowed him to be transferred to the moderate care unit when he was eight post-natal weeks. He continued to show instances of apnea-bradycardia about three times per 24 hour period and gastroesophageal reflux. The discharge plan called for a home cardiac-respiratory monitor.

Bobby's parents were informed of this plan and were asked to learn CPR as a means of intervening for him if it became necessary. The parents failed over two weeks to complete CPR training. They stopped after two sessions during which they had difficulty with the techniques. Contacted after two missed sessions, the parents were evasive and noncommittal regarding another session. Only their failure to demonstrate CPR competence was keeping Bobby from discharge. Some members of the medical team became openly angry and informed the parents that they would have to learn CPR on their own. We were contacted in conjunction with the child protection team.

A case discussion by members of the medical team, child protection team, and psychiatric consultation-liaison staff produced two nodal points of in-

formation: The Ls were at enormously high psychosocial risk for caregiving dysfunction, and the medical staff had recently discharged an infant on a cardiac-respiratory monitor only to learn of its death a short time later. These two factors converged to arouse considerable staff apprehension on behalf of Bobby. We moved in two directions: One member of the consultation-liaison staff (ST) met with the parents in order to evaluate their concerns and behavior in the past two weeks; the other (TH), an infant specialist, met with the parents and Bobby in the infant research laboratory that is apart from the medical unit.

*Parental interview.* Forty minutes late for the interview, the parents were initially guarded. Gradually they became more informative, particularly when they realized that the interviewer was from another service and therefore outside the medical team and nursing staff. Bobby was present at the interview. Although incidental observations were made by the interviewer, no direct involvement was initiated with him (see below).

The Ls married when Mrs. L was pregnant with Bobby. They had met only several months earlier. Neither was a high school graduate. Mr. L was an unskilled laborer who had just recently found employment as a machinist's assistant. He took the job without informing social service authorities; to have done so would have eliminated the public assistance they had been receiving. They were worried lest the hospital social work staff report them. Mrs. L was the youngest of nine children, Mr. L the second of four. For a time they had lived with Mrs. L's parents. They had recently moved in with

Mr. L's parents because Mr. L's father was certified in CPR.

The parents related to the interviewer that they had been surprised by Mrs. L's pregnancy. Curiously, they believed themselves both to be sterile—she by virtue of chronic pelvic inflammatory disease throughout adolescence, he by virtue of what his mother had told him was a complication arising from hernia surgery when he was six years old. Although unprepared, they recalled being pleased by the prospect of a child, and recalled that friends and relatives had given them a nice baby shower. They felt that there was substantial support for them.

Other features added to a picture of psychosocial and psychological vulnerability. Mrs. L's brother, with whom she was close, had recently committed suicide after a history of drug use. Bobby was to bear one of his names. Over the course of Bobby's hospitalization, the Ls visited irregularly, sometimes as infrequently as once a week. It was learned, then, that they lived some 50 minutes from the hospital, and that with Mr. L's recent employment it was now difficult to drive to and from the hospital in the evening.

During the interview, Mrs. L held Bobby, occasionally caressing or talking to him. Mr. L also occasionally stroked his head. Poignantly, they acknowledged that it was difficult to think about taking Bobby home. He had been so sick and in the hospital for such a long time. They could not elaborate further but it was evident that the shift in caregiving responsibility from the hospital, with its life-support systems and seemingly unanxious caregiving figures, to them was a major concern which was only partially offset by confidence that

they could manage. Mrs. L explained that she and her mother-in-law were close. She expected sufficient help and encouragement. Yet, as she commented along this line, she associated to two of her older siblings who had been born prematurely, one dying as a nine-day-old.

The interviewer spoke with them about the prospect of parent counseling focused on their expectable worries about caring for Bobby. Mr. L was receptive; Mrs. L was reluctant, wishing to be self-reliant. Both agreed to meet with a member of the psychiatric consultation-liaison staff who was a specialist in early infant development and special caregiving circumstances. In the meantime they once again presented themselves to the medical team for CPR certification and were both certified, Mrs. L being quite proficient.

*Infant-parent observation and evaluation.* The infant-parent session was conducted in a building separate from the medical unit to which Bobby was attached. The interviewer was introduced as a clinician interested in babies and parents. They were seen under laboratory circumstances, meaning that the setting conveyed the tacit message that curiosity and interest about babies and parents prevailed over conclusions and judgments. The Ls consented to the session being videotaped for teaching purposes.

