Infant Mental Health: A Review of Relevant Literature

Deborah J. Weatherston

ABSTRACT. This review explores diverse theories that provide the basis and rationale for infant mental health, a relatively new service designed to reduce social and emotional disturbances in infancy and early parenthood. Psychoanalytic theory, attachment theory, social and contextual theories, developmental theories and the work of Donald Winnicott and Daniel Stern contribute to the fundamentals of infant mental health practice, increasing the understanding of development in early childhood and the power of relationships in defining a context for social and emotional growth. Infant mental health practice influences psychotherapeutic change in early parenthood and the possibility of attachment security in early infancy. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.Haworth Press.com> © 2001 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. Infant mental health, early childhood mental health, early relationship development, infant-parent intervention, infancy and early parenthood

The practice of infant mental health is a relatively new service intended to meet the social and emotional needs of infants, toddlers and their families (Fraiberg, 1980; Weatherston & Tableman, 1989;

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Lieberman & Zeanah, 1999). Designed by Selma Fraiberg and her colleagues in the 1970s, infant mental health services offer parents and infants the opportunity to enter into and sustain healthy attachment relationships, reducing the risk of delay or disorder and increasing the possibility of optimal development in infancy and early parenthood. Unique in its attention to early development and emerging relationships, infant mental health service requires a dramatic and simultaneous shift in focus on the infant, the parent and their developing attachment relationship. What follows is a review of the literature that provides the basis and rationale for infant mental health practice. While integrating such diverse theories as psychoanalytic theory, attachment theory, social and contextual theories and the work of Donald Winnicott and Daniel Stern, the infant mental health literature is also a distinctive literature that unites theory about development with effective clinical practice.

I have divided this review into two parts. In the first part, I review, albeit briefly, major psychoanalytic, developmental and contextual theorists who have had a profound influence on the understanding of early development and the importance of early experience and care. I begin with Sigmund Freud and two more contemporary psychoanalytic scholars, Anna Freud and Erik Erikson. I continue with Jean Piaget and John Bowlby. Next, I consider Mary Ainsworth, John Bowlby's protégé and collaborator, who is credited with expanding Bowlby's early thinking about attachment to a new understanding about early relationship development and maternal care (Ainsworth, 1973). Ainsworth's observational studies of infants and mothers in their own homes made it possible to describe the quality of a baby's attachment security within the context of specific care (Ainsworth, Blehar, Waters, & Wall, 1978). Mary Main, a protégé of Ainsworth's, continued the careful examination of attachment security and insecurity and extended Bowlby's thinking about internal working models to include the relationship of the adult's internal working model to a new baby's care (Main, Kaplan & Cassidy, 1985). Main later examined the adult's mental representations of attachment through the design and use of the Adult Attachment Interview (Main, 1995). Following a discussion of Main's research, I examine Donald Winnicott's theories about holding and handling as they affect caregiving (Winnicott, 1965a) and Daniel Stern's interesting and more recent work about motherhood as a context for development and change (Stern, 1995). I conclude the first part with a very brief discussion of the social, cultural and historical con-

text and its importance to development as understood by Vygotsky (1962) and Bronfenbrenner (1979).

In the second part, I review the fundamentals of infant mental health home visiting practice as originally developed in the late 1960s and early 1970s by Selma Fraiberg (1980) and continued by others in the following decades. The early infant mental health specialists intended to offer developmental and clinical services that might reduce the risks of early relationship failure and increase the possibility of attachment security in early infancy. I complete this section with a discussion of psychotherapeutic change that is possible within infant mental health services for infants, toddlers and families, most frequently carried out in their homes.

INFANCY AND EARLY PARENTHOOD

Freud. Freud saw the baby as filled with psychic energy and bodily needs, energized by internal forces and drives in relation to a primary object who is created by the infant to satisfy those needs (Greenberg & Mitchell, 1983). It is this early relationship that the infant internalizes that shapes subjective experiences in later relationships throughout the life span. Freud organized his thinking about early development in a series of psychosexual stages, believing that what happened in the early years was crucial to personality development throughout the life span. Freud initially described the infant as a bundle of needs demanding to be immediately satisfied. In his description of the first or oral stage, Freud emphasized the infant's experiences of the world through the mouth, searching for satisfaction through sucking, chewing and biting.

Of central significance is the infant's relationship with its mother as the one who feeds and meets immediate needs. Freud (1940/64) writes about the centrality of the mother-child relationship, describing it as "unique, without parallel, established unalterably for a whole lifetime as the first and strongest love-object and as the prototype of all later love-relations" (p. 188). From this, it is clear that Freud believed in the concept of an emotional attachment, established in infancy and influencing a person throughout the life span. Furthermore, an infant who is not adequately cared for, whose mother cannot optimally feed or gratify, will be seriously troubled. Freud believed that this would then lead to difficulties for the baby whose sense of self evolves out of this early and need-fulfilling rela-

tionship with a primary object (Greenberg & Mitchell, 1983). The object in this sense is the baby's emotional target created to sooth the needs and feelings the baby has. When not satisfied, the baby is conflicted. It is this original conflict that is likely to be carried throughout early childhood into adulthood, continuously resurfacing and affecting development at each stage of life. Greenberg and Mitchell (1983) describe this as Freud's original model, the *drive/structure model*. To the degree that the first relationship in the first year was a satisfying and need-fulfilling one, Freud's baby learns what gratification is and develops expectations within other relationships that will be met, a psychological fact with important and multiple ramifications for development of the total personality.

It is important to note that the role of the object as explained by classical psychoanalysis differs from contemporary psychoanalytic theorists, such as Bowlby, Mahler, and Kernberg, who believed that the early object relationship between mother and infant is a real and fundamental tie to be understood. Relational theorists expanded the importance of the early and dynamic relationship between caregiver and child and infused the understanding of relationships, past and present, into treatment paradigms.

According to Freud, by the end of the first year, the baby enters a second stage (the anal stage), where pleasures and tensions focus on physiological needs and toilet training. This stage becomes a potential "battle ground" between parent and infant. The parent's response to the baby's needs and demands at this time establishes a prototype for many later behaviors. Issues of control, retention, cleanliness, frugality, and order originate here. Of additional interest, the seeds are sown here for generosity, gift-giving, creativity, and production. How toddler and parent handle the tension of this stage is reflected in their continuing relationship and the child's personality development through the life span.

