# Section 1 - How to Take a Baby History and Understand Its Implications

Axiom #1: Nothing in a baby history has an absolute 1:1 correlation with difficulties in life. Instead, these are relative tendencies to be aware of so that they can be aware of the possible need to explore an area further.

Axiom #2: The transference will ultimately reflect the patient's unconscious inner world as it is recreated. It is helpful early in treatment to have an estimate, based on the baby history, of what may come in the treatment.

General:
1 – Look for information at every opportunity, starting with the first phone call.
– make note of boundaries, appropriateness, presumptuousness, diminishment of your significance, naivete', etc.
2 – Take information with a grain of salt, especially from parents who may have denied or forgotten their child's infancy.
3 – Transference will ultimately lead to what was actually experienced by the baby i.e. recreate internalized situations.
4 – Be on alert for quirks, anxieties, etc. that hint at baby level possibilities of which the patient may be unaware.
– e.g. excessive emotionality of any type
– e.g. inability to wear a tie or anything around the neck, alternately tight clothing or preferring loose clothing
– e.g. inability to sleep without light on, sound on, significant restrictions or obsessions with food, etc.
– e.g. a fear of commitment, excessive dependence or independence, failure to have had an intimate relationship
– e.g. psychosomatic issues including bowel issues, regular headaches including migraine headaches, etc.
Note: No symptoms are pathognomonic for a particular issue, but all hint at baby level issues to be uncovered/explored. Adolescence is the period in which the possibilities finally coalesce into more permanent personality patterns.
5 – Never avoid an obvious, but scary question. Tactful and respectful curiosity will allow you to approach anything as long as you don't seem judgmental.

Initial Meeting:
1 – Let the patient lead the way but the therapist should "associate" to early life based on hints from patient.
2 – Test the patient's reaction to the concept of infancy affecting personality.
– indicates psychological mindedness, tolerance of contact with 'baby core' feelings, how accurate the history will be, etc.
3 – I don't take a formal history but get it piecemeal as the patient talks, linking current issues to possible early ones.
4 – I do "educate" about the importance of early experiences.
5 – Ask the patient if they remember dreams, if had one before this session, or if have recurring dreams. Be sure to mention that dreams are written by the baby core of the personality.

Initial Meeting with a Child as the Designated Patient:
1 – First – Why is the child the designated patient?
– Are you known to the parents? – If not, then they will probably need to meet you first but let the parents decide how to initiate contact between the therapist and child/family.
– Are both parents equally on board with the plan for the child?
– Are parents afraid child will be traumatized by talking to you? How did they prepare/explain the meeting to the child?
2 – With the occasional exception of a first meeting with a teenager, it is usually most effective to see the

family for at least part of the first meeting with the child, and again at the end of the meeting.
– Children can almost always benefit tremendously from hearing their own early history as I talk with the parents, in front of the child, while getting an initial history.
3 – Use a minimal toy box, paper, crayons/pencils – point it out to child, and let them go from there.
4 – Look for boundaries or lack of them between child and parent.
– which parent does the child go to
– how psychologically minded is each parent, how controlling, how "respect" oriented, etc.
5 – How emotionally available is the child for treatment?
– e.g. 5 year old w/ bees in baby jar (representing her divorcing parents that she said she ran over with her bike)
– e.g. a surly, sulking 13 y o suddenly blurted "listen to him, he knows what he is talking about" as I started explaining how his infancy seemed to be related to his unhappiness and behavior
– e.g. 8 year old designated patient with a chronic illness whose 11 year old sister sat on floor in corner of room furthest from the family and was clearly the one suffering the most