The Ls were seen for about 45 minutes. The session was divided into two parts. In the first part rapport was engendered by inquiries into current concerns and circumstances and their antecedents. The Ls openly expressed many of the things that had emerged in the interview with the consultant. It was evident that they maintained an affec-

tive investment in Bobby: worried and afraid at the onset, grateful to a surgeon whose name they did not know, and increasingly hopeful about his future now that his condition was more stable. They seemed naively, but perhaps not unwarrantedly, confident about their ability to care for him. They seemed to have a realistic sense of how long Bobby would require the home monitor if all were to go well.

To be sure, Mr. and Mrs. L were anxious about Bobby's coming home. There were indications of considerable ambivalence about his having been conceived at all, and there were the troublesome psychosocial parameters that have been described. But withal, the parents seemed to have settled their doubts and achieved domestic stability in order to get a confident start with Bobby.

The transition to the second phase of direct observation saw the interview focus the parents' thinking on Bobby as a new force in their lives. Their feelings and attitudes were expressed through their expectations of and ascriptions toward Bobby. He was, they said, becoming more active and more curious. He could look them in the eye and even follow their movements. He was, in their eyes, *interested* in them. Even though he could get angry, which caused him to arch at times, he was usually in a good mood. Mr. L seemed happy that Bobby was awake more and for longer periods of time. Several times, Mr. L commented that Bobby had come "such a long way." Both parents viewed him as moving toward a normal developmental track.

Up to this point Bobby slept, cradled in his mother's arms, except for a brief time when he was held by his father. The

interviewer asked Mrs. L to rouse Bobby. Gingerly she stroked his cheeks. She tried jiggling. Bobby barely moved. The interviewer suggested that she unswaddle him, explaining that temperature change often has a rousing effect. Gently she did so and Bobby came squintingly and unfussingly awake. The bright lighting caused him to grimace and turn his head, but in a matter of moments he was alert, focusing eventually on his mother's face. "See?" she said, "He looks at me. He's really good at that." Her reactions and comments indicated her developing closeness with Bobby. She talked like a mother who believes her baby knows *her* and is interested in *her*. She detected moments when he involved himself with her and she, in turn, involved herself with him. To be sure, there was an unmistakable quality of adolescence in her further interchanges with the interviewer. Her discoveries about her baby clearly called for an adult partner with whom to share these experiences. Mr. L watched from nearby, commenting now and then on Bobby's "acceptance" of them.

After a brief while, Bobby began to cry. Mrs. L identified this as his being hungry. He cried vigorously but not oppressively—he was demanding but not terrorizing. Mr. L prepared a bottle while Mrs. L awkwardly tried to soothe him with a pacifier. Quieted by the bottle he once again became alert, focusing significantly on her face. She began to explain his mannerisms to the interviewer. When he ceased to suck she patted him, and when he fussed again she covered him at the interviewer's suggestion. Warmed, he fell again into the sleep from whence he had been roused.

In the closing moments of the interview, Mrs. L commented that one of the nurses had seemed particularly good with and interested in Bobby. She seemed appreciative although she did not say so explicitly. Despite some residual anger about the doctors not always being friendly, the evasiveness and resentment that had characterized their behavior in the weeks before were gone. The session ended on a note of cordiality and with the interviewer's explicit interest in seeing them again in a few weeks to chat about further developments. They accepted.

*Assessment.* Bobby showed, on this single occasion, rather well developed state organization capacities when augmented by his mother. A more extensive examination was not conducted due to the brevity of the session and the brevity of Bobby's period of wakefulness. In the ten minutes during which he was awake he showed characteristics that were both highly evocative of involvement in the mother and highly reinforcing to any nascent sense she might be forming that she could be an effective caregiver. On her part, Mrs. L showed an intrinsically generated set of positive, although at times awkward, reactions to Bobby. Both parents appeared to be positively invested in this baby that was about to come home with them, but were able also to voice some of their apprehension. Moreover, they seemed to welcome the interviewer's interest. Transactionally, mother and baby showed fairly well developed capacities to evoke and regulate, suggesting a readiness to deepen a relationship that would soon become mutual, reciprocal, and increasingly synchronous.<sup>16</sup>

Observed, then, were potentials in the dyad that might not otherwise have been

expected given parts of the social history and reported behavior on the part of the parents. While these potentials far from entirely offset the high risk factors evident in this case, they were sufficiently represented in the session so that confidence was raised about their capacities as caregivers, the step toward which it was now necessary to take.