Moving into the third stage (phallic stage), when the child is between 3 and 5 years, Freud identifies a period of central importance to his theory. Sexual desire for the parent of the opposite sex, and rivalry with the parent of the same sex are intrapsychic experiences that may produce tension and intense psychological conflict. Resolution varies and has lasting effects on the nature of attachments to both parents, as well as feelings about oneself and future relationships with peers, lovers, and mates.

The ability to be separate and independent emerges as an equally intense issue during this third stage. How the developing child ne-

gotiates the task of separation is related to later anxieties and intense conflicts. Freud believed that children work hard to be separate and detached from parents, moving from passivity to activity in achieving this milestone (Greenberg & Mitchell, 1983). Again, we may turn to more contemporary psychoanalytic theorists such as Mahler or Bowlby to appreciate the developmental achievement of separation differently.

Freud understood infancy and early childhood as he listened to adult patients share childhood memories through free association, dreams and the transference relationships (Miller, 1993). Of interest to this review were his concerns for the psychological events and relationships established in infancy and early childhood as they influenced personality development later in life. He appreciated the importance of early internal conflicts to development, beginning in infancy. He understood the relationship of external frustration and deprivations to a child's emotional pain. He realized the etiology of psychological pain in the threat or loss of primary relationship. Freud's thinking influenced contemporary theorists, among them Anna Freud and Erik Erikson, and has also shaped John Bowlby's interests in interpersonal relationships, internal working models, and the emotional world of the infant (Bretherton & Munholland, 1999). Freud's ideas undoubtedly are also reflected in Donald Winnicott's concepts of holding and early relationship development. His thinking certainly affected Selma Fraiberg's construction of infant-parent psychotherapy as a major component of infant mental health treatment services (Lieberman & Zeanah, 1999).

Anna Freud. The daughter of Sigmund Freud, Anna Freud played a vital role in extending classical psychoanalysis to include psychosocial and emotional development in early childhood. Anna Freud's contributions to contemporary thinking about early childhood development are most significant. Her interest in normality as well as pathology provides a framework for organizing contemporary thinking about ego development and mechanisms of defense (A. Freud, 1936). She preserved the classical psychoanalytic belief in drive theory, but extended it to incorporate defense theory, the psychoanalytic treatment of children, and developmental lines (Brandell & Perlman, 1997). Her elegant descriptions of early development in *Normality and Pathology in Childhood: Assessments of Development* (1965) provides us with a way to understand the young child's achievements and failures along multiple lines of development from early infancy through adolescence.

One developmental line is referred to as a prototype (A. Freud, 1965, p. 64), the line from dependency to self-reliance. Ms. Freud begins with the infant's dependency on a caregiver for nurturance, moves to the young child's capacity to maintain an inner representation of the caregiver when absent, moves on to consider the ambivalence and strivings for separateness in toddlerhood and early childhood, the transfer of emotional investment from parents to peers, and, in adolescence, the struggle for independence from parents and emotional self-reliance. Other developmental lines that are critical to consider in the child's achievement of emotional independence include feeding or eating, toileting, the child's care of his or her own body, relationship development, and play. An important observation Anna Freud makes is that the lines of development in infancy and early childhood are fueled by the quality of the mother's attention, responsiveness, and ability to provide care. To the extent that mothers vary in the ways that they provide or do not provide care, development along these lines will vary and contribute to unique profiles of normality and risk (A. Freud, 1965).

Erikson. The field of psychoanalysis was broadened and deepened by another contemporary scholar, Erik Erikson. Among the most creative, his focus on psychosocial development across the life span was of major importance to the understanding of infancy and early childhood, adolescence and adulthood. Erikson's contributions provide a framework for thinking about infancy that evolved from Anna Freud's emphasis on psychological structures and stages, early experiences and parent-child relationships, and the influence of the drives. However, Erikson took into account the developing child within a broad, social context, bridging the external and internal worlds. His theories are summarized in *Childhood and Society* (1950) and *Identity and the Life Cycle* (1980).

According to Erikson, development occurs in a series of 8 psychosocial crises. Of greatest interest to this study are the first three stages, Trust vs. Mistrust, Autonomy vs. Shame or Doubt and Initiative vs. Guilt. Caregivers are of significance to the healthy resolution of each of these crises. The identity of each child is clearly established within a parenting relationship, family context, and culture. The infant who experiences a trusting relationship with a primary caregiver in the first years of life is more likely to be secure in the ability to be separate and independent in later years. Clearly, healthy development evolves within healthy relationships and healthy families.

Adaptive and interactive, the infant, from Erikson's point of view, matures within a particular relationship and culture. His identity is embedded within that culture, affected by it and transformed by stages within it. In sum, Erikson was a careful observer of children, learning about them through observation and play, understanding them in a social and cultural context, and deeply aware of the importance of each child's psychosocial history. Growth and change occur through continuous strivings for identity as the infant, child, adolescent and adult interact with, react, and adapt to an increasingly complex social world. Erikson's approach to the study and understanding of early childhood was clearly influenced by his relationship with Anna Freud, his analyst and teacher.

Piaget. Perhaps the most famous of all developmentalists, Jean Piaget was most curious about how young children think and learn (Piaget, 1954). Trained in biology, psychology, and philosophy, Piaget observed babies (his own) very closely in the effort to understand how a child begins to know about the world (Piaget, 1954). He believed that intelligence was inherent, constructed in stages, and reflective of the child's adaptation to the world of events and things. His cognitive-structural theory has profoundly influenced the way that psychologists and educators view the development of young children, the acquisition of knowledge, and the process of knowing. He organized cognitive development into periods, beginning with the sensorimotor period in early infancy (birth to 2 years) and continuing through the preoperational period (2-7 years), concrete operational period (7-11 years), and formal operational period (11-15 years). It is Piaget's description of the sensorimotor period and the 6 stages within it that are of particular interest to this review (Flavell, 1963; Miller, 1993).

Piaget defined the sensorimotor period as spanning development from the first reflexive responses in the newborn stage to more intentional behaviors, to discovery through trial and error, to the child's use of symbols to represent things. From birth, the infant is an eager participant with the potential for relationship to the external world. As such, the infant learns through active involvement with things, sucking, mouthing, handling, shaking, and so forth and by about two years of age is able to know his or her world and begin to solve problems through imitation and mental representation.

Piaget understood cognitive growth as similar to embryonic development, increasingly organized, complex and differentiated with the passage of time. Piaget explained development as orderly and

sequential, involving qualitative changes, integrative, invariant, and universal. The infant, from Piaget's description, is an active and interactive agent, who learns about the world through the adaptive processes of assimilation and accommodation. The child learns through continuous interaction, gradually constructing an understanding of the world and establishing a sense of self as separate from objects in the surrounding environment. After reviewing the six stages of the sensorimotor period, one can't help but be convinced that this is how a baby acquires knowledge of worldly things.

