

An Infant Mental Health Perspective

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SIGMUND FREUD SAID that mental health consists of loving well and working well. We can quibble with what this really means, because there are so many ups and downs in the quality of our loving and of our working, but who can ask for more than loving well and working well as emblems of a life well lived? If this is so, we can define the mental health professions at their best as disciplines that aim at helping people love well and work well by alleviating rigid patterns of thought, feeling, and behavior that result in damage and pain to the person and/or to those who come in contact with him or her.

The joy and vibrancy of babies, as they relate to others and master new skills, seem an embodiment of the mental health landmarks of loving well and working well. Still, it is essential to understand the origins and the course of mental health disorders in the first years of life, both for appropriate intervention in the moment and for successful preventive efforts.

When we look at the field of infant mental health specifically, it seems to me that there are five main principles that define this point of view and transcend specific theoretical frameworks. The first three principles have to do with looking at external behavior as an expression of inner, subjective experience. The second two principles have to do with how we frame and carry out intervention.

External behavior as an expression of inner subjective experience

1. Babies are by nature social creatures. They exist and develop in the context of relationships, and their functioning needs to be assessed and understood within the framework of these relationships. These relationships are always dyadic at one level, in the sense that they involve the baby and a specific other person, but this does not mean that babies have meaningful relationships with only one primary caregiver. On the contrary, deep emotional bonds develop between the baby and a variety of people who have a regular role in his or her life. These emotional bonds influence each other and come to form a matrix of interpersonal connections that in normative conditions build the earliest foundations for mental health by helping the baby feel loved, val-



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Some observers suggest that "infant mental health" and "early intervention" should be seen as aspects of a single field of inquiry and integrated practice. Others, focusing more, perhaps, on the inevitable limits of any single practitioner's knowledge, skill, and professional passion, emphasize complementarity. They envision infant mental health practitioners and early interventionists working directly with families in a variety of ways to support the optimal development of young children, and learning from each other in an ongoing process of professional development.

The contributors to this issue offer both theoretical perspectives and field-tested practical approaches to the integration of "infant mental health" and "early intervention" perspectives in work with infants and toddlers with disabilities and their families. In order to offer points of departure to readers, we open the issue with two statements of the principles that underlie infant mental health and early intervention perspectives and practice. We encourage readers to compare, contrast, read on, and write in. Letters to the editor are welcome and will be published.

ued, and competent, as opposed to feeling unwanted, burdensome, and ineffective.

When one of the baby's primary relationships does not support the baby's developmental needs, the baby's confidence in himself and others is undermined, but he can continue to maintain a basically sound developmental course if other appropriate and satisfying intimate relationships are available. The adults support each other in supporting the child, and compensate for each other when one of the caregivers falters. This is why committed family networks and other social supports are important in childrearing. Adults, like babies, are social creatures by nature, and they need each other in every important facet of their lives, most particularly in demanding emotional endeavors such as raising a child.

Straightforward as it may sound, this principle that babies are social creatures functioning within the matrix of relationships is also deceptively simple. While it is true that several people may have a central role in caregiving, it is inaccurate to assume that these relationships are interchangeable from a baby's point of view. A baby can love several people, but each of these loves has a specific quality and a unique place in the baby's internal landscape. Being a social creature does not mean being an indiscriminate creature, and it is the passionate, "only you," sustaining power of intimate relationships that is at the core of the baby's capacity to love well and to grow well.

2. Individual differences are an integral component of babies' functioning. The specific terms that we use to describe babies' individual differences may differ, depending on our professional discipline and theoretical preferences, but we share a recognition that each baby and each parent is unique in many different ways. This means that while we can understand important aspects of the baby's functioning by relying on developmental principles, we also need an appreciation of each baby's individuality along a variety of dimensions. Each parent is also unique. To understand the baby and her relationships in depth, we need to become acquainted with each partner's temperamental style, skills, areas of vulnerability, motivations, fears, and wishes and how each partner's characteristics interact with one another. Only then can we appreciate fully the areas of goodness of fit and the inevitable areas of mismatch and tension in every baby-parent dyad and in every family constellation.

