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The Awakening and Growth of the Human Infant: A Telecourse Study Guide for Infant Mental Health Practitioners

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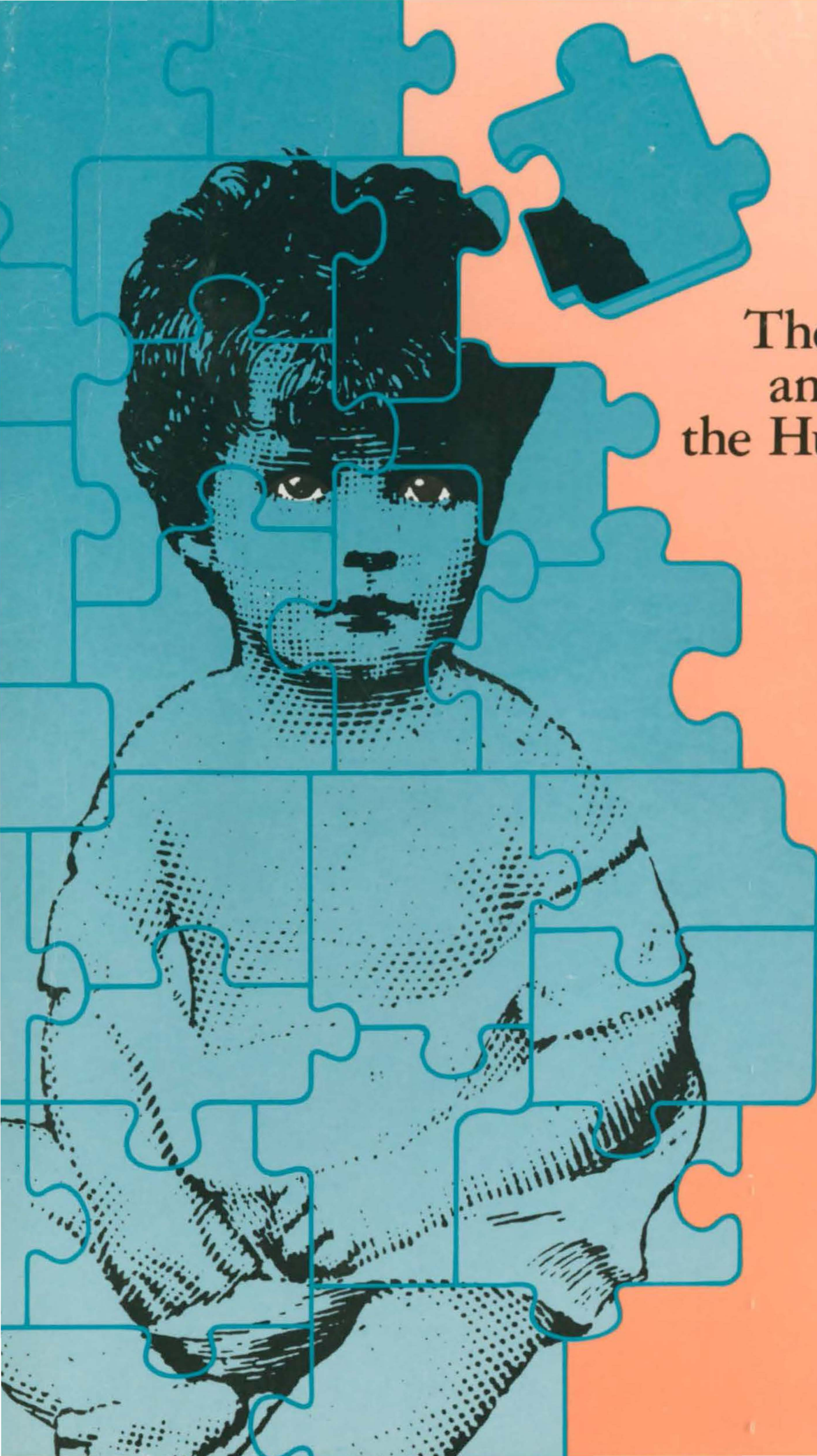