Briefly, *Stage 1 Reflexive,* the baby arrives with the ability to suck, grasp, step, and explore the world visually. Between 1-4 months, *Stage 2 Primary Circular Reaction,* the baby repeats behaviors that become schemas through which it is discovered that when the baby does something with its body, it feels or looks a certain way, often pleasurable, sometimes not. Between 4-8 months, *Stage 3 Secondary Circular Reactions,* the baby pays attention to things or objects that move or fascinate, like a rattle or mobile. Between 8-12 months, *Stage 4 Secondary Schemas Coordinated,* the baby mounts an effort to get or make something happen. Discovery is possible! Between 12-18 months, *Stage 5 Tertiary Circular Reactions,* the baby experiments and invents new ways of using or playing with things. By 18-14 months, *Stage 6 Invention of New Means,* the baby begins to use a mental symbol, remember events or things, and see self as separate from things around him. That objects exist permanently and separately is one major mark of the sensorimotor period. The infant who discovers this is well on the way to understanding and exploring his world. In sum, the Piagetian baby is a self-regulating, organized whole striving to maintain equilibrium within the environment (Miller, 1993). Although Piaget's emphasis was on emerging cognitive development, his observations were crucial to the understanding of the infant's contributions to the early developing parent-infant relationship and its importance to optimal growth in multiple domains. This concept propels me into thinking about the infant in interaction or relationship with another.

INFANT DEVELOPMENT WITHIN THE CONTEXT OF RELATIONSHIP

Bowlby. Described as a seminal thinker within the British psychoanalytic community, John Bowlby departed from the classical

Freudian tradition and developed his own views about human development based on his interest in ethology (Miller, 1993), object relations (Brandell & Perlman, 1997), the etiology of disorder and adaptive behavior (Bowlby, 1958). He viewed early relationship development from an evolutionary perspective (Cassidy, 1999). Survival of the human infant depended on being in close proximity to a nurturing and responsive caregiving adult. Bowlby examined specific careseeking and caregiving behaviors that assured proximity and recognized the significance of responsive caregiving to the organization of behaviors in infancy and healthy emotional development throughout the life span. This led to his theory of attachment, the significance of early relationships to development, as well as the importance of separation and loss to security of attachment relationships across the life span (Bowlby, 1969; 1973; 1980).

Most importantly, Bowlby viewed the infant as an active participant within a relational context. He emphasized the significance of the infant's signals as well as the importance of responsive caregiving to the course of development throughout the life span. Devoted to the baby's needs, an attentive caregiver, most often the mother, responds to her baby's signals to move closer;–cooing, crying, smiling and so forth–with sensitivity and warmth. Confident that the caregiver will consistently meet the need for protection and affection, the baby feels well nurtured and safe within that relationship. Later behaviors, for example, crawling, walking and talking, assure that the baby can keep his caregiver in view as he seeks out interesting playthings and activities. The transactions between caregiver and infant in the first year provide the building blocks for security in the attachment relationship.

Toward the end of the first year, the baby develops an attachment to the caregiver that is specific. The baby notices when this beloved figure leaves and protests to bring that person close. Infant and caregiver together effect the construction of an early developing relationship in which the infant grows and changes. Most optimally, within the context of the trusting relationship that develops between them, the baby develops healthy self-confidence. This working model affirms the very young child's expectation of security in that relationship, and that a particular caregiver will meet many needs consistently and sensitively (Bowlby, 1969; 1979).

The attachment relationship, described as secure or insecure, has powerful implications for the young child's development and consequent interest in the larger social world. Secure in the emotional re-

lationship with his caregiver, the infant reaches away with zest and curiosity and returns to the caregiver, "the safe base," for comfort and support as needed (Ainsworth et al., 1978; Bowlby, 1969). An infant who is insecure in the relationship has no "safe haven" and appears hesitant or fearful, muted in attempts to seek out new experiences with people or playthings (Bowlby, 1973). The attachment relationship is clearly important for the child's continuing development in cognitive as well as affective domains. Secure in knowing that the caregiver is available, the infant blossoms through continuous exploration and interaction with people and things.

SECURITY OF ATTACHMENT AND EARLY CAREGIVING

Mary Ainsworth. Mary Ainsworth was among the most important of John Bowlby's collaborators to explore the importance of the very young child's tie to his or her mother as well as caregiving behaviors vital to an infant's social and emotional health (Ainsworth, 1973). She and her colleagues made essential contributions to Bowlby's work on Attachment Theory (Ainsworth et al., 1978). They observed 24 mother-infant pairs in their homes monthly during the infant's first year, noting interactive behaviors and maternal responses. They brought each mother-infant pair into a lab setting when the babies were 12 months of age. There they observed mother and infant together, in the presence of a stranger, in the mother's absence, and upon reunion of mother and child.

Their research at 12 months, known as the Strange Situation Paradigm (Ainsworth et al., 1978), permitted a remarkable view of the internal world of the infant's experience within the caregiving relationship when the infant is under some stress. With this method, Ainsworth and her colleagues identified two major categories of attachment in infancy: secure and anxious, the latter described as avoidant or resistant. Infants identified as secure in their relationships were described as curious, able to use the caregiver as a safe base, able to explore with interest, responsive to the parent, and able to seek comfort upon reunion. Infants described as avoidant in their relationships were seen as somewhat playful, unsmiling, ignoring of the parent upon reunion. Infants identified as resistant in their relationships were described as uncertain in the parent's presence, very distressed when the parent was absent, and unable to be comforted by the parent when the parent returned. There was evi-

dence that the history of caregiving, particularly maternal sensitivity and responsivity to the infant's needs and cues, was related to attachment security as assessed by the Strange Situation at 12 months (Bretherton, 1985). An interesting meta-analysis of 66 studies in which examiners looked at the relationship between maternal sensitivity and an infant attachment security supported Ainsworth's early findings (Dewolff & van Ijzendoorn, 1997).

Mary Ainsworth and her colleagues gave careful consideration to the antecedents of attachment. They discussed differences in maternal caregiving that explained qualitative differences in the attachment relationship (Ainsworth et al., 1978). Mothers who were described as sensitive, accepting, cooperative, consistent, available, and skillful in providing infant care had babies who were rated as secure in their attachment relationships. Mothers who were described as less sensitive to infant cries and cues, inconsistent, unavailable, and rejecting had babies that were identified as insecure in their relationships (Egeland & Farber, 1984).