3. Every individual exists in a particular environmental context that deeply affects the person's functioning. When we think of a baby in the context of her relationships, we often make the unconscious assumption that parents can control their circumstances and what they offer to their children. But parents are not independent agents. How they raise their children is influenced not only by how they were raised themselves and

who they become, but also by the everyday circumstances of their lives, the resources to which they have access, and the quality of life they can provide, materially and psychologically. As the Spanish sociologist Jose Ortega y Gasset put it, "Yo soy yo y mi circunstancia" (I am myself and my circumstances). Humans exist only in the context of their life situations; there is no "me" independent of the circumstances of my life.

We usually think of support systems in human terms—a spouse, a parent, a friend. But support systems consist also of community networks of supplies and services that keep us safe, able to take daily survival pretty much for granted, and therefore free to devote a considerable portion of our energy to relationships and to work. For a child raised in the middle-class circumstances that are still the norm in this country, life tends to unfold in a concentric series of circles that support each other—her resourceful parents, her decent house, her good school, her safe neighborhood, her access to adequate and affordable medical care. American society is not classless, however. Social class is one of the most important predictors of developmental outcome, as it molds the child's identity by shaping the specific circumstances of his life.

We must also consider culture as a shaper of children, defining culture as the sum total of a group's ways of living and being, including language, ethnicity, religion, moral values, rules for relating in social situations, expectations of oneself and others and, most basically, the question of what meaning people find in different aspects of life. Cultural differences are to groups what individual differences are to individuals. Understanding a child, therefore, needs to involve an understanding of the psychological and sociological configurations created by the parents' culture and specific circumstances.

The framing and implementation of infant mental health intervention

4. Infant mental health practitioners make an effort to understand how behaviors feel from the inside, not just how they look from the outside. This means asking ourselves: What is this father's motivation, what is he thinking and how is he feeling when he yells at his child? What is this mother's experience when she does not respond to her baby's crying? How does this toddler feel while having a tantrum? In other words, what inner states made these behaviors come about/ How do these behaviors reflect the person's frame of mind and ways of perceiving the world and her place in it?

The same effort to understand how behaviors feel from the inside applies when we look at external circumstances and their impact on children and families. This means asking ourselves: How does this 10-month-old feel when she is switched from one caregiver to another without any transition time? How does this

mother feel when her toddler runs away from her and refuses to come back when called? How does this father feel when he comes home unexpectedly and finds me there talking to his wife? This attunement to the subjective meaning of behaviors and external circumstances makes the mental health practitioner search for answers to these and many other questions. Our intervention is shaped by the tentative answers we find.

5. The intervenor's own feelings and behaviors have a major impact on the intervention. We need to keep a sharp eye on how we are feeling towards each of the family members with whom we are working, how we are responding, and how we are coming across to them. We then use our own emotional responses to what is happening as a way of deciding whether to intervene and how to intervene in a particular situation. A corollary of this principle is that, as Robert Emde has observed, every relationship affects every other relationship. This means that what happens between the parent and the intervenor affects what happens between the parent and the child. A parent who feels supported

and understood by a gesture from us is more likely to do something kindly for her child; conversely, a parent who feels judged by us is likely to behave in a harsh and critical way towards her child. Similarly, our relationship with the child affects our relationship with the parent. If the child has so much fun with us that he begins to prefer us to the parent, a competitive struggle is likely to follow over who owns the child. Conversely, if we help the child look at the parents with more accepting eyes, this will strengthen the parents' confidence in our good will towards them. This parallel process is an excellent built-in mechanism for testing out the efficacy of our interventions.

An awareness of inner feelings—children's, parents', and our own—allows mental health practitioners not to focus only on outer behavior. This flexibility in moving back and forth from a focus on inner experience to a focus on behavior is, I think, the hallmark of a mental health perspective, and its most useful contribution to other disciplines.