Background to a Baby History, Early Brain Development:
1 – No two brains function identically because of the unique feedback of nature and nurture so that even the brains of identical twins are different by the time they are born due to tiny divergences in fetal environment as experienced by each twin. Neuronal pathways that are beneficial to survival of the infant are replicated and those that are insignificant are scrapped. This "neural Darwinism" ensures that thought patterns that help the organism thrive are laid down permanently. Some of the basic pathways are genetically determined, and like speech, are so strongly inherited as a predisposition that it takes an extraordinary environmental influence to distort them.
– The infant starts forming its main brain components within 7 weeks of conception but even by birth, although it has a full complement of neurons, many are not yet sheathed with myelin and the connections are sparse. Cells that don't find a place in the linked team-work of the brain suffer programmed cell death, "apoptosis". This effectively strengthens useful connections, avoids the brain becoming overpopulated with useless ones, and thus creates a sculpting process.
– This is why the child that is not engaging with the world in infancy is going to be so tough to treat later, as seen in childhood schizophrenia and infantile autism. In other words, they have failed to build the requisite foundational neuroanatomical, mental structure from which to develop a proper mind and personality.
2 – The infant has connections between structures that the adult does not retain. For example, there are connections between the auditory and visual cortex, and between the retina and the part of the thalamus that takes in sound. These connections probably give the infant the capacity to "see" sounds and "hear" colors (known as "synaesthesia" when it continues into adulthood). Furthermore, although babies show emotions dramatically, the areas of the brain that are linked to emotions in the adult are not active in the newborn. It appears that the conscious appreciation of emotion is quite small, even inessential, to the system of survival mechanisms that mainly operate at an unconscious level. This relates to the fact that we typically cannot remember emotionally significant things before the age of three. The hippocampus, the brain nucleus that lays down long term memories, is inadequately developed until later in early childhood. However, it is likely that long term emotional memories may be stored in the amygdala, a structure that is functioning at birth.
– "Limbic leakage" is a useful phrase to capture the essence of midbrain level "memories as feelings" being stored in infancy, and leaking out throughout the lifespan. The cortical brain structures that come online later are forever trying to play 'catch up', attempting to make sense of these earliest, stored experiences that cannot be thought about consciously and directly. These will be Klein's 'unconscious phantasies' (i.e. the later cortical ideas elaborated about those earlier "memories as feelings".)
– Infant brains are more plastic than they will be later in life. If you take away one hemisphere the other will take over the tasks of both.
– As brain myelination continues, development expands outward. The parietal cortex begins to work in the baby making it able to be aware intuitively of spatial qualities of the world. This makes infants, for example, enthralled with "peek-a-boo" games because they know faces cannot disappear behind hands but they don't yet have the brain modules online to know why.
– The frontal lobes first kick in at about six months of age (which corresponds to Klein's 'depressive position'). This leads to the first glimmerings of cognition so that by the age of one they are gaining control

of the drives of the limbic system. Thus for example, if you offer two toys, they will make a choice rather than try to grab both. After a year, babies begin to have an agenda of their own.
– At about 18 months, the language areas become active. Wernike's area that confers understanding of language begins to mature before Broca's area that produces speech. Thus, there is a period in the second year of life, i.e. the "terrible twos", in which the infant can understand more than it can say.
– At the same time as speech is developing, the prefrontal lobes are becoming sufficiently myelinated so that children begin to develop self-consciousness, differentiating what they see in a mirror from themselves. Thus the development of an internal "I".
– Some brain structures take years to develop. For example, the reticular formation, which plays a major role in maintaining attention, usually only becomes fully myelinated at or after puberty. Hence the short attention span of prepubescent children. This may also explain why young adults are more emotional and impulsive than those who are older.

