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*A Developmental  
Psychiatrist Looks at*  
**INFANT  
MENTAL HEALTH  
CHALLENGES FOR  
EARLY HEAD START:**  
*Understanding Context and  
Overcoming Avoidance*

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PHOTO: MARILYN NOLT

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I would like to share how a developmental psychiatrist's way of thinking might contribute to the work of Early Head Start and other community programs for infants, toddlers and their families.

What is the job description of a developmental psychiatrist? Such a person attends to the problems and prevention of mental disorder *throughout* the lifespan—early in life and later, in children, parents, and grandparents. Moreover, a developmental psychiatrist thinks about health as well as illness: 1) pathways that lead to competence, as well as pathways that lead to disorder; and 2) factors that promote healthy development as well as factors that are involved in risk and protection with regards to the onset, course, and treatment of mental disorder. A developmental psychiatrist involved in infant mental health also has a dual responsibility, to attend both to the “now” and to the “future.” It is important to both alleviate current problems and suffering of very young children, and address adverse circumstances that might interfere with the achievement of expectable developmental competencies or lead to identifiable mental disorders. Finally, an important feature of clinical

work in infant mental health necessarily consists of understanding and treating the child-in-context. Considerations of context include appreciating the child with parents and the child within other relevant caregiving relationships, as well as thinking about developmental “systems” and looking at changes over time. It should also be mentioned that such work is necessarily multigenerational and multidisciplinary.

I have worked for nearly four decades as a developmental psychiatrist and consider myself fortunate to have been closely involved with the conceptualization and continuing study of new programs in Early Head Start. My experience suggests two themes I would like to emphasize in this essay. The first is understanding the child in context, as introduced above. The second concerns a different topic—namely our difficulties in overcoming a tendency to avoid addressing mental health problems.

#### **Understanding the Child in Context**

The theme of context has two aspects for emphasis: that of development and that of embeddedness in relationships.

We might state this in the form of a principle: It is important to understand the very young child in the context of early development as well as in the context of that child's relationships with family, caregiving staff, and the larger community.

### The context of early development

What, precisely, do we mean by "development"? A few years ago, a group of senior researchers of human development offered this definition:

*Development consists of change within individuals over time. It involves increasingly organized complexity. As such, it also involves processes of differentiation (divisions into subsystems), integration (articulation of wholeness), and hierarchicalization (successive ordering of parts and wholes). Moreover, development necessarily involves dynamic exchanges within the environment. As a consequence of this definition, human behavioral development must therefore be considered not only in its biological context – wherein adaptive aspects of interactions involving genetic expression, maturation, physiological patterning, and cognitive construction are salient – but also in its socio-cultural context – wherein adaptive aspects of interactions with an arrangement of social roles, networks, and environments are salient. Human development must also be considered not only from the perspective of continuity, but from the perspective of transformational change; not only from the perspective of successful adaptation and health, but from the perspective of unsuccessful adaptation and disorder<sup>1</sup>.*

This definition offers us two important perspectives on the developmental context for infant mental health. First, we must think about infant mental health in terms of the *development of competencies*. It involves, for example, increasingly organized complexity in the acquisition of abilities to learn and to accumulate knowledge, to regulate one's emotions, and to build social skills within relationships. It also involves the child's ability to gain satisfaction during exploration, social exchanges, and play. Second, we must think about infant mental health in terms of *successful adaptation in the midst of challenges and opportunities*. Successful behavioral adaptation involves the ability to respond meaningfully to changing circumstances across time – simply put, the ability to be flexible.

At this point, our consideration of early development turns to pathology. From the perspective of developmental psychiatry, pathology has two core features that distinguish it from mental health. The first is *rigidity*, or the inability to change. We recognize the presence of pathology when an individual has trouble responding appropriately in the midst of new circumstances. The second core feature of pathology is *pain or suffering*. Both rigidity and pain interfere with development as we have defined it. These two features of pathology are especially compelling when we remember the typically rapid pace of development during the earliest years.

<sup>1</sup>The group, as part of the MacArthur Research Network on Early Childhood Transitions, consisted of Mark Applebaum, Elizabeth Bates, Kathryn Barnard, Robert Emde, Marshall Haith, Robert Hinde, Joan Stevenson-Hinde, Jerome Kagan, Marion Radke-Yarrow, and Arnold Sameroff.

We can summarize a developmental way of thinking about infant mental health by asking two questions: 1) What do we want to strengthen? and 2) What do we want to prevent?

