

Returning the Treasure to Babies

An Introduction to Infant Mental Health Service and Training

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Imagine that you are an infant mental health practitioner and that you are sitting in a family's kitchen. The young mother, her infant, and her toddler were referred to you by a nurse practitioner who had some concerns about the baby's care and development following the baby's discharge from the newborn intensive care unit. It is about 2 P.M. Dishes are piled high in the sink; food from several meals sits on the counter. It is hot. The windows are shut tight, and although the sun is shining, the shades are drawn as if to protect against the intrusion of daylight. The baby, three months old, cries in the back room. The information that you were given tells you that the baby was premature and had been separated from her mother's care for three weeks before hospital discharge. The twenty-two-month-old toddler, a boy, brings you toys and indicates with a grunt that he wants to climb up on your lap—you, the stranger. His face is smudged with traces of chocolate. He is pale and unsmiling. There are significant developmental questions about both small children. Their mother, a single parent, twenty-four years old, is alone in caring for her children and isolated from family or friends. She seems agitated and surprised that you have come, although you spoke to her yesterday on the phone. She, too, is unsmiling, unable to pay attention to the toddler or to hear the baby's continuing cries. She lights a cigarette, pours a cup of coffee for herself and asks you, "So . . . why are you here?"

This vignette marks the beginning of an infant mental health intervention in which the focus is on early development and relationships between a parent and her two young children. The scene is a familiar one in the world of infant mental health, challenging and complex. What is it that you, in the role of an infant mental health practitioner, will do? What core beliefs, skills, and strategies will guide you to work effectively from an infant mental health perspective? Finally, what training experiences will you need to have in order to offer this family meaningful service support? The intent of this chapter is to introduce the reader to the practice of infant mental health and the experiences that contribute to the growth and awakening of an infant mental health therapist.

WHAT IS INFANT MENTAL HEALTH?

Selma Fraiberg and her colleagues in Michigan coined the phrase *infant mental health* in the late 1960s. It is defined as the social, emotional, and cognitive well-being of a baby who is under three years of age, within the context of a caregiving relationship (Fraiberg, 1980). Fraiberg understood that early deprivation affected both development and behavior in infancy and reminded us that an infant's capacity for love and for learning begins in those early years. She had been trained in a psychodynamic approach to mental health treatment for adults and children, which she adapted for work with parents and young children from birth to three.

Fraiberg was attuned to the power and importance of relationships and understood that how a parent cares for a very young child has a significant impact on the emotional health of that child. She also understood that parental history and past relationship experiences influence the development of relationships between parents and young children. Fraiberg referred to this new knowledge and understanding about infants and parents as "a treasure that should be returned to babies and their families as a gift from science" (1980, p. 3). She spent the remainder of her career returning that gift through training and a carefully crafted approach called *infant mental health service* (Weatherston, 2000).

Four questions are of great significance to the scope of infant mental health practice and to the training needs of infant mental health specialists: What about the baby? What about the parents who care for the baby? What about their early developing relationship and the

context for early care? What about the practitioner? These questions shape the framework for infant mental health practice and training (Weatherston, 2001).

INFANT MENTAL HEALTH PRACTICE

Regarded as a unique approach to the understanding and treatment of infants, toddlers, and families, infant mental health practice embraces the belief that all babies and young children can benefit from a sustained, primary relationship that is nurturing, supportive, and protective (Stinson, Tableman, & Weatherston, 2000; Shirilla & Weatherston, 2002). The developing parent-child relationship should be placed at the center of the therapist's work from the moment a family is referred or asks for help through the period of observation, assessment, and intervention (Lieberman & Pawl, 1993; Lieberman & Zeanah, 1999).

Parents and infants are seen together, often in the intimacy of their own homes, where the infant mental health therapist offers his or her relationship as a therapeutic context for shared observations, careful listening, and empathic response. It is most customary for an infant mental health therapist to work with a family weekly or even more frequently, for a maximum of one-and-a-half hours per visit. Some interventions may be short term or for a crisis response; others may be for assessment purposes. Most continue for three months to one year, and some sustain the work for longer periods of time, depending on the infant's or family's need. The goals are to support the social and emotional development of an infant or toddler, to identify and reduce the risk of disorder or delay, to nurture the emerging caregiving competencies that each parent has, and to strengthen early developing relationships in families.

The stakes are high. Babies and families in crisis cannot wait. Effective infant mental health practitioners observe infants and parents together and wonder about the nature of their interactions and developing relationships (Trout, 1982; McDonough, 1993; Cohen, Muir, & Lojkasek, 1999). Practitioners listen carefully, ask questions that are thoughtful, and gather information about the baby and early care. They may use formal developmental guides or diagnostic criteria, as appropriate. Practitioners invite parental participation throughout the assessment and treatment process, make an effort to establish warm and trusting relationships with parents, and consider parents'

feelings in response to observations and interviews (Hirshberg, 1993). Knowledgeable and skillful infant mental health practitioners organize their understanding in a meaningful and practical way. They listen carefully to parents and are not judgmental. They communicate clearly and invite a supportive partnership with parents (Hirshberg, 1996).