Overview of Memory:
1 – The human brain has the distinctive feature of creating a map of everything that occurs in the organism's interaction with an object. Everything that exists outside the brain is mimicked inside the brain's networks in the form of a map. It turns out that the cerebral cortex has layers that resemble a two dimensional square grid. When various sensory modalities activate neurons, the grid assembles all of those inputs into a map that mimics the external object or event and we experience that map as an image. Consciousness allows us to experience these maps as images in our conscious minds, manipulate those images, and apply reasoning to them. Note that these images are private, unique, individual experiences only available to the mind of the person experiencing them.
– It is important to remember that our minds have many images of which we are never conscious and yet they can influence our thinking and actions. Thus very rich reasoning and thinking can take place while our minds are consciously focused on something else. [See criminal behavior, accidental behavior, Freudian slips, etc.]
2 – Sub cortical structures can also create maps, albeit more crudely, and provide the earliest maps of the whole body and thus contribute to the production of 'primordial feelings'. Structures at the level of the brain stem may be the first in generating basic aspects of mind as they process the feelings generated by ongoing life events along the yardstick of pain or pleasure.
3 – The brain DOES NOT record experiences like an accurate camera, permanently storing the faithful representation of the original. Instead, as the organism interacts with objects, and the brain reacts to the interaction, the brain actually records the multiple consequences of the organism's interactions with that entity.
– What we normally refer to as the memory of an object is the composite memory of the sensory and motor activities related to the interaction between the organism and the object during a certain period of time.
4 – Our memories are prejudiced by our past history and beliefs. Perfectly faithful memory is a myth! We perceive by engagement, rather than passive receptivity. This is the reason why we often recall contexts rather than just isolated things.
– Babies look longer at things they like.
3 – The hallmark of brain 'maps' is the relatively obvious connection between the thing represented, i.e. shape, movement, color, sound, etc., and the map's contents. In other words, the pattern in the map has some clear correspondence to the thing of which it is a map.
– Mapping represents a system for storing prodigiously large 'files' (using a computer analogy) of recorded images. There isn't the brain power or space to store the experiences in their original content form. So the brain evolved a system for storing numerous memories in a limited space, yet retain the ability to retrieve them rapidly, as needed, and with considerable fidelity to the original experience.
4 – In recall, the larger the sensorimotor context that is reenacted, relative to a particular entity or event, the greater the complexity in the recollection process. Thus, being asked to describe the generic concept of a house evokes a much simpler image than being asked to recall your childhood home or seeing a picture of it. The number and variety of items recalled in the latter will be much greater. Unique and personal entities and events have the highest complexity in recall. Unique, non-personal entities and events are next in complexity, and non-unique entities and events require the least effort in recall.
– This probably has great import regarding memories of emotionally powerful events that occur in middle childhood. I would offer two dramatic examples among the many that are possible, ongoing sexual molestation or a divorce.

5 – Images can be experienced during perception and during recall. But it would be impossible to store all the maps that underlie these images. It is instead likely that the human brain uses the phylogenetically inherited capacity to store maps in 'dispositional format'. In effect, the disposition is commanding the process of reactivating and putting together aspects of past perceptions. One is not holding on to explicit representations of maps of objects and events, but rather that cell ensembles at the top levels of processing hierarchies would retain the know-how for the eventual reconstruction of explicit representations when they become needed. In other words, the dispositions would act on a host of early sensory cortices originally engaged by perception. The result is that the memory is played back in an area of the brain that would not be that different from the site in the brain of the original perception.
– It is important to remember that the contents of dispositions are always unconconscious, existing as it were in an encrypted and dormant form until reactivated by some stimulus. Basic dispositions may lead to the release of a hormone into the bloodstream, the contraction of muscles or viscera or of muscles in a limb or the vocal apparatus. But cortical dispositions also hold records of images perceived on a previous occasion and participate in the attempt to reconstruct a sketch of that image from memory.
– In summary, recalled memory represents images that are reconstructed and are approximations, not replicas, so they are neither as vivid or accurate as the original experience. Thus our knowledge base is implicit, encrypted, and unconscious. Dispositions are not words, they are abstract records of potentialities.
6 – Summary: Memory appears to be a complex process that can be modeled by the use of a number of concepts. In any given memory, multiple regions of the brain have complicated connections from multiple regions that are connected together both by time and emotionality. Thus multiple regions of the brain record the coincidence of activity at a given moment in neurons hailing from different brain sites that are microscopic in size. These in turn have links to much larger nodes in multiple, strategic regions of the brain so that the entire system can be pictured as analogous to local airports connecting to regional hubs in big cities.
– Note that this model of memory implies that we tend to retrieve memories as maps experienced as primarily visual images (with the addition to other sensory modalities). Thus imagination is the recall of images that can be manipulated by cutting, enlarging, reordering, and so forth.
7 – Experiences with emotional elements attached tend to reinforce the creation of the small zones of neurons and give the memory more power to remain influential. This is probably a key element in the disproportional influence of emotionally significant experiences in infancy that are recorded without adequate higher brain functions yet available to locate them more realistically in life's panorama of meanings.