The Awakening and Growth of the Human Infant:

A Telecourse Study Guide for Infant Mental Health Practitioners

By Susan E. Partridge

University of Southern Maine

The Awakening and Growth of the Human Infant:

A Telecourse Study Guide for Infant Mental Health Practitioners

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Prepared for: The Child & Family Institute
of the Division of Human Resources
University of Southern Maine

This Study Guide is an accompaniment to

> "The Awakening and Growth of the Human: Studies in Infant Mental Health", a series of 10 videotapes, produced and narrated by Mr. Michael Trout.

The Infant Mental Health Telecourse materials consist of the Study Guide, the Trout Videotapes, and 30 highly recommended readings on infant mental health topics.

An Instructor's Guide is available.

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The Telecourse Study Guide is the result of collaboration by some staff of two units of the University of Southern Maine: The Human Services Development Institute of the Center for Research and Advanced Study and The Child and Family Institute of The Division of Human Resources. The project was funded by The Department of Education and Cultural Services, The Developmental Disabilities Council and The Department of Mental Health and Mental Retardation of the State of Maine.

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Child and Family Institute, State of Maine, 1987.

Contents

Unit 1
Introduction to Infant Mental Health Practice 9

Unit 2
The Nature of Human Attachments in Infancy 21

Unit 3
The Psychological Dimensions of Pregnancy, Labor and Delivery for Mothers and Fathers 32

Unit 4
Conducting an Infant Mental Health Family Assessment 42

Unit 5
The Newborn's Capabilities and Temperament: What He Brings to His Parents 51

Unit 6
Impact on the Family of the Birth of a Sick or Handicapped Infant 59

Unit 7
Special Issues in Infant Mental Health Practice 69

Recommended Readings 83

Acknowledgments

What you are about to embark upon—the study of infant mental health practice, through a telecourse format—is the result of a widespread enthusiasm in Maine for early intervention, with particular regard for the emotional well-being of young children and their families.

The idea of a telecourse grew out of Maine's five year history of seminars presented by Michael Trout on infant mental health. These seminars were highly appealing to a host of workers within Maine, including public health and maternal and child health nurses, child development and early intervention specialists, and numerous other professionals who daily struggled with the needs of the many vulnerable parents and babies in their practice.

Influenced by the work of the late Selma Fraiberg, Michael Trout's model of teaching complemented the learning styles of Maine's proponents. His style integrates personal feelings with professional learning, combining affect and thought to arrive at a better understanding of the client, of self, and of the work occurring between the two. The *infant* and *very young child* are at the center of the stage, but workers also identify the emotional needs of the *parent* and the *family*. And because early childhood work is often intense, the infant mental health practitioner manages complex *personal* feelings such as helplessness, sadness and loss. It is the blend of such orientations to the feelings of self and to the feelings of others that ultimately lead to the real joys of infant mental health practice, the exhilaration of witnessing a baby problem-solve and thrive, the intimacy of understanding a parent's dreams, and the pleasure of watching a parent and child grow closer to one another.

I would like to thank Michael for his willingness to enter into the production of this telecourse, for sharing his teaching style with us and for his consistent availability to the Project staff. It has been a pleasure to work with him.

But Michael Trout is not the only individual who has nurtured Maine's training efforts in infant mental health. The late Margaret Bruns, R.N., not only introduced Michael to Maine, but maintained a steady commitment to young children and their families. The fruits of her work in Maine have taken hold and continue to grow; Maine's Infant Mental Health Telecourse is dedicated to her memory.

Edward Hinckley, an administrator in the Department of Mental Health and Mental Retardation, has provided strong leadership in early intervention programs. He played a major role in enabling the Trout seminars, in obtaining advanced training for child development workers on infant mental health issues, and in investing enormous time and energy in preventive intervention programs. His "can do" attitude

and "creative bureaucracy" skills were instrumental in the development of this Infant Mental Health Telecourse.