Core Infant Mental Health Beliefs

Core beliefs guide infant mental health practitioners to cherish each encounter with infants or toddlers and their families and to think deeply about early developing relationships (Trout, 1987; Stinson, Tableman, & Weatherston, 2000; Weatherston, 2000). These beliefs are the bedrock of infant mental health practice. They shape a practitioner's approach to all infants or toddlers and families who are referred for early services. Some of the most fundamental beliefs are the following:

- Optimal growth and development occur within nurturing relationships.
- The birth and care of a baby offer a family the possibility of new relationships, growth, and change.
- What happens in the early years affects the course of development across the life span.
- Early developing attachment relationships may be distorted by parental histories of unresolved losses or traumatic life events.
- The therapeutic presence of an infant mental health practitioner may reduce the risk of early relationship failure and offer hopefulness for change.

Key Components of Infant Mental Health Practice

Infant mental health services include a variety of components: concrete resource assistance, emotional support, developmental guidance, advocacy, and infant-parent psychotherapy. Some or all of these components will be appropriate when working with individual infants and families (Fraiberg, 1980; Weatherston, 1997; Weatherston & Tableman, 2002). All provide opportunities to nurture early development and relationships when responding to families.

- *Concrete resource assistance* refers to the meeting of basic needs for food, clothing, medical care, shelter, and protection. The practitioner who feeds or clothes or takes a family to the clinic assures parents and young children that he cares about them and will work to ease their burdens of care.
- *Emotional support* is defined as compassion offered to a parent who faces a crisis during pregnancy or in caring for a new baby or toddler. Alone, or without emotional reinforcement, a parent needs someone who is emotionally available, listens carefully, ask questions sensitively, and holds the many feelings that threaten to overwhelm or confuse.
- *Developmental guidance* is the shared understanding about the baby's development and specific needs for care. The practitioner and parent carefully identify emerging capacities and concerns, reaching an understanding of the uniqueness of each baby through careful observation and words.
- *Advocacy* is the offer of help to parent or infant when they cannot successfully ask for it themselves (for example, a safe place to live, assistance in finding child care, support for a special needs assessment). To speak effectively on behalf of an infant's need for early care or a parent's need for support is often a daunting, but critical, task.
- *Infant-parent psychotherapy* offers a parent the opportunity to explore thoughts and feelings awakened in the presence of an infant or toddler. In the intimacy of the home visit, a parent may share stories of past experiences and significant relationships, major fears, disappointments, and unresolved losses as they affect the care of a baby and the early developing relationship between parent and child.

Crucial to the effectiveness of these service components is the working relationship that develops between each infant mental health practitioner and parent (Fraiberg, 1980; Lieberman & Pawl, 1993; Hirshberg, 1996). Respectful and consistent, the infant mental health practitioner must remain attentive to each parent's strengths and needs. Within the safety of the relationship with the infant mental health practitioner, parents feel well cared for and secure, held by the therapist's words and in her mind (Pawl, 1994). The practitioner listens carefully, follows the parent's lead, remains attuned, sets limits, and responds with empathy. Well held, the parent experiences possibilities for growth and change through the relationship with her infant.

Infant Mental Health Skills and Strategies

Clinicians identify basic skills and strategies that are ingredients for compassionate and effective work with infants and families (Fraiberg, Adelson, & Shapiro, 1975; Blos & Davies, 1993; Pawl, 1994; Proulx, 2002; Barron, 2002; Daligga, 2002; Oleksiak, 2002; Weatherston, 2002). These contribute to the infant mental health practitioner's understanding of the infant or toddler, the awakening or repair of the early developing parent-child relationship, and the parent's capacity to nurture and protect her young child. They help infant mental health practitioners engage and sustain relationships with parents, as they think deeply about the social and emotional health and needs of each parent and very young child (Weatherston, 2000):

Identify and respond to immediate concrete service needs, to the extent necessary and possible.

Meet with the infant and parent together throughout the period of observation, assessment, and intervention, nurturing relationships and using them as instruments of change.

Invite parents to talk and listen carefully to what each parent has to tell you.

Sit beside the parent to observe the infant or toddler's growth and development.

Offer anticipatory guidance to the parent that is specific to the infant or young child, remaining sensitive to the parent's readiness to listen.

Alert each parent to the infant's or toddler's accomplishments and needs.

Create opportunities for pleasurable interaction between parent and infant.

Allow the parents to set the agenda and take the lead.

Identify and enhance the capacities that each parent brings to the care of the infant or toddler.

Speak for the infant and parent on behalf of their developmental and relationship needs.

Wonder about the parent's thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood.

Listen for the past as it is expressed in the present.

Allow core relational conflicts and emotions to be expressed; hold, contain, and talk about them as the parent is able.

Attend and respond to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant, the infant's development, the parent's emotional health, and the early developing relationship.

Identify, treat, and collaborate with others in the treatment of disorders of infancy, delays and disabilities, parental mental illness, and family dysfunction.

Use the supervisory relationship as a context for personal and professional development.

Remain open, curious, and reflective.

All of these strategies support key tasks within infant mental health practice: to develop a trusting relationship with each infant and family referred, to identify emerging capacities and risks in infancy and early parenthood, and to construct an intervention that nurtures and sustains the parent-child relationship. Together, these approaches help define the unique specialization of infant mental health (Weatherston, 2000; Weatherston & Tableman, 2002).