<u>Essential Components of a Baby History</u>:
[Note: All milestones are relative!]
[Note: Many of these issues are only pursued in greater detail with a patient when there is a preliminary suggestion of possible importance of a particular area.]
1 – Composition of family w/ emphasis on spacing of siblings (ideal = 24 to 36 months)
– CRUCIAL: every month younger than 18 months, sibling rivalry (i.e. envy + jealousy) increases logarithmically because the mother cannot use language to prepare the older child for the arrival of the new baby
2 – Historical context for pregnancy
– parents' ages, relationship, and life circumstance
– planned or unplanned, wanted or unwanted, easy or difficult to get pregnant, etc.
– number of children in nuclear family and overall family/extended family situation
– previous miscarriages, abortions, etc.
3 – Course of the pregnancy and delivery (usually from parents on request)
– mother's health and state of mind and behavior during pregnancy, e.g. smoke, drink, exercise, etc.
– e.g. Research has shown that pregnant women subjected to starvation or extreme stress give birth to children with a higher risk of schizophrenia.
– e.g. It may be that intrauterine life is a third pathway by which mental illness is passed down in families, in addition to genetic predispositions and being raised by a disturbed parent. For example, women who are depressed or anxious during pregnancy are more likely to have children who display disturbances of their own.
– full term versus pre- or post- mature (post-mature babies at times seem to act after birth like they hadn't wanted to come out of the womb)

– length and nature of labor, sometimes hear of a low "apgar"
*KEY QUESTION: When did mother and baby leave the hospital and were they together?
4 – Sleeping arrangements in first days, weeks, months, and year or more at home (sleeping in the parents bedroom after two or three months will have consequences that may affect later development)
5 – Ask about global personality traits at birth and through the first year. Ask what kind of a baby was he or she, e.g. easy, clingy, prickly, serious, ravenous, stubborn, explosive, etc.? [Like Snow White and Seven Dwarfs]
6 – Clues to mom and baby's bonding via a feeding history
– breast versus bottle feeding (*Key: focus especially on "attempted" breast feeding which is often dismissed as having no meaning when it may have been traumatic)
– thumb or finger sucking (it may start as an attempt to comfort or organize self but it always ends up later in infancy or childhood as angrily turning away to self-sufficiency when feeling upset)
– eating history and habits throughout childhood, feeding oneself early, food fads, eating fast or slow, etc.
– colic – you may need to explain to patient what this is
– age at weaning from the breast (occasionally the bottle) – less than 4 months is likely traumatic, greater than two years is always for the mom more than child
7 – History of separations
– prematurity, being a twin (if one physically impaired, the healthy one will invariably and paradoxically be the one to have emotional difficulty)
– adoption (which is first and foremost about separation and loss)
– illness and hospitalizations, especially at birth, including asthma
– mom going back to work
– father's role in the family, availability, travel, etc.
8 – Relationship of the patient to father and siblings (dad almost always less influential in infant's early life)
– the older child ordinarily turns to dad when younger sib is born (and thus monopolizing mom)
– most children go through phases of favoring one parent over the other, especially in second year
9 – History of psychosomatic issues and illness in childhood and adolescence (all have genetic predisposion)
– e.g. high sensitivity to motion sickness (often linked to separation, e.g. leaving home in car)
– e.g. migraine headaches (= emotional states converted to unthinkable pains in the head)
– e.g. gastrointestinal syndromes (ulcerative colitis, Crohnes regional ileitis)
– other autoimmune diseases like Multiple Sclerosis, Rheumatoid Arthritis, Lupus, Scleroderma, etc.
10 – Toilet Training: It ain't all that it is cracked up to be unless a parent is disturbed!
– most children will spontaneously bowel and bladder train in their third year of life
– all kids will have occasional accidents through the age of 5 or 6
– regular "pooping" in one's pants (encopresis) after the age of 5 or 6 is suggestive of psychotic disturbance
– eneuresis after the age of 4 or 5 is suggestive of anxieties about certain emotional states which are, in effect, being emptied out under the cover of darkness
– battles around toilet training, where the child is quite resistant, are usually about something more elemental e.g. growing up, controlling mom, resentment about felt neglect, envy of younger sibling, etc.
11 – Language, walking, and other later developmental milestones tend to reflect and follow dramatic issues from infancy