John Serrage, Helen Zidowecki, John Hornstein, Irving Williams, Susan Mackey-Andrews, and John Green, state administrators in maternal and child health, public health nursing, special education, and developmental disabilities areas, respectively, each made significant contributions to the telecourse production and to staff and program development in early intervention.

As a group, these hearty state administrators gave birth to the idea of the telecourse project, in order that more professionals across Maine could learn about and incorporate the focus of infant mental health practice into their work with families.

I would also like to express my appreciation to the Trout seminar students, workers and parents whose enthusiasm for learning and using infant mental health training underscored the need to make educational material more accessible to a broader audience.

Finally, I would like to acknowledge the work and the support of the Infant Mental Health Telecourse Project's multidisciplinary "production team." They are: Catherine Ayoub, Sherry Barghi, Ingrid Chalufour, Norman Lapointe, Elpiniki Leodas, Erik Van de Bogart, and Mary Veit. As Project Director, Norman worked on several administrative aspects of the project, including matters of budget, copyright permission to use the readings, and working with the University of Southern Maine to obtain graduate course credit for the telecourse. Erik paved the way for us to make use of public television to air the videotapes and as an expert on television productions, he provided constructive comments on the pilot videotapes. Educators and a social worker, Ingrid, Elpiniki and Sherry read stacks of articles and book chapters to facilitate a final selection of recommended telecourse readings. Mary and Cathy provided feedback on the written materials of the study guide. Mary's superlative editorial skills made a significant difference in the quality of the curriculum guide, and Cathy raised many essential questions and sharpened our focus. Four others also helped a great deal: Alma Newell in coordinating typing, xeroxing, and numerous communications among those involved; Lisa Sawyer in assembling the articles; Camille Buch in designing the cover of the study guide and its layout and Julie Cameron in assisting with production. In all, these people greatly added to the value of the product and of the project itself. I am grateful to all of them for their time, assistance, and support.

Susan Partridge, M.S.W., Ph.D.
Project Coordinator
Portland, Maine
1987

Preface

Welcome to a special world, a world of feelings, images, and ideas, a world of resilience and of vulnerability. This is a world enlivened by the passions with which we, as caregivers, surround the babies entrusted to our care.

Most people, adults and children alike, are drawn to the warmth and the hopefulness of a young baby. We see infants smiling and hear them cooing at their mothers and fathers, and we feel pleasure. We recognize the lasting significance and depth of the parent-child bond, knowing that it is through this bond that the earliest feelings of security, frustration and anxiety are mediated.

As a society, we now have far more knowledge about the infant than ever before. We are learning that the infant has complex abilities to perceive animate and inanimate objects, to comprehend sameness and differentness, to influence people through sophisticated social signalling, and to create his or her own sense of how the world is organized. The infant is an active, processing, dynamic being.

We are also learning more and more about the infant's capacity to feel, and to feel deeply. Just as we are drawn to the happy baby, so are we drawn to the depressed or withdrawn baby, whose cries are barely heard, and to the inconsolable baby, the one who cannot be comforted, whose cries we cannot bear to hear. There is a compounded sadness if we see in the parents of these babies a *desire* to connect, to provide, to nurture, but an *inability* to do so.

As child development specialists, educators, nurses, psychologists, social workers, physicians and other intervenors in the lives of babies, we now have a growing body of knowledge about how to work supportively with parents and their young children. We feel an urge to set life on a different course for the vulnerable babies and their parents. As we understand more about the factors that stress and the resources that strengthen families, we seek to release these partners from the obstacles that impair their abilities to grow and develop through their relationships.