Mary Main and the Adult Attachment Interview. Mary Main, a noted developmental psychologist and research scientist, developed the Adult Attachment Interview following her graduate study with Mary Ainsworth (George, Kaplan & Main, 1985). The interview is a set of 18 questions developed to gather information about an individual's representations of early and current relationship experiences. The initial questions inquire about the composition of an individual's family, relationship experiences as remembered with each parent, and the use of those relationships for comfort, safety, or support. Later questions focus on issues of abandonment and loss and the events themselves, as well as feelings surrounding those experiences. The final questions attempt to assess current relationships and feelings about parents, grandparents and other children.

The interview is semi-structured and conversational. Answers to these questions relay the story of the adult's relationships with people who were and are important. The interview is transcribed and reviewed for both content and process (Main, 1995). Main and her colleagues reviewed the transcripts of 34 individuals according to the coherence (and incoherence) of the AAI transcripts. Main (1995) identified three adult attachment classification descriptors: secure/autonomous, dismissing, and preoccupied. These rate the adult's mental representation or state of mind in relationship to attachment. They correspond and are predictive of the three patterns identified by the Strange Situation (Ainsworth et al., 1978): secure,

avoidant and anxious/resistant. A fourth adult classification, unresolved/disorganized (Main, 1995), corresponds and is predictive of a fourth infant pattern, disorganized/disoriented (Main & Solomon, 1990).

Others replicated the initial correspondence between the adult attachment classification system and the infant attachment descriptors (Ainsworth & Eichberg, 1991). Still others analyzed the relationship between women's representations of attachment during pregnancy and the infants' attachment classifications through the Strange Situation at 12 months, finding a 75% match (Fonagy, Steele & Steele, 1991). Benoit and Parker (1994) extended the research efforts across three generations, finding a 75% correspondence. A subsequent meta-analysis by van Ijzendoorn (1995) validates the relationship between the AAI and the infants' classifications. How the information is transmitted from mother to infant needs further investigation, however, as well as the timing and influencing of very early experiences within their relationship (Hesse, 1999). This is an area that is crucial to the infant mental health home-visiting practice and the continuing need to understand the complexity of the intergenerational transmission of secure and insecure attachment relationships.

EARLY MOTHERING CARE

Winnicott. The work of Donald Winnicott (1965a; 1965b), a psychoanalytic theorist, pediatrician and developmental specialist, provides a link that relates the care that mothers provide to the development of attachment security in infancy. Holding, handling, and relating were essential components of mothering care that Winnicott studied and discussed in many of his lectures and publications throughout a 40-year career (Phillips, 1988). He viewed the infant as ready for interaction and relationship with a mothering person. Secure in that relationship, the baby flourishes.

Holding is a concept central to Winnicott's beliefs about early development and an infant's emotional health and growth. The way in which a parent holds a baby affects the baby's security and developing relationship to that parent. The parent who picks the baby up, cradles it securely, supports its head, and attends to its needs communicates an important message to that baby: "I can take good care of you." The baby feels safe in the mother's embrace. Within the

arms of an attentive and comforting parent, the baby is assured of support and protection. Reliable and predictable, a parent provides continuity of relationship and caregiving. Organized around the parent's face and voice, the baby is anchored in those arms. Safely held, the infant is confident that physical and emotional needs will be met. It is this holding experience that contributes to the baby's sense of security within the emerging parent-child relationship. Winnicott's phrase, "holding," provides a most concrete metaphor for the work of the infant mental health home visitor.

Infant mental health home visiting practitioners have a solid commitment to understanding and supporting the parent's ability to hold the infant securely, strengthening the developing attachment relationship. Strategies include emotional support, concrete service support, developmental guidance, advocacy, and infant-parent psychotherapy (Lieberman & Pawl, 1988; McDonough, 1993; Weatherston & Tableman, 1989; Wright, 1986). All of these strategies affect a mother or father's capacity to handle and hold the infant with care, confidence and affection. These same strategies affect the infant's sense of security within the caregiving relationship. Winnicott's commitment to the concept of holding provides a window into the attachment process and informs us about the important transaction between parent and infant that leads to an infant's security of attachment (Winnicott, 1965b).

Stern. Daniel Stern, a contemporary scholar schooled in the psychoanalytic tradition, unites the thinking of clinical and developmental theorists, exploring concepts from multiple traditions, e.g., psychoanalysis, systems theory, and behaviorism. His work has been crucial to the understanding of early motherhood. Throughout his career, Stern has focused on the early relationship between parent and infant (Stern, 1977), introducing us to the importance of reciprocal interaction and moving to more challenging concepts like the role of emotion in organizing early experiences, affective monitoring, the core self and interpersonal relationships (Stern, 1985). More recently, Stern introduced the term "motherhood constellation" to describe four major challenges that a mother faces in adapting to the care of a new baby (Stern, 1995).

The first concept that Stern presents is the life growth theme. He asks if a new mother is able to sustain and support her baby. The second theme is primary relatedness. Stern asks if a new mother is able to enter into a nurturing relationship to protect her baby and develop a secure and affectionate tie. The third theme is the sup-

porting matrix theme. Stern wonders if a new mother is able to make use of the supportive relationships available to her–parents, husband, siblings, and friends. The fourth and final theme is identity reorganization. He inquires about the mother's ability to integrate her other identities–wife, daughter, working woman–and do what she needs to do to keep her baby safe, offer a relationship of trust, and gather in people who can support her in these first months. These four themes offer a unique framework from which to consider a woman's development as she becomes a mother to her child. The motherhood constellation assumes that each mother is an active participant, a change agent, capable of adapting to a new set of needs and demands, preserving what and who she was and is.

Stern (1995) asserts that it is within the new caregiving context that a woman begins to alter her identity as "a mother." He considers the holding and handling of a baby as instrumental to the development of the attachment relationship. His interest is in the importance of these caregiving behaviors to the mother's development as well as to her baby. While holding, feeding, diapering, caressing or comforting her own baby, a mother recalls experiences of motherly care. The interactions with her baby awaken thoughts and feelings of another mother-baby pair–her own mother and the baby she once was. She may identify at the same time with the mother and also with the baby. It is within this present context that old memories are stirred (Stern-Bruschweiler & Stern, 1989; Fraiberg & Adelson, 1977; Fraiberg, Adelson & Shapiro, 1975). This is crucial to the infant mental health home visiting model of intervention in which the practitioner offers a context for thoughtful exploration of the emotional experience of caregiving and the meaning of the infant's care.