<u>Adolescence and the Resurgence of the Baby Core</u>:
1 – Puberty can functionally be thought of as beginning with menarche and ejaculation. It is possible to take a presumptive baby history by taking a careful history of puberty and the next few years after because, for a number of reasons, all of the major baby states of mind resurface and dominate emotional functioning, typically for two to four years after puberty.
– this contributes to the massive instability, withdrawal, capricious unpredictability, etc. seen at ages 13 to 15
2 – Look at adolescent behavior in broad strokes:
– Did the pubertal child turn toward good objects, or away to create a 'narcissistic personality organization'?
– Were confusional states about good and bad food in evidence as manifested in drug usage, Satanism, etc.

– What degree of narcissism and omnipotence was in evidence, esp. as seen in grandiosity?
– Did depression and/or manic defensive postures take over, e.g. emotional withdrawal, eating disorders, etc.? Was the child a "loner", socially isolated, or in the role of a Pariah?
– Did the pubertal child retreat back to the safety of latency age obsessional states keeping thought apart from feeling? This can be evidence of serious problems but the kids are liked by surrounding adults because they cooperate.
– Did psychosomatic illness become prominent?
3 – When an adolescent deteriorates for no apparent reason, look to the baby history, an explanation is always there!

Some Common Hints at the Baby History in an Adult Patient Interview:
1 – Global emotional, relational characteristics: e.g. appearance, appropriateness, activity level, thing versus people orientation, history of close relationships, work history, etc.
– e.g. attractive women who dress themselves in a manner that is excessively bland, hidden, etc. because they unconsciously fear being the object of envy or fear triumphing over mother or siblings
– e.g. someone who has failed to rise to anywhere near their potential intellectually, monetarily, etc.
– e.g. someone excessively nice, mean, prickly, deferential, smiley, anxious, serious, confused, controlling, etc.
2 – Masturbation and sexuality: e.g. masturbation history, when lost virginity, nature of sexuality including promiscuity, infidelity or selecting unfaithful partners, sadism, perversions, etc.
– first intimate relationship often recreates infancy relationship to mom or dad, if cannot get over it then that indicates an infantile situation is being relived and not relinquished to move past it
3 – History of any form of intense emotion dominating the person, momentarily or constantly
4 – History of violence , or when projected, excessive fear of anger and violence in others

Evidence of "Splitting Off" the Baby Core in Childhood and Adolescence:
1 – Children often "split off" their baby difficulties during and after early infancy, thus giving the appearance of always being happy, cooperative, and good. Later schizophrenics were often "perfect babies"
– This is commonly accomplished by keeping thought rigidly separated from feeling, simultaneously keeping their objects equally separated apart in their unconscious inner worlds, while projecting the undesirable characteristics or states of mind into some container, typically a parent, sibling, or object of a phobia (with which a parent colludes unconsciously).
– This makes it necessary to make intuitive inferences, based on subtle childhood cues, to extrapolate back to infancy.
2 – This rigid, obsessional type of control breaks down after puberty such that intense emotions resurface and vacillation between various states of mind and parts of self becomes the dominant mode of experience.
3 – While there are occasionally hints suggesting death instinct issues during the "latency" age period (e.g. roughly ages 5 or 6 to ages 9 or 10), it is much more common to only see evidence of the death instinct after puberty (e.g. risky behavior, off-hand comments about wanting to die, etc.).
– If being born and out in the world seems like more pain than it is worth, and the parents are unavailable or disturbed throughout childhood, then the child will be more obviously ambivalent about life, and very uncommonly, even suicidal as a child.
– Where life gets a bad start, but the parents are adequately involved, then the ambivalence about being out in the world is less likely to be in evidence during childhood but will resurface in some form after puberty.