Our enthusiasm for early intervention matches our respect for the capabilities of infants and the persevering commitments of parents. We acknowledge that in the life and presence of the newborn and young child, there lies the hope of not only the next generation but also of the current generation. For, it is through providing for the needs of others, in recognition of our interdependence—child, parent, social network, and professional caregiver—that there is nurturance of the future and healing of the past.

The Infant Mental Health Telecourse

The Infant Mental Health Telecourse is a collection of videotapes and print materials organized into a course format and specifically designed for practitioners who work with infants, babies, toddlers, preschoolers and their families. There are seven topics covered:

1. introduction to infant mental health practice
2. the development of infant-parent attachment
3. the psychology of pregnancy and birth
4. clinical assessment of the infant and family
5. capabilities of the newborn
6. impact on the family of the birth of a sick or handicapped infant
7. special issues and challenges for the practitioner.

Objectives of the Telecourse are two: to educate human service professionals about the development of infants' relationships with their primary caretakers; and to advance professionals' knowledge of the factors that limit or obstruct parents and infants in their abilities to form attachments and achieve mastery of the changing developmental challenges which face them. We define the infant mental health field as an interdisciplinary field concerned with the optimal physical, social, emotional and cognitive development of the human infant in the context of his family.

The Telecourse consists of two major components: ten, half-hour *videotapes* on infant mental health and this telecourse *curriculum package*, containing a Study Guide, an Instructor's Guide and selected readings.

The Organizing Framework

Each of the seven units provides the learner with two points of reference:

1. a conceptual framework, and
2. practice-oriented applications

Each unit contains a description of the unit's *objectives*, an *overview* of the material presented in the videotapes and the assigned readings, a glossary of *essential concepts*, a listing of the *overarching themes and central points*, and *self-study questions*. At the conclusion of the seven units, a selected list of recommended readings for advanced study completes this Study Guide.

The Study Guide has been organized with particular ideas in mind. First, like any rapidly developing field, the infant mental health field will witness several changes in focus over time as questions are increasingly clarified and concepts refined. To reinforce only those principles which appear most likely to survive the rigors of additional research and theory-building, three criteria were used in selecting the most pertinent overarching themes and central points to highlight in the

Guide: that the idea is based on solid research; that the idea has been current for some time; and that the idea is espoused by several theorists or authors.

Second, the essential concepts have all been defined from the point of view of clinical practice with very young children, from infancy to five years old, and their families. The same is true with regard to the choice of self-study questions. Confining the application to this narrowed age group is meant to sharpen the focus of the reader or student.

Third, the Study Guide suggests a sequence to the student's learning activities. The Unit Overview and definitions of Essential Concepts orient the learner to the specific readings of the Unit and also to the Trout videotape lecture and illustrations. After reading the overview and glossary, the student is expected to study the videotapes. Subsequently, the Overarching Themes and Central Points section reinforces the most important principles in the readings and videotape. Self-study questions then encourage the student to apply what he or she has learned to clinical practice and/or social policy.

Fourth, as a Study Guide, the content of the Units conforms to the topics covered on the Trout videotapes and is intended to *supplement* and *complement* them. The Production Team recognizes the breadth and richness of the topics chosen for study but also acknowledges that the infant mental health field is broad in its theoretical and practice-orientations, and that Michael Trout's perspective, and our commentary and reviews, do not necessarily incorporate the entire range of viewpoints on infant and family mental health.

Fifth, and finally, the Study Guide raises self-study questions and suggests activities for further learning and application in order to spur the student's *active* involvement in the field. Space is provided for the student to raise questions, take notes, keep track of assignments and work on personal learning objectives, or on the objectives of specific telecourse instructors. The possibilities of application of the Telecourse material are boundless and only constrained by the imagination and energy of the student. The Telecourse project staff encourage a wide range of applications and professional usage of these curriculum materials.