We want to strengthen individual pathways for development, including:

- Motivation for learning and positive experiences with exploration;
- Motivation for reciprocity in relationships, communicating, and positive experiences with caring and support;
- Confidence in the use of emotions for self and other that includes expectations of meaningful emotional experiences with significant others, dealing with conflict, and the capacity for play and imagination;
- Character-sense that includes planning skills, confidence in mastering challenges, effectiveness in social exchanges, and a sense of "conscience" or responsibility; and
- Behavior that protects safety and health.

We want to prevent developmental compromises and problems of adaptation in:

- Learning (e.g., learning inhibitions and failures);
- The formation and maintenance of relationships (e.g., relationship disturbances and disorders as described in Axis II of DC:0-3 [ZERO TO THREE, 1994]);
- Emotional regulation (e.g., disorders of affect as described in Axis I of DC:0-3; internalizing problems of behavior);
- Behavioral regulation (e.g., externalizing problems in behavior, including planning difficulties, dysregulation of aggression, problems of reciprocity and empathy); and
- Risk-taking and attention to physical health (e.g., accidents and injuries, lack of immunization, poor utilization of health services, poor nutrition, substance abuse).

### The context of the child's relationships

What can we say about the young child's relationship context? In 1994, the Advisory Committee on Families with Infants and Toddlers articulated the guiding principles for Early Head Start. The Committee's report emphasized that the young child cannot survive – let alone thrive – without the nurturance, protection, and regulation provided by the caregiving environment (Advisory Committee, 1994; also see conceptual review in Sameroff & Fiese, 2000). On the positive side, the Advisory Committee described how caregiving relationships contribute to infants' and toddlers' emotional and psychological health. Their language seems worth quoting:

*Within the context of caregiving relationships, the infant builds a sense of what is expected, what feels right in the world, as well as skills and incentives for social turn-taking, reciprocity, and cooperation . . . During the toddler period, the child, through repeated interactions with emo-*

tionally available caregivers, also begins to learn basic skills and self-control, emotional regulation, and negotiation. Empathy for others and prosocial tendencies for caring and helping also develop during toddlerhood, as well as the emotions of pride and shame; experiencing and learning about these capacities require responsive caregiving in the midst of life's inevitable stresses and challenges. . . . A sense of pleasure, interest and exploration, early imaginative capacities, and the sharing of positive emotions also begin in infancy – all of which require repeated and consistent caregiver relationship experiences and form a basis for social competence that carries through toddlerhood and the preschool period . . . (Advisory Committee, 1994, p. 7).

More recently, a panel of experts convened by the National Research Council and Institute of Medicine and charged with the task of integrating the science of early childhood development, described the risks to healthy development that can arise from the context of the child's relationships:

. . . (Y)oung children who do not have a relationship with at least one emotionally invested, predictably available caregiver – even in the presence of adequate physical care and cognitive stimulation – display an array of developmental deficits that may endure over time. Some children develop intense emotional ties to parents and other caregivers who are unresponsive, rejecting, highly erratic, or frankly abusive. These relationships can also be a source of serious childhood impairments, ranging from problems with focused attention and problem-solving to difficulty in forming healthy relationships, failure to thrive, and a variety of serious psychiatric disorders. The remarkable recovery that many such children demonstrate, once they receive responsive and consistent caregiving, provides some of the strongest evidence of the power of these earliest relationships (Shonkoff and Phillips, 2000; also see the April/May 2001 issue of *Zero to Three*.)

All infant mental health interventions seek to support and improve early caregiving relationships. We have learned from both practice and research that those interventions that are helpful involve the influence of relationships on other relationships – in other words, practitioners who work with infants, toddlers and their families make an

### at a glance

- It is important to understand the very young child in the context of early development.
- It is important to understand the very young child in the context of that child's relationship with family, other caregivers, and the larger community.
- It is difficult – but essential — to recognize suffering and pain in young children.
- Consultation, coaching, and reflective supervision can help staff recognize and address mental health problems in infants and young children.

impact by strengthening caregiving relationships that, in turn, can be internalized by the child (Emde, Korfmacher & Kubicek, 2000; Stern, 1985; Sameroff & Emde, 1989). The network of relationships in the community – including those involving parents, staff, and community partners in Early Head Start and child care programs – also acts to support the young child's social and emotional development.

### Recognizing and Addressing Mental Health Problems in Very Young Children

The second theme of this essay is of a different order and is a more troublesome one. It is often painful and difficult to recognize and address mental health problems in infants and young children. This was given recognition by an Early Head Start program director who recently said to me, "As difficult as it is, it's time to address the uncomfortable." My colleague was confronting how hard it is for us to admit that infants and young children suffer, and that they can experience pain and disorganization, as well as a narrowing of their adaptive capacities and impediments to their development. I would like to direct attention to four kinds of mental suffering in young children:

- Pain and distress from trauma, abuse, or loss of a caregiver;
- Misery from neglect;
- Suffering from cumulative stress; and
- Suffering from lack of opportunity.