Prematurity in Detail:
1 – Do not assume that the parents will volunteer that their child was born before its due date
– As little as one week early can be profound in some situations and the parents may not have made the connection.
– Ask when the mom and child left the hospital and if they left together?
– Ask how soon and often the baby was brought to mom. Was it in an incubator, have surgery, O2, or bilirubin lights, immature lungs, etc.?
2 – Ask parents how they coped? This will tell you how accepting they may be about it, how guilty or angry, etc.
3 – It is useful to think of prematurity as analogous to being born like a burn victim without a skin barrier

to shield from stimuli.
4 – Every week of prematurity will contribute to increasing developmental delays, often quite significant but variable within areas of development in a given child
– physical coordination is often significantly impacted permanently
– learning disabilities are more likely to be present linked to developmental delays and preoccupations
– most developmental milestones will be delayed in proportion to the length of prematurity
– e.g. don't be surprised to see milestones in the first year delayed by one or two months with just one week of prematurity.
– e.g. one month or more of prematurity may put a child a year or more behind for each month, by the age of five
5 – Emotional development is typically altered significantly, in proportion to the degree of prematurity
– the ability to regulate emotional states, states of arousal, etc. is often very underdeveloped
– a greater than usual desire to be an unborn inside baby is common, often combined with a greater struggle with separation anxiety
6 – Very primitive, midbrain, unthinkable, limbic level memories are likely to regularly erupt throughout childhood and the parents who understand this are more likely to be able to respond constructively

Separation and Asthma in Detail:
1 – At birth, after being wrenched from the safety of the womb, every infant has to perform a shocking and terrifying act, that is take its first breath!
2 – For some infants, the conjunction of separation and a fear that one won't be able to breathe, when combined with a genetic predisposition, leads to bronchospasm and asthma
– Therefore, it is useful to think of asthma as an emotional issue linked to separation, compounded by physical triggers.
3 – Asthma is so early in its emotional origins that it is common for patient to be unable to see any emotional link to attacks. The therapist should always consider a trigger linked to separation as an unconscious issue.
4 – The combination of serious asthma, separation anxiety, ambivalence in a mother, and anger in the child can be lethal.

Colic in Detail:
1 – A Useful Definition of Colic: A condition, typically commencing in the second or third week after birth, lasting potentially for several months, almost always abating spontaneously by the beginning of the fourth month of life. In it an otherwise healthy infant, for no discernible reason, has an extended daily period of period inconsolable distress and crying. This period typically begins after an afternoon feeding, causes the crying infant to arch its back and behave as if it has extreme abdominal discomfort, and does not diminish despite being held and comforted. When extreme, the colic and distress do not abate until the infant falls asleep, hours later, seemingly from exhaustion. The episodes of colic, when intense, can be extraordinarily distressing to both parent and infant.
2 – Origin: The causes are unknown and are probably linked to genetic predispositions and a wide possible array of environmental contributions. I find it most helpful to focus primarily on neurophysiologic development , maternal mental states including anxiety or emotional unavailability, and overstimulation.
– It is likely that colic is linked to the central nervous system building up an array of stimuli by the mid-afternoon that the infant's underdeveloped brain cannot organize and adequately process. This results in the infant becoming overwhelmed with tension that is experienced abdominally in the gastrointestinal tract as a 'cramping distress'.
– Breast fed babies can also get colic but it is significantly less common.
3 – Treatment: A pediatric nurse now residing in Santa Barbara, Patricia Walbarger, developed a technique for aiding colicky infants that involved laying them over the parent's legs, on their stomach, and stroking the infant's back from head down to lower spine with a stiff brush for periods of time during the periods in the day when the infant appeared to be starting its daily bout of colic. This stroking seemed to bring a degree of order to the stimulation that was overwhelming the infant and significantly diminish the daily episodes and overall course of the colic.
– Because extreme colic is hugely traumatic to the infant and parents, I believe that medication is worth considering in addition to the above types of measures to "organize" the infant's developing nervous

system (which it will achieve by about four months of age in any case). An antispasmodic medication like Donnatal Elixer, etc, may be helpful but antacids are most likely not going to help.
– In a very small percentage of truly colicky infants, there may be an additional component of allergy to some component of the infant's formula, or the mother's diet', that may be making a contribution to the colic. Additionally, if overstimulation is in fact an aspect of the infant's colic experience, then it is logical for the lactating mother to remove both possible allergens or gas producers, and stimulants from her diet. These might include chocolate, brassica (e.g . cabbage, cauliflower, broccoli, brussel sprouts, etc.), onions, cow's milk, and caffeine.