Unit 1
Introduction to Infant Mental Health Practice

"Grace (21 months old) had her first temper tantrum the other night. In the past, she's been very nurturant with her babies, her dolls and stuffed animals, kissing and holding them. Well, the other night, she couldn't move one of her dolls the way she wanted, and she began screaming and crying. She threw the doll on the floor and began jumping on it! Robert got concerned and he asked 'What should we do now?' I said, 'don't do anything yet, just let her work it out. She's just frustrated. We'll go to her when she calms down and can hear us.' When she stopped tantruming, we then both went over to her, hugged her and told her she was okay. I wanted her to know we weren't angry with her for being frustrated. Since then, she hits and yells at her doll, then gets the doll, picks it up and very nurturantly says, 'It's okay, baby. It's okay.'"

Introduction to Unit

Unit Objectives

1. To understand the roots of infant mental health practice—a basic concern for the infant's emotions and his earliest connections and relationships with primary caretakers.
2. To identify the major clinical perspectives of professionals who specialize in infant mental health practice.
3. To develop an appreciation of the variety of approaches in infant-parent work.

Unit Overview

In this section, we consider the following questions:

What is infant mental health?
What is infant mental health practice?
Where is the field of infant mental health going?

Infant mental health may be defined as the infant's freedom to develop physically, cognitively, and socially, thereby enabling him to master the essential emotional tasks of early childhood, unimpeded by excessive, inadequate, or harmful stimulation.

Throughout the first five years, the infant's and young child's emotional or psychological tasks consist of developing his ability to regulate tensions autonomously, and to achieve a sense of order and routine to bodily functioning through appropriate eating, sleeping, playing, and resting cycles, especially as these cycles occur in the context of the family. At the same time, as the infant establishes psychological equilibrium, he must learn to be an active partner in the development of attachments, and to make behavioral and emotional investments in the world of people and objects. Upon this foundation of burgeoning inner resources to a responsive outer world, the infant gradually constructs ideas and images of how this world is organized and how he fits into this world. An emotionally healthy infant finds the world a somewhat orderly place where people value his presence and abilities and interact with him in ways which foster his growth and maturation.

Out of such experiences, repeated again and again, the child comes to have a sense of himself as a good and capable individual. He enjoys his closest relationships, learns from his dealings with people and things, and can adequately manage life's expectable tensions and inevitable disappointments. Furthermore, he learns to control unacceptable impulses and to resolve problems in ever more effective means.

Stressors which challenge the very young child's ability to achieve self-esteem and mastery include experiences with abuse, maltreatment or neglect, or chronic lack of learning opportunities. Also severely challenged are children suffering from chronic illness or other handicaps that make it difficult for the child to enjoy being active or unable to manipulate objects without pain. Lengthy separation from loved ones, such as loss of a parent, are especially problematic. Any trauma that severely disrupts an infant's basic schedule, violates his social expectations or imposes cumulative, overwhelming stress also present obstacles to healthy emotional development.

Not to be underemphasized in examining infant coping is the infant's own reaction style, his temperament. Some young children are more vulnerable to stress than are others simply by virtue of their greater sensitivities. Transitions, unexpected or new stimulation or demands from the environment can be very stressful to sensitive young children. Inhibited children often respond to many ordinary events with anxiety, while bolder, more exuberant children seem undaunted. A good fit between a parent and child and a supportive environment are essential in facilitating a child's ability to make the most of his strengths and special traits.

While emotional health in early childhood is not an impossible task to achieve by any means, neither is it a given. We have come to see that infants, babies, toddlers, and preschoolers are not immune from depression, rage, sadness and undue frustration, anymore than we, as adults, are. Even the youngest of humans have complex emotional lives.

Infant mental health practice is a multidisciplinary group of services provided to children, prenatally to age five, which is oriented towards optimal child development, parent-child relationships and the ecological framework of the family system. Those who provide services include social workers, early childhood educators, speech, physical, occupational therapists, psychologists, counselors, psychiatrists, physicians, nurses, nutritionists, day care providers, and others who work with families with young children. Where these service providers incorporate in their practice the principles and dimensions of the infant mental health field, they share in conducting infant mental health practice.