A new parent's internal working model for relationship, developed out of her own experiences of early care, affects the ways in which she is now able to care for her own child (Fonagy, Steele & Steele, 1991). The parent's adjustment will be influenced by her own relationship history. The following information is important to understand. Who took care of her? How available, consistent and responsive was the caregiver? What was the nature of that relationship and how enduring is the tie? Following a psychoanalytic line of thinking, what happened to the new parent in her early years now influences the care she gives to her baby. We see in this newly developing relationship remains of the old parent-child relationship (Fraiberg, 1980). It is this internal model for relationship that

shapes the new parent's care of the baby and adjustment to her new mothering role.

Stern's attention to the motherhood constellation is directly related to treatment within an infant mental health intervention. Early mothering memories are particularly vivid and accessible to the new mother in the first months of her baby's life (Lieberman & Pawl, 1993). Like ghosts, they may hover in the nursery (Fraiberg, Adelson & Shapiro, 1975). They may be made more concrete through a clinical interview or therapy experience, enabling a new mother to do differently with her own child and make the transition more smoothly to motherhood. As new memories are awakened in the presence of the baby and the infant mental health practitioner, a new mother may reflect on her relationship with her mother in a way not previously available to her. In this way, she will begin to transform her understanding of the daughter she was and the mother who took care of her, to become the mother she wants to be. Stern believes that this "present remembering context" is a powerful catalyst for transformation and change in the early developing relationship between parent and child (Stern, 1995). His work helps to integrate what we understand about attachment in infancy and the importance of maternal sensitivity and responsivity (Ainsworth et al., 1978) with the adult's representations of attachment (Main, 1995), caregiving history (Fraiberg, 1980), and parenting role.

THE SOCIAL-CULTURAL-HISTORICAL CONTEXT

Vygotsky. Finally, it is of great importance to consider the development of an infant, a parent, and their new relationship within a larger social, cultural and historical context. The initial work of Len Vygotsky (1962) expands our view of individual development to include the understanding that individuals grow and change through the continuous and active exchange of knowledge, values and beliefs between an individual and a particular context or setting. "The child, the other person, and the social context are fused in some activity. The social-cultural-historical context defines and shapes any particular child and his experience. At the same time children affect their contexts," describes Miller (1993). It is the interrelationships of people and their environments that fascinated Vygotsky and influenced others.

In addition to his contributions about social and cultural context, Vygotsky also developed the concept of the *zone of proximal development* as significant to a very young child's acquisition of new knowledge or skills. It was the parent's understanding of the child's actual level of functioning as compared to what might be possible with parent guidance that Vygotsky called "the zone" (Miller, 1993). The parent may collaborate, prompt, model, explain, and so forth to encourage the young child's accomplishment of a new task or solution of a problem. The learning is shared as parent and child participate together with a single focus. Learning is also bidirectional, keeping in mind the important effect that the young child has on the adult who is beside or near him or her. The parent who recognizes the infant or toddler's level of functioning, observes closely, and encourages emerging competencies will help the child reach new levels of understanding in multiple developmental domains. From this perspective, the parent's role is crucial to a child's early development and change. This is very consistent with infant mental health practice that emphasizes the presence of the parent, the parent-child relationship and guided interactions.

Bronfenbrenner. Bronfenbrenner (1979) expanded Vygotsky's thinking about the social context, defining it as a system of ecological structures including relationships, parental values, a home setting, day care, a peer group (a microsystem). These are interconnected to form a larger structure (a mesosystem). The way in which they are linked influences the individual (an exosystem). Finally, beliefs, life styles, language, customs, and social patterns embedded in each of these smaller systems define a particular culture and influence the thoughts and behaviors of individuals living in that culture (the macrosystem).

Embedded in these systems, an infant or parent exist only in relation to the culture, affected by it, and contributing to it through continuous processing and interchange. From this perspective, an infant or parent cannot be understood separate from its social-cultural-historical context. This is basic to an infant mental health approach that encourages and supports an infant and parents within the cultural context of their early developing, social, and emotional relationships. Culture is broadly defined and includes those relationships, past and present, which shape each emerging relationship and contribute to shared understanding and effect change.

INFANT MENTAL HEALTH HOME VISITING SERVICES

In the last 50 years, clinicians and researchers have confirmed the understanding that a baby must have at least one nurturing relationship in order to thrive (Weatherston, 1999). Early observations of infants who were reared in institutions, abandoned by their mothers or left in the care of many different people alarmed clinicians and raised questions about the relationship of maternal deprivation to infant development and emotional health (Burlingham & Freud, 1944; Spitz, 1946). In the absence of nurturing relationships, many young children regressed or became significantly delayed in their development. Some children failed to survive (Bowlby, 1953).

Understanding the importance of caregiving practices that nurture and protect babies, clinicians wondered about the design of intervention services that would strengthen early attachment relationships and improve developmental outcomes in the first years of life. Many professionals knew of parents who could not provide adequate infant care; many young children appeared to be at grave emotional risk. "What about the baby?" Selma Fraiberg and her colleagues in Ann Arbor, Michigan dared to ask. "What about the parent who cannot provide consistent nurturing care?" "How can we offer a clinical intervention to protect both?" (Fraiberg, Adelson & Shapiro, 1975; Fraiberg & Adelson, 1977).

Selma Fraiberg, a respected social worker and psychotherapist, and her devoted staff dedicated their clinical services to infants and parents. They constructed a new model that integrated approaches from the separate fields of developmental psychology, education, social work, nursing, pediatrics, psychiatry and psychoanalysis. They called the method of treatment, infant mental health (Fraiberg, Adelson & Shapiro, 1975). By this, they meant the treatment of children under the age of two and their parents, within a therapeutic environment that would nurture early attachment relationships and interrupt cycles of hurtful or neglectful care. Upon entering the family's world, each clinician was close to "the source," with an endless number of opportunities to watch the infant and parent(s) in interaction, to understand and hold their developing relationships, and to offer a therapeutic context for trust and support (Fraiberg, 1980; Fraiberg, 1987). Because they worked in the intimacy of parents' homes, they called their intervention "kitchen table therapy."