#### DISCUSSION

The above case raises a number of points that are connected on the one hand with the actual dynamics surrounding discharge planning for infants at high medical and psychosocial risk, and on the other hand with the consulting role of the infant specialist.

#### *Discharge Dynamics*

Dynamics such as those observed as Bobby reached discharge readiness are familiar in our consultation-liaison experience. They sort roughly into two main components: 1) staff apprehensions about the baby's welfare after discharge, and 2) parental apprehensions about assuming full caretaking responsibilities. Each set of apprehensions may fuel the other, launching a mutually reinforcing set of negative perceptions and actions. Frequently there are latent catalysts in this process. In this case, the staff's recent experience of an infant death subsequent to discharge and parents' travel hardships comprised such catalysts.

The condition of mutual influence is a central feature of any consultative approach to the case. The behavior of the Ls, which included what seemed to be a reduction in involvement with Bobby (e.g., decreased visits, passivity vis-a-vis the medical staff, avoidance of CPR training), fed the concerns and under-

mined the confidence of the staff. The behavior of the medical staff, which entailed intensified attempts to place greater caretaking responsibility on the Ls and an apprehensive insistence on demonstrating CPR competence, frightened the parents as they contemplated the transition being made.

It would be an error, we believe, to view one component as basic and the other as reactive in such cases. Apart from spuriously ascribing an underlying blame to one side or the other, such a view presumes a linear causal relationship between the two main dynamic components rather than the mutually influential (transactional) features which more accurately characterize the circumstances. Medical-nursing teams will always have concerns and apprehensiveness about the infant's welfare when medical risk is present. So too will the parents, particularly those with first newborns. It is when concerns and apprehensiveness by one about the other are exacerbated by perceptions (realistic and otherwise) of the other that crises will frequently arise at the discharge planning phase. Thus, the crisis is made up of *convergent* forces acting on the baby and which are focused on its welfare.

*Staff reactions as bonding behavior.* The pediatric and infant psychiatric literature is replete with references to the importance of parental bonding in the early phases of infancy. Recent well-drawn and timely critiques of the concept and the research methodology on which it is largely built notwithstanding,<sup>9, 13</sup> we view the concept of parental bonding as elaborated by such authors as Klaus and Kennell<sup>12</sup> and Brazelton<sup>2</sup> to be of continuing heuristic value. Parental affects associated with attach-

ment and nurturant attentiveness to the newborn are vital to the navigation of a safe and warm caregiving relationship.

In our working model, bonding entails three principle components: 1) a sense of shared heritage and destiny born of the generative needs of the parents, 2) a sense of possessiveness (*my/our* baby), and 3) a sense of predominantly positive involvement. (See Horner<sup>11</sup> for further comments specific to these components.) As Call<sup>4</sup> has pointed out, parental bonding is not, as much of the bonding literature suggests, analogous to epoxy glue which sets in a critical period of time and lasts forever. Rather, it is a gradual process of subjective change in the parent vis-a-vis the baby which, because of its affective nature, enlivens the relationship along the three component lines just mentioned.

Is bonding strictly a parental or kinship phenomenon? We think not. In fact, we believe that many of the dynamics arising in nursing teams during protracted hospitalizations of newborns are derivatives of natural bonding processes activated by the circumstances. The second and third components, possessiveness and involvement, are transparently replicated in the attending staff. Day-to-day ministrations over weeks or months cannot help but augment the sense of belonging and personal investment nurses feel as time creates patterns of caregiving and interaction. But the first component, shared heritage and destiny, *also* obtains in such circumstances, being born of the cumulative experiences of under-

going difficult periods concomitant to distressing medical factors. Those infants who survive, recover, and make it through these difficult periods evoke and reinforce strong feelings of efficacy and self-worth in their professional caregivers, feelings that renew dedication as well as compensate for the pain of lost battles and failed efforts in other cases. The shared heritage, then, is the staff's sense of "what we've been through together," and the shared destiny is the sense of *what must be* in order to maintain continuity with that experience.