First, there is a focus on *development.* An infant mental health practitioner is ever mindful of the dynamic and changing nature of human beings and their relationships. With each new stage or phase of growth, come changes in the infant's capacities to move, feel, behave, and think. Some changes are dramatic, others subtle. Furthermore, as the infant develops, so do parents, often encountering memories of the pleasures and pains of their own childhoods. Parents have opportunities to "re-do" their developmental tasks as they care for and observe their own children confronting such tasks. One of the primary goals of the practitioner is to facilitate this development of *both* infants and parents. Helping parents to identify and remove obstacles to their child's development and to encourage their *own* mastery and pleasure in growth, is a basic service goal. Thus, knowledge of the developmental stages of infant, parent and family is an essential part of infant mental health practice. Teaching families these steps is not the point of such practice; what is the point is mutual understanding of developmental tasks.

The **infant mental health field** is acutely oriented to *interpersonal* relationships. Infants generally receive primary nurturance from their parents. To the extent that parents receive the nurturance and support they themselves need, they are more able to effectively care for their children. Practitioners see evidence of this daily, and, therefore, work in two ways: a) directly with the infant to facilitate the growth and strengthening of the parent-infant bond; and b) indirectly with the infant, or on behalf of the infant, through direct counseling, education and support of the parents.

Infant mental health practice tends to work best within an ecological framework. An infant lives in a caretaking setting, usually a family; the family lives in a community; the community is part of a society. Each

arena influences and is influenced by every other arena. To thoroughly understand any given infant, one must understand the context in which the infant and caregivers function. An infant living in poverty, whose family does not have transportation to the physician's office for well-child care, and who lives in relative isolation, grows up in very different circumstances from the infant whose social environment is more privileged. Basic needs, situational distresses and constraints, services in the community, and the family's resources and access to essential commodities are taken into consideration by infant mental health practitioners. In many cases, a clinical intervention might consist of driving a mother and baby to the doctor's office, or providing them with diapers, all in the context of supporting the parent-infant caretaking environment, all with an awareness of the importance of establishing the soundest possible foundations upon which development takes place.

Where is the infant mental health field going? Currently, the field appears to be emphasizing the multidisciplinary or transdisciplinary aspects of effective early intervention. Transdisciplinary refers to not merely a mixture of disciplines but a cross-fertilization of disciplines, a sharing of skills and knowledge bases across areas of expertise. Behind this focus lies the belief that infants and their families will develop most readily when all aspects of their functioning (physical health, education and emotional health) are dealt with in a wholistic, rather than a serial, manner.

Secondly, the field is continuing to move towards a greater synthesis of social science *research* and *theory*, and subsequently to the application of knowledge to *clinical practice*. These three prongs are those traditionally highlighted as professional imperatives by the giants in the field—John Bowlby, Rene Spitz, Selma Fraiberg, Sally Provence, Daniel Stern, Stanley Greenspan and many others. A good example of the theory-research-practice paradigm is recent work on depression in parents, which documents a relationship between parental withdrawal and the infant's experiencing of violations of his basic social expectations.[1] Research on the notion of working models of attachment, is another example of material readily applicable to professional practice.[2]

Third, the notion of parents being resources and allies or partners in prevention is increasingly emphasized in the field. Many national efforts, such as the Zero to Three programs in several states, and the Maternal and Child Health Division of the Federal Health and Human

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[1]Tronick, E. & Gianino, A. Interactive mismatch and repair: challenge to the coping infant, *Zero to Three*, Vol. VI, No. 3, Feb., 1986, pp. 1-6.

[2]Main, M., Cassidy, J. & Kaplan, N. Security in infancy, childhood and adulthood: a move to the level of representation. *Monographs of the Society for Research in Child Development*. Serial No. 209, Vol. 50, Nos. 1-2, pp. 66-108.