Key Tasks of Infant Mental Health Practice: Developing Relationships

Attention to relationship provides the focus for infant mental health practice. The infant mental health practitioner understands that the development of a trusting relationship with each infant and family referred offers the hopefulness for intervention and substantive change. The practitioner also understands that the relationship between parent and infant or parent and toddler provides the focus for treatment rather than the infant alone or the parent in isolation. Finally, the practitioner knows that the supervisory relationship offers multiple opportunities for learning and reflective practice. What follows is a brief discussion of each of these relationships and their importance to infant mental health practice.

THE PARENT-PRACTITIONER RELATIONSHIP. The working relationship between parent and practitioner is fundamental to growth and change within an infant mental health intervention (Lieberman & Zeanah,

1999). A parent in treatment learns about relationships through interactions with the practitioner, who is consistently available, sensitive to the needs of the parent, and emotionally responsive (Lieberman & Pawl, 1993). Within the context of this working relationship with the infant mental health practitioner, a parent has the opportunity to feel supported, protected, nurtured, and cared for.

For some parents, the relationship offers a “corrective emotional experience” (Lieberman & Pawl, 1993, p. 430). For other parents, the relationship provides “moments of meeting” with the practitioner, helping them to discover what is intensely important about interaction and response when there is a basis for mutual trust (Morgan, 1998). The working relationship offers parents opportunities to learn about relationship and to transfer that understanding to new interactions and ways of relating to their infant or young child. It is the relationship between parent and practitioner that offers a context for growth and change between parent and infant.

The working relationship begins with the practitioner’s undivided attention to what a parent wants or needs and where the parent wants to begin. The practitioner’s invitation to a parent to talk and the practitioner’s willingness to listen are hallmarks of best practice. Reliability, consistency, and follow-through are equally important, especially as the relationship is beginning. In addition, the practitioner’s sincere interest in the infant or toddler, balanced with concern for the parent’s emotional well-being, helps the working relationship develop.

The development of a working relationship takes time and energy. The practitioner needs to be patient, aware of the family’s need to move slowly and to develop courage in learning to trust and accept help. The practitioner needs to be willing to reach out, often many times. The practitioner needs to persist in face of many challenges (for example, crowded homes, intrusive visitors, severe disorganization, missed appointments). Often tentative, the relationship between parent and practitioner needs to be carefully constructed and protected.

Resistance may mean that a parent is fearful of entering into the relationship with the infant mental health practitioner. The practitioner thinks about the meaning of the parent’s resistance, addresses it with the family, and is often able to reduce the parent’s worry as they reach an agreement about their work together. Engaging parents and infants in relationship-based work requires training, practice, and continuing support.

THE PARENT-INFANT RELATIONSHIP. The working relationship between parent and practitioner provides a context in which parent and practitioner are able to consider the parent-infant relationship. Working with parent and infant together, the practitioner has multiple opportunities to observe and wonder about their developing relationship (Trout, 1987; Weatherston & Tableman, 2002). What is the nature of their interaction with each other? Is there a sense of reciprocity between them? How much pleasure does there seem to be? Are they emotionally available to each other, or are there frequently missed cues and misunderstandings? Is there a feeling of warmth or affection between them?

Sensitive inquiry might include questions about the parent's experience of the infant, the meaning of the infant to the parent, what the parent cherishes about the infant, and what is difficult. The practitioner may use what she sees in the interaction to ask about the parent's caregiving experience of the infant or toddler. Or the practitioner may ask questions about other babies or early care experiences that now affect the interaction with this baby. There is no script in infant mental health, only the guiding principle that it is the development of an infant or toddler within the caregiving relationship that provides the focus for the work.

THE PRACTITIONER-SUPERVISOR RELATIONSHIP. There is a third relationship that is significant to the first two: the supervisory relationship. Selma Fraiberg believed that infant mental health could be most successfully taught and explored within the supervisory relationship between a senior staff person and an individual trainee. Her unwavering belief that relationships affect relationships influenced the service that she and her staff developed to guide and support parents and infants (Fraiberg, 1980). This commitment to reflective practice influences the shape of infant mental health practice today (Schafer, 1992).

Respect, mutuality, and safety characterize what is optimal within the supervisory relationship (Shahmoon-Shanok, 1992). It is within a trusting supervisory relationship that an infant mental health practitioner grasps what is fundamental about infant mental health practice: the power and centrality of relationship. All of the work that is carried out with infants, toddlers, and families requires a belief and commitment to relationship. The practitioner's opportunity to be in a sustaining relationship with a supervisor while providing relationship-based services to infants and families is crucial to best practice within the infant mental health field.

In sum, these three relationships form the overarching context for thinking about infant mental health practice: the relationship between parent and practitioner, the relationship between parent and infant, and the relationship between practitioner and supervisor.

Key Tasks of Infant Mental Health Practice: Identifying Capacities and Risks

The ability to identify capacities and risks in infancy and early parenthood is essential to infant mental health practice. For the purpose of this discussion, the emphasis will be on understanding risk factors generally considered in referring and enrolling infants, toddlers, and parents for infant mental health services. However, it is important to keep in mind that risk is understood within the context of capacity. The infant mental health practitioner is always balancing risk with capacity and asking this question: Where does the hopefulness lie?