Developing a model. Working with parent(s) and infant together, Selma Fraiberg and her staff hoped to reduce the dual risks of jeopardized attachment and developmental delay. They brought knowledge of development in the first years of life to the practice of adult psychotherapy. They combined clinical understanding from the fields of psychiatry and psychoanalysis (e.g., transference and countertransference [Wright, 1992], consistency of relationship, empathic response) with social work practices (e.g., service coordination, home visiting, resource identification [Weatherston, 1999]. The practice of infant mental health has flourished for over 25 years, with some modifications of the original model made to address problems specific to urban or rural communities and rapidly changing social environments (Lieberman & Pawl, 1993; McDonough, 1993; Weatherston, 1995).

Regarded as a unique approach to the treatment of very young children and families, the Fraiberg Model set a standard for early home visiting practice. It offers an intensive and comprehensive set of strategies to support development and relationships, reducing the ominous risks to the baby of delay, abuse or perpetual neglect (Weatherston & Tableman, 1989).

The working relationship. Crucial to the effectiveness of these strategies is the working relationship that develops between each infant mental health practitioner and parent (Fraiberg, 1980; Lieberman & Pawl, 1993). Respectful and consistent, the practitioner remains attentive to each parent's strengths and needs. Within the safety of this relationship, parents feel well cared for and secure, held by the therapist's words and in her mind (Pawl, 1995). The practitioner listens carefully, follows the parent's lead, remains attuned, sets limits and responds with empathy. Within the context of the working relationship, the parent experiences possibilities for growth and change through the relationship with her own infant.

THE PRACTICE OF INFANT MENTAL HEALTH

Nontraditional in their approach to infants, and with respect for the uniqueness of each family's needs, Selma Fraiberg and her colleagues offered treatment to encourage optimal infant development in multiple domains (social, emotional, cognitive and motor), strengthen caregiving responses, and promote the security of attachment in parent-infant relationships. The service was ambitious.

When an infant and parent were referred, one therapist responded to the call. Most often, the therapist visited the family in its own home, providing an initial assessment to determine the most immediate needs. Response varied according to the individual circumstances of each infant and family. Some families might be seen for brief crisis intervention and referral to other community agencies for more appropriate care. Others might be offered short-term developmental guidance and support for specific problems or concerns. Still others might enroll for long-term treatment that was intensive and focused on relationships, past and present, possibly continuing through the baby's second or third year (Fraiberg, 1980).

PRINCIPLES AND STRATEGIES

The following principles were fundamental to the strength of the original model: (a) careful observation, listening and empathic response; (b) nurturing of the parent to better nurture and respond to the child; and (c) interest in a parent's feelings, behaviors and past experiences as they dramatically influence a parent's ability to provide sensitive and appropriate infant care. The early practitioners believed that all families want what is best for their babies and offered a therapeutic relationship experience to promote healthy attachment relationships with possibility for growth and change. Briefly summarized, each of the five components provides opportunities for respectful and therapeutic response, the nurturing of caregivers to enhance their responsiveness to their infants, and support that leads to security of attachment development in the first years (Weatherston, 1995).

Emotional support. Emotional support refers to the compassion that an infant mental health therapist offers to a family following or in the midst of a crisis: for example, premature birth, hospitalization, chronic illness, the loss of a parent, abandonment by a partner.

Concrete resource assistance. Concrete resource assistance includes identification and meeting of basic needs for food, clothing, medical care, transportation, shelter and protection.

Developmental guidance. Developmental guidance is the offering of information to parents about each baby's development and specific child care needs. Opportunities to watch and respond to the baby with the therapist at their side, helps parents to begin to appre-

ciate the uniqueness of each baby, to feel more confident in their responses to the infant, to ask questions and to celebrate changes, week to week.

Infant-parent psychotherapy. In instances where emotions are intense and parental conflicts about the baby complex, infant -parent psychotherapy may be the treatment of choice. Watching and listening carefully and following the lead of each parent and infant, the infant mental health home visiting practitioner gently explores thoughts and feelings that are awakened in the presence of the baby. In an attempt to understand, the therapist may ask questions. "What is it like for you when the baby begins to cry?" "How do you understand what it is he needs?" "How did you learn to feed him in just that way?" "Who was there to hold you when you were just your baby's size?" Answers often lead to the telling of stories that explain the parent's present difficulties and pain. In the quiet of the parent's kitchen, the therapist explores the feelings and can offer many opportunities for an emotional response. Major clinical concerns may include parental histories of abandonment, separation and unresolved losses; broken relationships; maternal neglect, paternal abuse. These past experiences and relationships are often reawakened in the parent with brutal intensity following the birth of a new baby. The infant mental health therapist listens, comforts, and confronts the feelings when a parent is able to acknowledge these difficulties as they threaten caregiving and relationship development in the present. For many parents, this is the first time that they have shared their vulnerabilities and feelings with someone who is empathic and trustworthy. The therapeutic experience may relieve the hurt or shame or guilt that threatens to interfere with the parent's ability to care for the baby and establish a relationship that is secure and mutually rewarding.

Advocacy. The fifth strategy is advocacy, in which the infant mental health home visiting practitioner identifies a baby's needs for appropriate care as well as each parent's responsibility to provide that care. The practitioner speaks for the baby who has no words and the parent who is often silent and overwhelmed.

In summary, each strategy helps parents and clinicians to understand, nurture and sustain the infant's development within the context of a relationship in the early years. Some or all of the strategies may be needed to encourage the parent's interest in the baby, to understand the uniqueness of the developing relationship, and to interrupt an intergenerational cycle of inadequate care and failed or

jeopardized attachment relationships (Weatherston & Tableman, 1989; Weatherston, 1999).

ADAPTATIONS OF THE ORIGINAL FRAIBERG MODEL OF INFANT MENTAL HEALTH INTERVENTION

Selma Fraiberg and her colleagues demonstrated the significance of early intervention to the emotional health of infants within the context of relationships, as well as the emerging capacities of parents to provide appropriate, affectionate and empathic care (Fraiberg, 1980). Others grew interested in efforts to address infant development within the context of family care. As a result, relationship-based home visiting interventions were designed to promote the well-being of children under three and their caregiving families (Pawl, 1993; Lieberman & Pawl, 1993; Wright, 1986/1992; Weatherston & Tableman, 1989). Some focused on maternal sensitivity to infant needs (van den Boom, 1994) and others focused on caregiving skills to enhance parental empathy (Erickson, Korfmacher & Egeland, 1992; Erickson & Kurz-Reimer, 1999). Still others focused on the reduction of abuse or neglect in early childhood and the promotion of appropriate parental skills (Olds, Kitzman, Cole & Robinson, 1997).