Services Department mandate the involvement of parents on boards, at committee meetings and in all program deliberations. Underlying this movement is a recognition of the role of parents as teachers or professionals. Parent involvement has broadened the focus away from the traditional medical model out of which the earliest clinical applications to infant-parent or family work grew, and towards a more collaborative model.

Fourth, the field is struggling to adopt a model of health and normalcy rather than one of pathology. Efforts are underway to dispel parents, providers and families of the myth that only pathology or disorders warrant early intervention. Families are always problematic environments and every child faces some challenges to his development. Normal reactions to stress can contribute to difficulties. The difference in an emphasis on health rather than pathology, lies in an acceptance of children's, families', and provider's interdependence. Maximizing and building on strengths is the essential goal of a health-oriented stance.

Fifth, the field continues to improve upon systems and methods of preventive intervention. Efforts to define prevention and to structure programs around this concept continue to struggle against the competing needs of other populations, such as the elderly, the chronically mentally ill, and teenagers in need of residential care. The concept of prevention is not new, but the obstacles to its becoming an institutionalized idea, built into the fabric of social policy and human service programs, has not yet become a reality.

Finally, the field appears to be increasingly investing energy into disseminating information generated from infancy and family research, practice, and theory to all human service providers at all levels of education, as well as to the general public.

These six thrusts in the infant mental health field capture the spirit and imagination of those who work on behalf of infants, very young children, and their families. These and undoubtedly other challenges will spur additional research, theory-building, and application of knowledge to clinical practice in the years to come.

This is the world of infant mental health. It knows no boundaries of geography, social class, gender or ethnicity. Its proponents come from all over the world, its base of knowledge from many different professions. The common bond within its diversity is the enthusiasm for a very simple idea—that if we can capitalize on the developmental potential of babies and very young children while they remain young, then the promise of their futures will be brighter.

In this first unit, the reader will be introduced to the diversity of clinical approaches and the breadth of ideas about infant mental health practices. The readings will present some information on the history of

the infant mental health field, and some examples of techniques, which involve direct and indirect work with infants and group work with parents.

Essential Concepts

infant adaptability: the resilience of infants to stress, to challenges, or to limited failures of the environment to meet their specific needs; strengths and capability to develop, despite imperfections in the environment; numerous, innate, and wide-ranging capacities to move towards growth and maturation.

temperament: the infant's basic style of acting, reaction and influencing his world in general; how the infant moves about in regard to the world of things, people, stimulation and even his own feelings; ranges from "easy" to "average" to "difficult"; incorporates such aspects of style as rhythmicity, tone, distractibility, activity level, tolerance for changes or novel stimuli, frustration tolerance, and ability to be consoled.

cue: the verbal or nonverbal signal or message which the infant conveys to caretakers about his state, feelings, or needs.

interaction: the occurrence of behaviors or messages sent from infant or parent to one another; a give and take process, the basis through which relationships and expectations develop; the source of a young child's major learning about the world of people and feelings.

parental capacity: the innate ability of a primary caregiver to adequately raise a child; alternatively, the potential of the parent to nurture a specific child in the absence of conflicts or barriers within the environment, the child, the family or the parent's personality; theoretically, a fuller capacity can be achieved by proper therapeutic learning, and growing experiences.

early intervention and prevention: the provision of professional services in education, speech, occupational or physical therapy, nutrition, medical, or mental health care to an infant and family, at an early age, an early stage of concern, prior to the onset of worsening of more serious problems, *or* where an at-risk condition has been identified; often refers to any services provided to children from birth to age three or five, usually a mixture of education, support, concrete help, and therapeutic guidance; once a term referred primarily to services for children with developmental disabilities, now refers to any young child.

developmental guidance: provision of emotional support and non-didactic education to the mother or primary caretaker of an infant about normal child development, or about a specific child's needs and abilities.