Frequently, the staff of newborn units develops somewhat of a working alliance with parents of medically compromised infants, an alliance that fosters mutual confidence in the caregiving motives and competence of each. Nurses help frightened and confused parents establish routines with the baby, and parents gradually instill confidence in the professional that the baby will continue to be well cared for after discharge. It is fascinating how often nurses from the newborn intensive care unit maintain an ongoing interest in infants discharged from the service after protracted hospitalization;\* it is equally noteworthy that parents often maintain affective links with the ICU staff long after discharge.

The unequivocal interests and apprehensiveness experienced by the hospital caregiving team during the discharge planning phases of some infants are, we believe, derivatives of affective bonds developed over the period of time

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\* To be sure, many professionals isolate their affective investments in their hospitalized charges. Or, in self-defense, they do not allow them to develop at all. In both instances there may be feared anticipations of loss or concerns that the development of such feelings is likely to interfere with, rather than enhance, the medical care of the infant.

in which the infant's viability and well-being have depended upon their actions and attitudes. As in any parent whose affective bond with an infant is built of the three components we have enumerated, the willingness to turn over primary care of the baby to others will be very much governed by feelings about those others (*i.e.*, the natural parents) and their capacity to care effectively for that infant.

*Parental avoidance as bonding-based anxiety.* In the healthy newborn situation there is considerable joy and exhilaration on the part of the delivery team, neonatal care personnel, and the parents. The natural feelings of maternal let-down following the discharge of the healthy neonate from the hospital ordinarily occur outside of the perceptual field of the hospital staff. In the words of one articulate mother:

"Even though we were joyous over bringing the baby home, the first few days at home, away from the attentive and interested nurses, with my husband away at work, were a little unnerving. There I was, never a mother before, now in charge of and responsible for this little life."

We believe that the parents of high-risk infants are not only subject to the same sobering realizations but that they are vulnerable to *anticipatory realizations* of this kind which raise the likelihood that they will deal with such feelings in a *compensatory, anxious* or, as was evident in Mr. and Mrs. L, *avoidant* manner.<sup>10</sup> Although it never surfaced directly, the prospect of Bobby's coming into their full responsibility, epitomized by the CPR techniques they were being asked to apply to his tiny body, aroused considerable apprehension resulting in their evasive behavior. Matters could not have felt worse to a staff that had,

only weeks before, lost an infant to cardiac-respiratory failure.

The consultation with the Ls helped remove the impasse that had arisen in the previous days. The parent interview broke the ice, so to speak, adducing from them the gravity of the impending discharge. The parent-infant observation session allowed capacities for involvement, which in recent days had been clouded by avoidant behavior, to emerge for a moment untarnished by parental apprehensiveness. A sense of shared beginnings, possessiveness, and growing involvement were all evident, convened somewhat awkwardly but nevertheless palpably in the lap of a 17-year-old woman and her husband.

#### *Defining the Role of the Infant Mental Health Specialist*

In a recent contribution to the literature on assessment of children, Emde, Gaensbauer and Harmon<sup>6</sup> have emphasized the central role played in diagnosis by emphatic factors in the diagnostician. Such factors are integral to realistic appraisals of adaptive capacities on the part of parent-infant dyads, sometimes offering the first or most salient clues of troublesome circumstances when things seem, on the surface, to look good—or, in the case of the Ls, strengths when things seem to look so bad.

When there are acute interventions followed by a protracted monitoring and recovery phase on the intensive or moderate care unit, there are inherent potentials for clashes between family and team, particularly when, as we have stressed, there are factors of psychosocial risk involved. These inherent potentials become manifest variously in disturbed communications, in acting



out, and in other familiar ways of dealing with distress. It is common under such circumstances for the hospital team to be perceived by the parents as a group holding several different opinions (some conflicting, some incomprehensible) or as a unit where no one is really in charge (each member refers the parents to someone else when questions arise). However, parents frequently sense the team's consensus that they, the parents, are less than adequate or even incompetent. On the other hand, it is common under such circumstances for the parents' cogwheeling involvement and understanding to be perceived by the team as bordering on incompetence, especially if their modes of dealing with their apprehension or anger are avoidant or antagonistic.

As has been suggested by the foregoing case material, an infant mental health component of psychiatric consultation-liaison units can be an effective mechanism for resolving problems between family and staff. In our experience, there are four principles that best define the role and activity of the consultation-liaison unit in cases such as this.