We have problems in recognizing all of these kinds of suffering. But young children do suffer, often horribly. All too often we would rather not be confronted with our own pain and sense of helplessness in the face a baby who is miserable or in miserable circumstances. In talking about this tendency to pediatricians over the years, I used to use a phrase about our struggles in "coming to grips with the painfully obvious." More recently, I have become more aware of the latter two kinds of suffering. Sadly, we seldom try to measure suffering from cumulative stress or lack of opportunity.

Why has it been so difficult to recognize suffering and pain in young children? As a clinician and researcher, I can say that it is not that adults do not resonate with the pain. Rather, we struggle to avoid it. We do not want to believe that infants and young children suffer because their helplessness all too often confronts us with our own helplessness. As a result, we are often literally unable to recognize evidence of sadness and emotional "shutdown" in the infants and toddlers we see in our daily work.

When we are able to overcome our denial of children's suffering, we can bring about important change. It is only within the last 40 years that we have recognized child maltreatment — including child physical abuse and trauma, child neglect, and child sexual abuse — as one of the most pervasive public health problems in our nation. Rene Spitz described developmental delays, depletion, and depression in

infants who were deprived of personal caregiving in orphanages or who were separated abruptly from their mothers after six months of age (Spitz, 1946). His descriptions initially met with disbelief and disregard, and probably would not have been believed even by sympathetic colleagues had he not filmed the depressed infants he saw. The diagnostic category of depression in children younger than 10 years did not become accepted by the American Psychiatric Association until 1994. This was the same year in which ZERO TO THREE published its *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)* (ZERO TO THREE, 1994), a descriptive classification system based on current knowledge and practice which appreciates that very young children's mental health disorders are embedded in caregiving relationships. The DC: 0-3 approach to assessment includes an evaluation of a number of dimensions of developmental functioning, as well as the evaluation of very young children's suffering and the factors that may interfere with their adaptive capacities. Recognizing the realities of child maltreatment has led to the establishment of legally binding systems for its recognition, reporting and interventions. If we can overcome our denial of infant suffering and problems of adaptation and development – as advances in infant mental health theory, research, and practice can help us to do – we may be able to design and establish community-based systems of care to achieve the twin goals of strengthening pathways to healthy development and preventing developmental compromises and serious mental health disorders.

With this background, we should not be surprised that staff in Early Head Start, child care, early intervention, and other community programs that serve young children and families may have difficulties in recognizing infant suffering and in talking about mental problems and pathology. In addition to the struggles in recognizing infant suffering that we have already discussed, staff often fear that "labeling" a child or family will result in stigmatization, devaluation, or blame. A lack of knowledge about mental health problems and diagnosis also contributes to avoidance, and the training of infant/family practitioners seldom includes the recognition and management of mental disorders. Fortunately, difficulties of recognizing and helping with mental health problems in children and their parents in Early Head Start and other community environments are by no means insurmountable. A culture of consultation, coaching and reflective supervision in infant/family programs, where it exists, can offer opportunities to staff for sharing, support and learning about mental health problems. Trained infant mental health specialists, working on site in early childhood environments, can provide infant mental health supervision and also can consult daily with staff, families, and children. Sufficient skilled support can help Early Head Start and other infant/family settings to facilitate a network of consistent nurturing relationships that, in addition to directly influencing the child, also influence other relationships – especially

the relationship between child and parent (See Bertacchi, Emde, & Mann, this issue his issue, for a more detailed discussion of elements of an environment that facilitates infant mental health.)

## Conclusions

Many thoughtful community programs are providing innovative and effective ways to help infants and toddlers develop strengths in the midst of consistent caring relationships. Such programs, I believe, are shifting the odds toward more healthy and adaptive outcomes for children. The time now seems appropriate for addressing the mental health needs of very young children. We know that recognizing problems, let alone helping with them, can only be done by attending to the child in context, and by addressing the mental problems not only of children but also of parents and other adults in the caregiving environment. Support – in the form of training, consultation, coaching, and reflection – is the key to overcoming reluctance to discuss conflicts, difficulties, emotional problems and entanglements. It is time to use the knowledge and skills we have been developing in recent decades in order to address the uncomfortable. It is time to learn to recognize suffering in babies and toddlers, to heal, and to prevent later adaptive compromise and disorder. In order to do this, it is also time to give more attention to ongoing support and time for staff to engage in reflective supervision. ♣

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