Most generally, the indications of risk and need for supportive intervention are identified within the infant or toddler, the parent or caregiving figure, the developing parent-child relationship, and the context in which the infant and parent live. In some instances, the risks are constitutional and rest mainly with the infant or toddler. In other instances, the risks cluster around the parent as primary caregiver, often the mother. In many cases, there are worries about both child and parent, including constitutional and maturational factors, psychosocial indicators, and the context of relationship-care (Emde, 1989).

A trainee or practitioner new to the practice of infant mental health becomes familiar with many risk indicators, in order to observe or inquire about them, listen carefully to the parent's concerns, and relate them all, in partnership with parents, to a meaningful service plan. At the same time, the trainee or practitioner keeps in mind the infant or toddler's strengths, parental capacities to provide adequate care, and aspects that offer hopefulness for development and change. The last is often a challenging requirement, but it is extremely important to the early work with a family.

IDENTIFICATION OF RISK: FOCUS ON THE INFANT OR TODDLER. Practitioners learn to appreciate the variety of risks that encompass early development programs. The infants referred may be constitutionally vulnerable babies who cannot wait beyond the first weeks or months of life for prevention or early intervention support. They may be

premature babies, underweight, irritable, difficult to comfort, or difficult to feed. Slow to gain or failing to thrive, they are at high risk for significant disabilities or developmental delays. Others may be difficult to engage, inattentive, unresponsive, withdrawn. Still others may be highly active and hypersensitive, disorganized in their approaches to people or playthings, and unable to send clear signals to tell their caregivers what they want or need. They may be unrewarding babies to take care of and at high risk for problematic care.

Some babies may be referred because of maturational concerns. A health care provider may suspect a delay in one or several developmental domains (for example, slow to sit or crawl, slow to smile or respond, unable to separate). A parent may worry about a disturbance in development, a regression, or a developmental arrest. Still other referrals may be made because of a toddler's behavior (for example, biting, head banging, aggression that is out of control, significant withdrawal, emotional retreat). Infant mental health practitioners must learn to recognize a range of conditions in early infancy in order to become familiar with a range of developmental risks and delays.

IDENTIFICATION OF RISK: FOCUS ON THE PARENT. In a substantial number of cases, a referral may be made during pregnancy or immediately following a baby's birth. The pregnancy may be healthy and the infant may be constitutionally robust at delivery, with capacities to adapt and interact from the moment he opens his eyes. The referral is made because someone is worried about the parent or parents. Will the parent be able to take care of the baby without clinical support?

What factors may concern practitioners? If pregnant, a parent may express strong ambivalence or hostility about the birth of another child. A woman may have considered abortion or adoption up until the delivery of her baby. She may have lost previous pregnancies or delivered a stillborn child. Older children may have been removed to foster care due to substantiated reports of abuse or neglect. All of these factors raise red flags and suggest that the supportive presence of an infant mental health therapist may reduce the risk of rejection of the new baby, a jeopardized attachment relationship, neglect, abuse, or developmental delay.

Other conditions may also place infants and infant-caregiver relationships at risk. The primary caregiver, usually the mother, may appear unprepared for the care of a baby, overburdened, or seriously depressed. She may be inattentive to the baby's needs, unable to be

emotionally present. She may not be able to hold or feed or provide routine care. She may not be able to enter into a loving relationship, provide developmental encouragement, or keep the baby safe. A parent may have a history of early and unresolved losses that make the care of this baby troublesome (for example, extended separations in early childhood, maternal rejection, neglectful care, placement in foster care).

Another parent may be too young, alone in the care of her baby, impulsive or unrealistic in the expectations that she has. Of additional concern is a parent who has a serious mental illness or developmental delay and when faced with the responsibilities of parenthood is not able to provide consistent or contingent care. All of these factors place an infant or toddler and parent at risk. Early referral to an infant mental health service for assessment and treatment may reduce the likelihood of developmental failure, abuse, or parental neglect.

IDENTIFICATION OF RISK: FOCUS ON THE CAREGIVING ENVIRONMENT. The context in which an infant or toddler is raised is an additional and important concern. Homelessness, hunger, joblessness, poverty, alcoholism, and drug use place enormous burdens on families. These factors exacerbate the risks that parents face in taking care of their children and in responding to their needs to be fed, clothed, sheltered, comforted, and kept safe. Any of these conditions may place infants and families in jeopardy and at risk for developmental failures. In combination, they alert infant mental health practitioners to a family's need for immediate outreach, observation and inquiry, careful listening, nurturance, and relationship-focused responses.

Key Tasks of Infant Mental Health Practice: Developing a Plan for Intervention

It is important to understand that from an infant mental health perspective all contacts with an infant and family are integral to the intervention process. The first phone contact, early observations, and formal assessment experiences affect the infant and family and need to be seen as part of a continuum of service to the family (Meisels, 1996). How might the infant mental health practitioner develop a plan through careful observation, assessment, and intervention?