Breast Feeding and Premature Weaning in Detail:
1 – Ideal length of breast feeding: Infants do not develop a significant sense of differentiation between themselves and their mothers until the middle of the first year of life. Prior to that, they feel joined up with and attached to the mother so that weaning before four to six months of age becomes potentially increasingly traumatic and problematic for every month less than four months of age at which it takes place.
– Most infants (in the U.S.) spontaneously wean themselves between six months and a year of age but will hold on to one last feeding, typically the night one, for a number of months more.
– A breast feeding that lasts longer than twelve months needs to be explored. After that period it is either evidence of an infant whose first year had trauma in it, or it is evidence of a need of the mother intruding into the infant's space. After two years of age is always more evidence of a need in the mother than the infant.
2 – The most common potentially traumatic weaning, commonly left out of the history unless asked about, is the result of an attempted breastfeeding that lasts less than a week.
– This typically occurs because the infant fails to "catch on" how to do it, the mother is ambivalent, the breasts have "inverted" nipples, the mother has breasts that are large and become over engorged and painfully inflamed, etc.
– A well-meaning pediatrician or obstetrician commonly suggests stopping the feeding and gives a shot to stop lactation.
Note: I counsel pregnant mothers who say they intend to stop breast feeding before a minimum of 4 months that the infant may find the weaning traumatic and it might not be wise to breast feed at all under those circumstances.
3 – Evidence that the weaning was distressing may not show up overtly but can often be inferred by changes in the infant's behavior patterns that had become established before the weaning. These might be manifested by changes in sleep or eating patterns, increased clinginess or its opposite, turning away more, etc.
4 – Recognizing the association of weaning and behavior change is key to then considering that it may be a trauma that needs factoring in as later life milestones are addressed, particularly those linked to separation.

Adoption in Detail:
1 – Every infant spends 9 months inside mom learning the qualities of her speech, activation contours and rhythms of her activities, etc.
– At birth, if then transferred to a new person, all adopted infants have at least one question: Where did the person go that I was inside for 9 months?
– This will inevitably be followed later in infancy and childhood with the questions of (1) why did she go and (2) did I have anything to do with it?
– These and related questions will be embedded in the child's play, reactions in life, etc. A parent who is available for these questions and any related anxieties is more likely to be aware when any of these are becoming problematic.
2 – Adoptive mothers vary in their confidence about being a mother, feeling that they are justified in having another woman's baby, etc.
– Look to the adoptive mother's relationship to her own mother during childhood, and the reasons for not having her own child, to gain insight into the meaning of motherhood to the adoptive parents.
– The therapist has to be sensitive to the anxieties and areas of defensiveness in the parents when exploring these potentially vulnerable areas. The trickiest aspect is sorting realistic anxieties, like will the biological mother want the baby back, from projections and neurotic anxieties on the part of the adoptive parents.

3 – If one makes the assumption that every adopted baby and mother combination is different, then one has to evaluate each family situation in order to decide how to deal with issues as they arise.
– When do you tell the child that they were adopted? Do you tell them at all?
– What form of relationship do you have with the biological mother and father?
4 – It is very difficult to face the fact that adoption is simultaneously a blessing for the child and parents but is fraught with very great potential for difficulty.
– The potential for difficulty is in proportion, more than anything else, to the length of time after birth the adoption occurs and what the circumstances were for the baby or child between birth and adoption.
– Additional factors to be looked at include the biological mother's health and life circumstance during the pregnancy, the genetic background of the biological parents, etc.
5 – I personally think all parents considering adoption should have counseling and be encouraged to expect some form of therapy will likely be desirable or even necessary during childhood. I think all persons adopting older children should be especially well counseled about the potential difficulties after puberty that may arise.
– For the most part, these issues are now central parts of all adoption screening procedures by reputable individuals and agencies.
6 – This is one area where parents and children need all the support they can get from thoughtful and optimistic encouragement tempered with an awareness of adoption's relationship to almost inevitable learning disabilities and the adolescent resurgence of the baby core of the personality.