A cross-cultural adaptation. One study is of particular significance to this review and to the field because it illustrates home-based service delivery within the context of Fraiberg's traditional infant mental health model. Lieberman, Weston and Pawl (1991) provided in-home infant mental health treatment services, focusing on early attachment relationships, to Spanish-speaking infant-mother pairs beginning in the child's second year. Infants identified as anxiously attached according to the Strange Situation criteria (Ainsworth et al., 1978) were randomly assigned to a treatment intervention (n = 34) or control group (n = 25). Infants identified as secure in their attachment relationships made up a second control group (n = 25).

The intervention took place in each mother's home. The infant mental health home visiting therapist, trained at the master's level in psychology or social work, met each family weekly, for one-hour visits with mother and infant together, over a period of one year. Each therapist met weekly with an experienced therapist for intensive supervision related to home visiting work. Strategies included focused observations of mother-infant interaction, attention to the

mother's subjective experience of her infant, developmental guidance specific to the infant and intensive support for the developing attachment relationship. In each instance, the therapeutic relationship between parent and therapist was believed to be central to the mother's developing ability to think and explore her feelings related to her baby and her adaptation to early parenthood. In addition, if services such as food and transportation were needed, the therapist helped to find them, thereby reducing the high level of stress that often interferes with the parent's ability to provide affectionate, appropriate care.

After 12 months of consistent, infant mental health treatment intervention, each mother and toddler participated in an extensive, videotaped assessment of play and a separation sequence. The videotape was rated for maternal empathy, toddler behavior, social-emotional functioning and goal-directed interaction. While the intervention did not result in the toddler's shift to secure base behavior in home or a change in maternal attitudes about the care and raising of children, important intervention effects were documented. Most importantly, the results indicated that the treatment intervention was successful in improving maternal empathy, decreasing avoidant or resistant behaviors in toddlerhood and positively effecting the parent-child attachment relationship. These findings were particularly relevant to the field of infant mental health where the development of the parent-child relationship is of central importance.

Of additional interest to this study is the importance of culture and its profound influence on shaping parenting values; in this instance, values embedded in individual Latino families. Furthermore, maternal involvement in the therapeutic treatment, as assessed by the Level of Therapeutic Process Scale (Greenspan and Weider, 1987), was identified as central to shifts in maternal empathy, positive interaction and measures of security. Cultural context, engagement, participation and retention relate to change and should be examined closely when assessing infant mental health home visiting treatment outcomes.

A unique service model. The STEEP Program (Steps Toward Effective, Enjoyable Parenting) offers an example of intensive, broad-based service developed through a research project at the University of Minnesota to provide home visiting support to 74 women during pregnancy and continuing through the first year of the infant's life (Erickson, Korfmacher & Egeland, 1992). The in-

tent of the program was to strengthen caregiving practices, enhance a mother's understanding of herself and of her infant and encourage healthy attachment relationships in early childhood. The service included individual home visits and participation in a parent-infant group. Relationships past and present, with family members, and between therapist and parent, provided an important focus throughout the intervention. Insight into early personal experiences as well as guidance about development in the present, shaped the therapeutic work within this home visiting intervention. The families served were at high risk, e.g., adolescent, undereducated, isolated, impoverished and living in situations that were chaotic or stressful. Results suggest that parents enrolled in the home visiting treatment group had increased their understanding of their babies' cries and cues at 24 months when compared to the control group and had a more positive sense of themselves, with fewer symptoms of depression. They offered more interesting playthings to their children and their homes were more organized around the care of a child (Erickson, Korfmacher & Egeland, 1992; Erickson & Kurz-Riemer, 1999). These results have important implications for the nature of each developing attachment relationship between parent and infant and the intergenerational transmission of relationship risk or disturbance.

Interaction guidance. Interaction guidance is another approach important to consider from an infant mental health perspective. McDonough (1993) focused on the interplay between parent and young child in this relationship-based technique within the context of an infant mental health approach to service. With full appreciation for the importance of the early developing relationship, McDonough proposes encouraging a parent to talk about play-based interactions with the infant or toddler, supporting the parent's present capacities to interact and relate. She frequently uses videotape as a vehicle for shared observations about the transactions between parent and infant that may lead to change. Her method of intervention is focused, of shorter duration (10 sessions), and may or may not be carried out in the home.

Play-based psychotherapy. Another intriguing approach is an infant-led psychotherapy called "Watch, Wait and Wonder" (Muir, 1992). This is a carefully structured, play-based intervention in which the parent, usually the mother, is invited by the interventionist to follow the infant's lead for approximately 20 minutes. Following this, the interventionist invites the parent to talk about the

experience and what she felt happened, as well as thoughts or feelings that were evoked. This provides a focus on the infant and the developing parent-child relationship and provides opportunities for the interventionist and parent to explore strengths as well as risks that threaten the infant's development and the parent's ability to provide responsive care. It illustrates a variance to Fraiberg's original model, but preserves an important focus on the developing parent-infant relationship: infant development within the context of relationship and maternal empathy.

Cohen, Muir and Lojkasek (1999) summarized their comparison of infant-led and psychodynamic parent-infant psychotherapies in which 67 mother-baby pairs participated. Results suggest that greater gains related to infant security, maternal depression, infant coping behavior, and parent satisfaction were made in the "Watch, Wait and Wonder" group. Six months after treatment, the gains were equivalent for participants in both treatment groups. This may be explained by "sleeper effects" in which measurable results of treatment, particularly relationship and child development outcomes, may not show up for a period of years.

Case study materials. Qualitative summaries of infant mental health home visiting services include a rich store of case study materials that describe interventions with parent(s) and infant or toddler together, in a center or in-home, for short-term or long-term work together (Fraiberg, Adelson & Shapiro, 1975; Fraiberg & Adelson, 1977; Fraiberg, 1980; Blos & Davies, 1993; Pawl, 1995; Weatherston, 1995, 1997, 1999). These studies illustrate circumstances that are appropriate for enrollment in infant mental health home visiting programs and the ways in which clinicians carry out their work. A qualitative approach to summarizing what is possible through infant mental health home visiting service alerts us to the powerful aspects of infant-parent work. A review of these separate case studies is beyond the scope of this review. However, they reveal basic strategies that are fundamental to infant mental health home visiting work:

1. using the therapeutic relationship as an instrument of change,
2. having the infant present throughout the period of intervention,
3. observing and interpreting infant development,
4. anticipating developmental changes and guiding the parent,

5. alerting the parent to the baby's individual accomplishments and needs,
6. helping a parent to find pleasure in the relationship with her infant,
7. creating opportunities for interaction and exchange,
8. allowing the parent to take the lead,
9. identifying the capacities that a parent brings to the care of the infant,
10. wondering about parent's thoughts and feelings related to the presence and care of the baby, and changing responsibilities of parenthood,
11. listening for the past as it is expressed in the present,
12. allowing core relational conflicts to be expressed by identifying, containing and talking about them,
13. attending to parental histories of abandonment, separation and loss as these experiences affect the developing relationship with the infant.