There are several different ways in which the practitioner might work (Stern, 1995). The practitioner may look closely at the infant's

behavior within the context of the parent-infant relationship and work hard to bring about change there. The practitioner may focus on the parent's behavior in an effort to increase sensitivity to the infant or toddler's needs. The practitioner may work at the representational level, alert to the parent's thoughts and feelings about the infant and the meaning of early parenthood and change. In addition, the practitioner may focus on the interaction between parent and infant and their relationship, secure or insecure.

The Fraiberg model of infant mental health service encourages the infant mental health practitioner to consider all of these things as appropriate to an individual infant and parent pair. In addition, the practitioner integrates these in developing an approach that is interactional, behavioral, and psychodynamic (Hofacker & Papousek, 1998).

The infant mental health practitioner often visits families in their homes. Close to the source, the practitioner has many opportunities to watch the infant and parent together, to ask questions, to listen, to support their interactions and offer help within the context of the therapeutic relationship. The practitioner enters without judgment and makes the family comfortable. The practitioner is sensitive to the parent who is vulnerable: the mother who finds it difficult to hold and feed her baby, the father whose baby has multiple disabilities and delays, the foster mother who is caring for two toddlers who were removed from their mother's care.

Carefully following the parent's lead, the practitioner observes who is there and what is happening, asks careful questions, listens, and responds respectfully. A guest, the practitioner does not overwhelm, intrude, or offer judgments prematurely. The practitioner is there to learn what concerns the parents have and how to help them (Weatherston, 1997).

Clinical Questions

The questions raised in the following sections guide practitioners in their efforts to learn what is important when assessing the capacities and the risks of each infant or toddler and family referred for infant mental health or early developmental services. The questions are meant to encourage reflection. They may or may not be asked directly. The practitioner needs to approach each family individually and take great care when interviewing for clinical concerns (Hirshberg, 1996; Trout, 1987; Weatherston & Tableman, 2002).

THE BABY. The infant, small and dependent on a parent for protection and care, is a powerful and essential player in infant mental health practice. What does the baby contribute? How will the practitioner use knowledge and understanding about the baby to support developing competencies and reduce impending disorders or delays?

As the infant mental health practitioner works with the parents and infant together, there will be many opportunities to observe the baby and learn what life is like for them all. What experiences has the baby had that influence caregiving now? What is going well? What are some of the immediate risks?

More specific questions include the following: What does the baby look like? How interested is the baby in people and playthings? How able is the baby to communicate wants or needs? What language capacities are emerging? How adequately are the infant's basic needs for food, warmth, comfort, and protection met? Who cares for, plays with, or responds to the baby? Questions like these may be answered as the infant mental health practitioner sits at the kitchen table, observing parent and child together.

The practitioner may also wonder about the baby's history and early experience. What were the circumstances of pregnancy, labor, and the baby's birth? Has the baby been hospitalized or separated from the mother's care? Has the baby been exposed to domestic violence or trauma? These questions need to be asked with respect and as the parent is able to think about them.

A well-trained practitioner should also be familiar with developmental screening and assessment instruments to strengthen observation capacities. Guides such as the Denver II Developmental Screening Test (Walker, Bonner, & Milling, 1984) and the Ages and Stages Questionnaires (Squires, Potter, & Bricker, 1999) have been designed to help practitioners and parents screen for capacities and risks. The Bayley Scales of Infant Development (Bayley, 1993) and the Washington Guide for Promoting Development in the Young Child (Barnard & Erickson, 1976) are assessment tools that help professionals and parents consider the uniqueness of an infant or toddler's development and answer particular developmental questions.

These formal instruments guide practitioners and parents in focusing on the infant's adaptive and developing capacities, celebrating emerging strengths and describing observed behaviors and delays. In sum, screening and assessment tools provide a structure for

observation and questioning about a baby's progress and concerns that parents and practitioners may have that are related to development, emerging capacities, and risks.

More recently, practitioners from a variety of fields and across disciplines worked together through the Zero to Three Task Force in Washington, D.C., to design a diagnostic framework to address mental health and developmental disturbances for infants and young children from birth to three years of age. The task force published the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* in 1994. This systematic approach to the early identification of developmental and behavioral disorders strengthens the infant mental health practitioner's ability to assess and diagnose infants and toddlers referred for treatment services.

The primary diagnostic categories include traumatic stress disorder, disorders of affect, depression, reactive attachment deprivation, regulatory disorders, and pervasive developmental disorders, to name a few. The recognition of these disorders in infancy and early childhood increases the possibility of early intervention in the first years of life, which reduces risk and makes restoration of health much more likely.

THE PARENT. Infant mental health service is complex. The practitioner needs to observe the parent who is caring for the infant. Initial questions to guide the practitioner include the following: How does the parent look or behave when you are present? How does the parent appear to feel about herself or himself? How well does the parent seem to know the baby? How attentive is the parent to the baby's wants and needs and emotional states? How does the parent respond when the baby is hungry, uncomfortable, or distressed? How able is the parent to interact with the baby in a playful or appropriate manner?

For some families, parental histories of unresolved loss, abuse, or neglect may interrupt the parent's capacity to provide appropriate, nurturing care. These issues place infants and relationships at serious risk. Assessment and intervention require extraordinary sensitivity to the parent, attention to the caregiving relationship, and responsiveness to the parent's own relationship history and intense longing for consistent care (Wright, 1986). Such issues are best explored within a trusting therapeutic relationship, while talking with the parent over a period of time.