### *1. Consultation Demarcation*

The first principle, demarcation of the consultation role, has two aspects—geographic and functional. The demarcation we have in mind involves space (consultation office off the ward) and function (visibly separate from the hospital team). Whether symbolic or actual, there should be clear means for the family to distinguish the operative modes and aims of the infant specialist from those of the team. To be sure, we view the infant specialist as making an important contribution to the team's

treatment and discharge planning. But the posture of the consultant vis-a-vis the family is one that is several steps removed from the team, allowing an alliance to be established that is unencumbered by acute or specific medical tasks, and is unfettered by the limited amount of time the primary care physicians have for intensive and extensive work around psychological issues bearing on the case.

The advantages gained from demarcation accrue to both family and hospital team. For the family, it is frequently the first genuine opportunity to focus questions, concerns, and feelings on one central person. At the same time, it often presents the first genuine opportunity to begin building an integrated picture of treatment and discharge planning; this, in turn, creates greater capacities for tolerating ambiguities, contradictions, and uncertainties about the future. Finally, it allows the parents to express anger toward the medical team without that expression being direct. The parents "successfully" avoid worries about retaliation. The consultant acts as a lightning rod. On the consultant's part, there is the opportunity to establish an alliance that serves to integrate the confusing and often contradictory statements overheard, fantasized, misheard, or not heard when communicating with the parents. There is the assurance of a "final common pathway" of information and planning. There is also, of course, the availability of evaluative consultation around issues that the team may, due to its medical focus, not be prepared to deal with extensively. Not just a go-between, the consultant works with the parents to unify as much as possible the experience of the hospital team and the specific

problems related to the infant's health. And the consultant works with the hospital team to tailor interventions as much as possible to the unique capabilities and concerns of the parent.

### 2. *Transactional Focus*

The second principle, adhering to a transactional focus, refers to the consultant's need to approach the parent-infant system *as* a system. Individual characteristics of the parents and infant, while integral to formulating ideas about adaptive capacities and potentials, must nevertheless be made a part of an overall conceptual framework wherein the parent-infant dyads and triad are seen as reciprocal feedback systems. The theoretical foundations for this view have been elucidated by Sander.<sup>1, 3, 16</sup> Despite all our knowledge and the impressions we may form of the individual traits and dynamics of each individual in the family, we look for how *this* parent (or set of parents) deals with *this* baby and, reciprocally, how *this* baby deals with *this* parent (or set of parents). We recognize implicitly that *this* parent, because of certain traits, might not work so effectively with *that* baby and vice versa. This working rule allows us sometimes to see the strengths that exist in particular dyads despite the presence of traits in parent or infant that might otherwise lead to an erroneous conclusion being made about dyadic potentials.

### 3. *Education-Intervention Component*

The third principle, building an education-intervention component into the consultation, ensures that both the family and hospital team, in their respective ways, will experience the consultant as a dynamic force in the consultation. While its summoned mandate

may be evaluative, the consultation specialist should maintain an interventive frame of mind, not only because interventions sometimes yield useful results of diagnostic significance but also because intervention challenges the system according to its adaptive potentials. Suggestions, advice, and forthright education about infant behavior and development can provide parents with a basis for establishing an alliance that can be maintained throughout the period of hospitalization and its aftermath. The focus of consultation should be on maintaining contact with the family and the hospital team throughout the hospitalization course, rather than as a hit-and-run diagnostic enterprise. As a corollary to this, we see the early involvement of the infant behavioral specialist as critical to the course of hospitalization and its aftermath. Systematic studies are needed to substantiate this notion and provide a foundation for its adoption as a part of standard clinical practice.

### 4. *Follow-Up*

The fourth principle, follow-up, builds upon the third in that it ensures that continuity of care and education occurs in the aftermath of hospitalization. Frequently, referral of the family to a follow-up unit that is wholly apart from the setting causes a disruption that results in the parents not following through. The infant specialist who has established an alliance through the consultative role he or she has occupied can help bridge the transition between hospitalization and home care, even if the specialist's direct involvement with the family is minimal as ties to other supports (*e.g.*, pediatrician, relatives, peers) are made by the parents.

## CONCLUSION

This paper has focused on a case of combined medical and psychosocial risk in the discharge planning of a neonate to illustrate certain dynamics arising within and between the parents of the neonate and the hospital treatment team. While the case material has served as a springboard for outlining certain principles of consultation-liaison specifically involving infants, many of the principles derive from and generalize to psychiatric consultation-liaison work throughout childhood.

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