In sum, these practices focus on the parent's capacities to respond sensitively and appropriately to the infant or toddler, reducing the risk of relationship disorder or failure and enhancing development in the early years (Weatherston, 2000).

POSSIBILITIES FOR CHANGE

How does the practitioner affect change in an infant mental health home visiting intervention? Is it through knowledge shared with a parent about the course of development? Is it through practical advice given about feeding or sleeping or response to cues? Is it through concrete assistance with housing or medical care or transportation? Is it through the practitioner's understanding of the importance of parent-infant interaction and relationship coupled with the ability to support that? Is it the practitioner's presence and supportive relationship with the parent that are the instruments of change?

Change. How change occurs may depend on what we are measuring. Infant mental health home visiting intervention is multi-focused. The infant mental health 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 infant mental

health therapist may focus on the parent's behavior in an effort to increase sensitivity to the infant or toddler's needs. The infant mental health therapist 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. Finally, the infant mental health therapist may focus on the interaction between parent and infant and their relationship classification, secure or insecure. The Fraiberg model of infant mental health home visiting service encourages the infant mental health practitioner to consider all of these things, as appropriate to an individual infant and parent pair, and integrate them in approaches that are interactional, behavioral and psychodynamic (Hofacker & Papousek, 1998).

The use of relationship. Lyons-Ruth (1998) raises the question, "What brings about change in psychotherapy?" Parent and infant interact with one another in increasingly complex ways. For some, the exchange is well regulated, leading to responsive interaction and a relationship described as secure. Each partner knows how to relate to the other. It is the interventionist's task to strengthen and maintain this. For others, the exchange is difficult, the signals and responses unclear, and the relationship described as insecure. The infant may struggle to make wants or needs known, development may be delayed, and pleasure for both parent and infant is minimal. The parent is inattentive, unresponsive, or unsure. The implication for therapeutic intervention is complex: to change the parent's attention and responsiveness to her infant; to recognize and change the parent's perceptions of the infant's strengths, signals and cues; and to change the way parent and infant interact and relate to one another.

The infant-parent relationship. As the infant mental health home visiting practitioner works with a parent and infant together, there are opportunities to acknowledge the reality of the developing relationship (Weatherston & Tableman, 1989). What is the parent's real experience of the infant? What is the meaning of the infant to the parent? Who is this infant? What is the infant able to do? What is difficult for the parent? The practitioner invites discussion about the infant or the parent that is present-focused, often leading to the parent's understanding of the infant and their developing relationship.

As the practitioner helps a parent reach a deeper understanding of the infant through intervention, there may be many opportunities to observe the interaction, invite comment about its meaning to

the parent, and encourage new ways of relating, as appropriate (Lieberman & Zeanah, 1999). These moments of shared experience provide the therapist and parent with occasions to effect changes in the way that the parent relates to the infant.

The parent-therapist relationship. A parent in treatment often learns about relationships through interactions with the therapist who is consistently available, sensitive to the needs of the parent and emotionally responsive (Lieberman & Pawl, 1993). Within the context of the relationship with the therapist, a parent has the opportunity to experience trust. Secure in that relationship, a parent feels respected, safe, and close. For some, it may be a "corrective emotional experience" (Alexander & French, 1946; Lieberman & Pawl, 1993). For others, it offers "moments of meeting" with the therapist, discovering what is intensely important about interaction and response when there is a basis for mutual trust (Morgan, 1998). Past or present focused, it is within this context that a parent discovers the power of relationship and transfers that understanding of authenticity to new interactions and ways of relating to the infant (Fraiberg, 1980; Lieberman & Zeanah, 1999). From this perspective, the importance of the therapeutic relationship as it relates to changes in the parent-infant relationship is apparent (Pawl & Lieberman, 1997).

Effecting change through mother-baby interventions. Bertrand Cramer (1998) examines two approaches used, psychodynamic psychotherapy (Fraiberg, 1980; Lieberman & Pawl, 1993) and interactional guidance (McDonough, 1993), in discussing the change process in mother-baby interventions. He summarizes the process in both approaches very carefully, identifying two sets of skills most commonly used in both models, non-specific skills and specific techniques of intervention. Non-specific skills refer to relationship building skills where the therapist invites a dialogue with the parent, maintains the interaction through conversation, shapes an emotional understanding and establishes a climate through gestures, tone of voice, facial cues, and response. Specific skills refer to the language a therapist uses in defining the focus of the intervention, reinforcing and clarifying statements, interpreting, and confronting the parent, as appropriate. Both sets of skills are important to activity within mother-baby psychotherapy (Cramer, 1998) and have meaning within the current practice of infant mental health home visiting service.

In examining the dialogue between therapist and parent in mother-baby psychotherapies, Cramer suggests that approximately 80% of the therapeutic conversation is non-specific and invites continued interaction between parent and therapist in hopes of establishing or maintaining a relationship between them. The other 20% of the conversation is more specific and involves clarifying, explaining, confronting, or interpreting something of therapeutic importance to the parent.

Can it be, then, that how the therapist behaves in interaction with the mother and baby is as important for change as what is said about the conflict or interpretation of an interaction or event? Cramer argues convincingly that where mother-baby psychotherapies are concerned, change occurs within the context of both relational (non-specific) and verbal (specific) treatment strategies.

SUMMARY

It is clear from this literature review that significant and diverse theories fuel infant mental health practice. Each contributes to the understanding of development in early childhood, the adjustment in early parenthood and the powerful role that the parent-child relationship plays in defining a context for social and emotional growth. Each contributes to the understanding of risk and treatment in infancy and early parenthood, reducing the grave possibility of developmental disorder, relationship failure or emotional disturbance. Individual scholars and clinicians have contributed to the construction of this psychodynamic and relationship-based approach to early childhood mental health, through qualitative and empirical studies and clinical case reports. In the process, many have influenced the construction of infant mental health practice that supports and sustains parents in meeting their infants' or toddlers' emotional and relationship needs.

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