A CONTEXT FOR CARE. The context in which an infant or toddler and parent develop is also important to understand and assess. The Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell & Bradley, 1978) contains forty-five items collected by observation and interview. The HOME Inventory helps practitioners consider the emotional and verbal responsiveness of the parent, the organization of the baby's world, opportunities for play, and caregiving routines. Training in the use of the HOME Inventory strengthens the practitioner's skillfulness in observing details of the environment that affect a small child's development and can easily be incorporated into strategies for relationship-based assessment and continuing intervention. The HOME Inventory is a critical observation tool for infant mental health and early intervention practice.

REPRESENTATIONS. The infant may represent many people, past and present, who have been important to the parent (Fraiberg, 1980). The infant mental health practitioner observes and listens carefully, wondering whom the baby might represent to the parent (for example, an abusive uncle, an abandoning mother, a grandparent, a sibling who required attention and care). It may be the representation, rather than attributes of the real baby, that makes the care of the infant or toddler difficult and interrupts the relationship. Over time, and within the context of their working relationship, a parent may share stories that suggest whom the baby represents and what the troubling aspects of the relationship included.

The infant may represent the parent as a small child. Faced with the neediness of a very small infant, the parent may feel all over again her own helplessness and may reenact, quite unconsciously, neglectful or inconsistent or teasing patterns representative of her own early care. Alert to the struggle, the infant mental health practitioner wonders what other baby may have been neglected or hurt, abandoned or teased. The earlier neglect or trauma may never have been spoken about before.

Within the context of the therapeutic relationship, aspects of early care may be more safely reexperienced, feelings attached to them expressed, and representations explored. It is not *this* infant who is causing the difficulty. It is the other infant, the remembered infant, and all that he or she now represents that is posing problems for the caregiver.

By separating the past from the present and talking about it, the infant mental health practitioner addresses the "ghosts" and helps

protect a parent from repeating a hurtful cycle of care (Fraiberg, 1980). It is this experience that awakens possibilities for different interactions with the infant or toddler and provides a context for more positive care. The discovery is often instrumental in effecting change in the quality of the relationship between parent and child (Trout, 1987; Lieberman & Pawl, 1993; Lieberman & Zeanah, 1999).

INFANT-PARENT INTERACTIONS. The infant allows a story to be told. The way in which a parent handles the baby, gestures of care, playful interactions or the absence of interactions suggest to the infant mental health practitioner what is going well but also what some of the conflicts, as yet unexpressed, might be. For example, the parent may cuddle the baby comfortably and stroke his arm as he falls asleep. The practitioner notices how easily the parent responds to the baby's need for a nap and comments on the parent's ability to read the baby's cues correctly.

Alternatively, the parent may leave the baby to cry in a darkened room while she cleans the kitchen. She responds at last, fixing a bottle and propping it, leaving the baby to feed alone. The baby sucks greedily and the parent observes angrily, "She'll eat me out of house and home if I let her." The practitioner may wonder what has happened to put such distance between the two. What demands does the baby make? What does the baby contribute to the difficulty between them?

She may also wonder how lonely and hungry the parent is. How many of her own needs are met and by whom? The infant mental health practitioner may ask, "Can you tell me about the baby and your caregiving routine? What have the first weeks with the baby at home been like for you? Who has been here to help you? Would it be helpful to talk about this?" The practitioner pays careful attention to the interactions, the nonverbal cues and the responses that carry complex messages about the baby, the parent, and the context of care.

Because infants develop within a context of caregiving relationships, the practitioner must learn to look at each infant with an eye on interaction and relationship development. There are many formal scales that invite the study of infants or toddlers in interaction with parents or caregivers. Two that are of particular interest are the Feeding and Teaching Scales from the Nursing Child Assessment Satellite Training (NCAST) Project (Barnard, 1976) and the Massie-Campbell Scale of Mother-Infant Attachment During Stress (ADS) (Massie & Campbell, 1983).

The NCAST captures the essence of interaction and relationship by teaching practitioners to focus on the infant's ability to signal wants or needs clearly as well as the mother's sensitivity and responsiveness to her baby's cues. The ADS assesses the infant's use of the parent-child relationship when under stress and the parent's ability to comfort or respond. These instruments guide the practitioner to look at the infant or toddler within a particular relationship. In a field that prides itself on relationship-based practice, these instruments are particularly useful.

Once trained in the use of these measures, the practitioner is better prepared to examine what the infant and the parent each contribute to the relationship and their developing capacity to signal and respond. In actuality, the practitioner may use these measures as frames of reference when thinking about the child and family. The observation skills that each practitioner develops when learning to use these tools are fundamental to careful infant mental health practice.

Relationship disorders may be identified by referring to the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (1994). In addition to focusing on the young child's presenting symptoms and behaviors, this classification system examines the parent-infant relationship as crucial to the diagnostic profile of the child. Disturbances and disorders are identified within specific interactive patterns and relationships. Relationships may be described as overinvolved, underinvolved, anxious and tense, angry and hostile, or abusive. The use of the classification system supports the practitioner's ability to identify characteristics of a relationship and develop an appropriate service plan.