Principles Underlying the Individualized Family Service Plan (IFSP) Process

from *Guidelines and Recommended Practices for the Individualized Family Service Plan*, 1989

Note: Public Law 99-457, the Education of the Handicapped Act Amendments of 1986, Part H (which has evolved into Part C of the Individuals with Disabilities Education Act, amended most recently in 1997) directed states "to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for handicapped infants and toddlers and their families." Many observers saw the law's requirement that an Individualized Family Service Plan (IFSP) be developed for all children and families receiving early intervention services as validation of the family-centered philosophy that had been steadily gaining acceptance in the field of early intervention. In 1989, a report prepared by a parent-professional task force, the National Early Childhood Technical Assistance System (NEC*TAS), with support from the Office of Special Education Programs, Office of Special Education and Rehabilitative Services, US Department of Education, and the Association for the Care of Children's Health, with support from the Bureau of Maternal and Child Health and Resources Development, US Department of Health and Human Services, suggested principles that can be used as a conceptual framework for family-centered IFSP policies and procedures, and, by implication, for all early inter-

vention services. There have been amendments to the IDEA, but these principles have prevailed and remain compatible with amendments to the Social Security Act that were based on Surgeon General Everett Koop's call for family-centered, community-based, culturally competent, and coordinated care for children and families.

- **Infants and toddlers are uniquely dependent on their families for their survival and nurturance.** This dependence necessitates a family-centered approach to early intervention.
- **States and programs should define "family" in a way that reflects the diversity of family patterns and structures.**
- **Each family has its own structure, roles, values, beliefs, and coping styles.** Respect for and acceptance of this diversity is a cornerstone of family-centered early intervention.
- **Early intervention systems and strategies must reflect a respect for the racial, ethnic, and cultural diversity of families.**
- **Respect for family, autonomy, independence, and decision making means that families must be able to choose the level and nature of early intervention's involvement in their life.**

- Family/professional collaboration and partnerships are the keys to family-centered early intervention and to successful implementation of the IFSP process.
- An enabling approach to working with families requires that professionals re-examine their traditional roles and practices and develop new practices when necessary—practices that promote mutual respect and partnerships.
- Early intervention services should be flexible, accessible, and responsive to family needs.
- Early intervention services should be provided

according to the normalization principle—that is, families should have access to services provided in as normal a fashion and environment as is possible and that promote the integration of the child and family within the community.

- No one agency or discipline can meet the diverse and complex needs of infants and toddlers with special needs and their families. Therefore a team approach, including the family and professionals, is necessary for planning and implementing the Individualized Family Service Plan.

She Needed To Talk and I Needed To Listen: *An Infant Mental Health Intervention*

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UNDERSTANDING THE IMPORTANCE of caregiving practices that nurture and protect babies, Selma Fraiberg and her colleagues designed a treatment model in the late 1960's referred to as the practice of "infant mental health." (Fraiberg, Shapiro & Adelson, 1976; Fraiberg & Adelson, 1977). Regarded as a unique approach to the treatment of very young children and families, this model embraces early developing relationships, holding parent(s) and infant together most frequently in the intimacy of their own homes and offering a context for shared observations, careful listening and empathic response. Infant mental health services offer an array of strategies for relationship-focused intervention: emotional support, concrete service support, developmental guidance, advocacy, and infant-parent psychotherapy (Lieberman & Pawl, 1988; McDonough, 1993; Weatherston & Tableman, 1989; Weatherston, 1995; and Wright, 1986). Each strategy helps parents and practitioners to understand development and nurture relationships in the early years.

Included here is a very brief description of infant mental health strategies integral to the nurturing of development and relationships in the first years of life.

- **Emotional support** may be defined as compassion offered to a parent who faces a crisis in caring for a baby. Alone or without emotional reinforcement, a parent needs someone who is able to be present, listens carefully, and holds the many feelings that threaten to make the care of a baby difficult.

- **Concrete resource assistance** refers to the meeting of basic needs for food, clothing, medical care, shelter, and protection. The infant mental health practitioner who feeds or clothes or takes a family to the clinic assures them that she/he cares about them and will work to ease their burdens of care.

- **Developmental guidance** is the offer of information to a parent about the baby's development and specific needs for care. The practitioner carefully identifies emerging strengths, holding parent and infant together with consistent presence, attention and words.

- **Advocacy** extends the infant mental health therapist's role by identifying the baby's needs for attention and caregiving, as well as the parent's capacity to provide that care. The therapist may need to speak on behalf of a baby who has no words or a parent who is silent, further protecting their right to be safe and secure.

- **Infant-parent psychotherapy** offers a parent the opportunity to explore thoughts and feelings that are awakened in the presence of the baby. 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 their early developing parent-child relationship. In sum, the infant mental health practitioner holds and supports families as parents assume care for their babies, in face of difficulties, past and present.

Crucial to the effectiveness of these strategies within the infant mental health model is the **working relation-**