The next section discusses the preparation of infant and family practitioners to work from an infant mental health perspective. The discussion is introductory and offers general training guidelines and principles. More detailed discussions on training appear later in this volume.

INFANT MENTAL HEALTH TRAINING

What training experiences do practitioners from multiple disciplines need to have to prepare them for infant mental health services? Training requirements are complex. First, practitioners need to build a knowledge base from which to understand infants or toddlers and the adults who care for them, as well as the complexity of early relationship development. Second, they need to develop a wide variety of practice skills appropriate for observation, assessment, and intervention with

children under the age of three and with caregivers whose capacities and needs vary. Third, they need opportunities in which to discuss the details of what they see and hear, a place in which to ask questions about infancy and early parenthood, relationship risks, disorders of development, and strategies for effective work. Fourth, they need individual guidance and opportunities for reflection with a training supervisor who is knowledgeable about early development and relationships and is able to sustain them in their work.

These four training elements—a knowledge base, skill development through direct service experiences, opportunities to question, and reflective supervision—are consistent with the training experiences first proposed by Fraiberg and her colleagues in the Child Development Project in Ann Arbor, Michigan, in the 1970s (Fraiberg, 1980). They reflect the early training guidelines recommended by the Michigan Association for Infant Mental Health in 1983 and revised in 2002 to influence the design of university and community-based programs in the preparation of infant mental health trainees and to strengthen the practice of infant mental health (Michigan Association for Infant Mental Health, 1983/2002).

The training elements mirror the training principles proposed by staff affiliated with the National Center for Clinical Infant Programs in Washington, D.C., who are highly regarded for their leadership in preparing infant and family practitioners (Fenichel & Eggbeer, 1990). They also reflect current thinking among those who are preparing practitioners from multiple disciplines to assess and treat young children with respect to the social and emotional context in which they are raised (Meisels & Fenichel, 1996; Harmon & Frankel, 1997; Lieberman, Van Horn, Grandison & Pekarsky, 1997; Weatherston & Tableman, 2002; Trout, 1987; Fisher & Osofsky, 1997).

Unique in its focus on children under the age of three, on parents, and on relationships, the practice of infant mental health requires specific course work and supervised, clinical training. Graduate students, interns, and professionals from a wide range of disciplines need to learn how to identify capacities and risks in infancy and early parenthood and how to structure relationship-based interventions.

Principles of Practice

Infant mental health principles, stated eloquently by Fraiberg (1980) and restated by Hirshberg (1993), Lieberman and Pawl (1993), Lieberman, Van Horn, Grandison, and Pekarsky (1997), Meisels and Fenichel (1996),

Meisels and Provence (1989), Trout (1987), and Weatherston and Tableman (2002), are integral to infant mental health practice and early development services. They shape the ways in which practitioners approach infants and families and influence the ways in which infants and families may be understood.

Trainees who are new to the field of early intervention or infant mental health will use these principles to guide them in their work. For some, the “rules” will seem odd or inconsistent with previous training they have had. They may struggle to integrate a relationship-guided assessment approach with one that focuses more individually on an infant or the parent of a child. Over time and within the context of supportive training relationships, infant mental health practitioners and trainees from very diverse fields can learn to provide relationship-based assessments and interventions with the following important tenets in mind.

INFANT AND PARENT TOGETHER. First, the trainee watches the baby in the context of a relationship in order to understand who that baby is, what the baby brings into the relationship, what the caregiver provides, and the nature of their relationship with each other. Looking at one or the other alone will yield half of the story. As Winnicott (1965) so beautifully reminds us, “There is no such thing as an infant” (p. 39). By this statement, he meant that there is always a baby and a caregiver. This powerful concept directs the infant mental health practitioner to consider both infant and parent together, not one in isolation from the other.

FAMILIAR SETTING. Second, the assessment occurs in a setting familiar to the baby and to the family—most ideally, the home. The trainee observes the surroundings in which a young child is raised in order to understand what life is like for the baby and the parent, what is going well, and basic wants or needs.

Another argument, eloquently stated by Fraiberg (1980), is the fact that a parent caring for a new baby and overwhelmed by the baby’s care may find it difficult to get out of the home. Lack of reliable transportation for many families makes this even more problematic. Some parents and infants may need the trainee to reach out, knock on the door, and enter their home. In addition to better ensuring that the infant and family will be seen for an assessment, visits in the family’s own home may be more comfortable and less threatening than those

at an unknown agency. Of additional importance, home visiting may strengthen the working relationship between the practitioner and family, reinforcing the practitioner's interest and offering a basis for greater trust.

TIME. A third important principle involves the number of visits needed to appreciate the problem with the baby or the reason that the infant and family were referred. Fraiberg (1980) advised her staff many years ago that an assessment might occur over four to six visits, including the use of informal and formal strategies. Others suggest four to eight visits (Lieberman et al., 1997). It is important to understand that a thoughtful, systematic assessment takes time. The process requires attention to the concerns that parents have, the opportunity for a relationship to develop with the infant or toddler's parents, structured and unstructured observations, details of the child's development, and family stories, past and present (Greenspan & Meisels, 1996). The trainee needs time to observe, listen, and begin to understand what is going well in a particular family, in addition to what concerns exist and how to be helpful.

WORKING RELATIONSHIPS. Finally, but of singular importance, is the fact that parents must be considered partners throughout the assessment process. The working relationship between each parent and infant mental health trainee is vital to the success of the assessment (Davies, 1992). A parent or caregiver is present, allows the practitioner to be involved, and understands why the infant has been referred. One significant challenge that the new practitioner or trainee faces is earning the parent's trust. Without trust, very little intervention can happen. In relationship-focused service, a working alliance with each parent or caregiver on behalf of a young child is considered essential for best practice.

Translating Principles into Practice

With these ground rules in place, how do trainers or supervisors help trainees reach an understanding of the infants and families referred to them for services? What tools do they need to guide them through the process? What training techniques encourage clinical growth? How can trainers or supervisors move trainees from knowledge to application? What follows is a brief discussion of methods that translate infant mental health principles into practice.

TRAINING TECHNIQUES. An infant mental health trainee or practitioner needs to learn to observe and listen carefully to a family referred for assessment or treatment services. Course work, as well as observation experiences with a typically developing, low-risk infant and family, prepares a practitioner-trainee to assess strengths and risks when an infant or toddler and family is referred for assessment or treatment. In instances where there is no formal training program or where it is not possible to observe a low-risk infant and family, the training supervisor plays a particularly important role. Experienced in providing relationship-based assessments and treatment services, the training supervisor will need to guide practitioners as they develop the art of careful observation, listening, and relationship-focused practice.

In all instances, the practitioner-trainee must learn how to define the relationship (Schafer, 1995; Zeanah et al., 1997). This means that the practitioner-trainee will try to observe and understand the infant and parent within the context of their relationship with each other. This will help the practitioner appreciate the dynamics of interaction moment to moment and to contain the feelings expressed or aroused. In order to do this, the trainee needs to observe the infant and parents together. For many, this is a unique requirement.

Students and professionals are customarily trained to work either with children or with adults. By contrast, practitioners within the field of infant mental health are taught to work with the infant and parent together (Fraiberg, 1980; Trout, 1982; Lieberman & Pawl, 1993). In relationship work, the presence of the parent is considered vital in understanding the infant (Hirschberg, 1993). Of equal importance, the presence of the infant is a powerful contributor to understanding the dynamics of relationship within families and caregiving responses, both nurturing and problematic.

When possible, trainees may arrange to visit parents and infant in the home, at a time that is convenient for the family. In instances where home visiting is not possible, trainees will work with parents and infant in an office, playroom, or center-based program. Regardless of the location, trainees must be taught to approach families with kindness and respect, keeping in mind the centrality of the therapeutic relationship to the success of assessment and treatment.

These expectations are consistent with infant mental health practices as described by Fraiberg (1980), Lieberman and Pawl (1993), Wright (1986), Weatherston and Tableman (2002), and Trout (1987). They are most important when a parent expresses concern about the

development of an infant, when a professional is worried about the caregiving capacity of a parent, or when an agency suspects a relationship disturbance or disorder due to serious neglect or abuse or placement in foster care.

THE SUPERVISORY RELATIONSHIP. The supervisory relationship is crucial to the development of clinical competency within the field of infant mental health. Whether enrolled in a formal training program or learning about infant mental health practice on the job, a practitioner new to the field of infant mental health needs a supervisor who will guide and support the integration of knowledge about infancy and early parenthood with best practice skill.

Because relationships affect relationships, the supervisory relationship offers the trainee a context for clinical growth that shapes the trainee's capacity to offer the same to the infants and families served. Secure in the relationship with a trusted supervisor, the trainee is encouraged to think deeply about infants and families and services within an infant mental health framework. The trainee also learns to reflect on personal aspects of infant mental health work. Over time, and within the context of the supervisory relationship, the trainee or practitioner new to the field integrates principles with practices of infant mental health.



“So . . . why are you here?” the young mother of two small children asks. Her question is a pointed and poignant one. The answer is complex. The infant mental health practitioner is there to support the social and emotional well-being of an infant and toddler within the caregiving relationship with their mother. The task is an ambitious one. It will require patience and persistence on the part of the practitioner, as well as careful observation, sensitive inquiry, and thoughtful response. It will require courage on the part of the parent to be present and to enter into a working relationship with the practitioner on behalf of her young children and herself. The practitioner will listen carefully, understand the parent's agenda, communicate clearly, and invite a supportive relationship with the family.

Once the relationship is under way, parent and practitioner will begin to acknowledge what is going well and what is not, what the children's developmental capacities are and where the risks lie, what the mother's caregiving strengths are and where the concerns lie.

Together they may wonder about the mother's feelings related to the care of two small children and the changing responsibilities of parenthood. They may discover core relational conflicts, old hurts, and unresolved losses that make the care of her children difficult. Their work together may take many months. Parent and practitioner will need to remain open, curious, and reflective. In sum, they will embark on a journey together, looking for the "treasure" that Selma Fraiberg (1980, p. 3) so artfully described—new knowledge and understanding "returned to babies and their families as a gift from science."

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