infant-parent psychotherapy: joint treatment of parent and child, where the infant's communications are heard and sensitively interpreted through the clinician's use of the working alliance with the parent; the infant is seen as communicating clues about the unmet needs of each; based on the premise that in-depth treatment of the parent's conflicts frees the parent to function more effectively as a caregiver; usually provided simultaneously with developmental guidance.

brief crisis intervention: assistance given to family in an acute crisis, where the family is temporarily unable to cope with substantial stress and the baby's development is or could be imperiled.

home-based intervention: provision of support, education, and assistance at the family home; thought to enhance the worker's level of understanding of the family, as well as parental comfort and the working alliance between parent and worker; once called "unconventional therapy" by Selma Fraiberg and her associates.

emotional milestones: emotional skills and feeling states achieved by the infant at different stages of growth; for example, self-calming and engagement with the social world during the first three months and intentional communication and self-esteem in later months of the first few years.

high-risk family: a family at-risk of abusing, neglecting, or significantly failing to meet the child's basic emotional needs, due to a variety of factors, including parental stress, mental illness, parental immaturity, severe child health problems, and environmental deprivation, to name some of the most prominent stressors.

transference: the process whereby in clinical treatment the therapist comes to represent in the client's mind a person from his past about which he feels negatively (negative transference) or positively (positive transference); the re-experiencing of old feelings and situations offers powerful clues about the origins of strengths and conflicts and can further the client's resolution of psychological issues.

therapeutic alliance: also called the "working alliance," in infant-parent psychotherapy or developmental guidance, the trusted relationship between therapist and parent as they jointly work on problems and concerns on behalf of the infant; the vehicle through which the parent can feel sustained during discussions of painful memories or intense conflicts.

repetition of the past: in infant mental health practice, the process by which the parent unconsciously sees in the infant aspects of the parent's

own childhood and the parent unwittingly recreates or allows a situation to repeat an earlier, painful experience; often one of the moving forces in intergenerational child abuse or neglect; can emerge at the point when the parent's child reaches the same age the parent was when a trauma, such as a major loss, occurred.

Assignments and Notes

1. Read the following material in the text or elsewhere:

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Application

Overarching Themes and Central Points

1. Infants have remarkable physical and intellectual abilities at birth; they also appear to have much more of a complex emotional life than many people thought.
2. Emotional problems can begin even during early infancy.
3. Knowledge of the infant's emotional health may be even more important to understanding him than knowledge of the infant's intellectual capabilities.
4. Essential for the infant's emotional health is care giving from a person who accepts the infant's individuality, can read his social cues, and respond with empathy.
5. Parents do not handle all stages of childhood development equally smoothly; parents themselves develop and change over time, in response to changes in their children's needs and behaviors, as well as to other changes in their lives.
6. Parents need social and emotional support for their parenting; no parent is immune to the demands of parenting or free from the conflicts and unresolved issues remaining from his or her past.
7. Early intervention generally aims at increasing the parent's enjoyment of the infant as well as helping the parent to learn more about the infant; pleasure in the infant increases the parent's sensitivity and caretaking abilities.
8. While in the past treatment for an infant's problem centered on the mother alone, now treatment focuses on the parent-infant interaction, and it takes into consideration the infant's contribution to the interaction.
9. When the baby is ultimately the benefactor of treatment, his or her presence during treatment sessions can be a powerful reinforcement for the parent's motivation to work through painful issues, as the baby symbolizes renewal of hope and the promise of psychological rebirth of the parent.
10. Detecting the beginnings of emotional problems during infancy offers infant mental health service providers an opportunity to intervene before serious psychological problems develop, and, in a preventive fashion, it offers society a chance to realize substantial financial savings.

Self-Study Questions

1. Why is the infant mental health field such a burgeoning one? What lies behind the growing interest and enthusiasm in its potential to help families?

2. The statement, "Emotional problems can begin in infancy" frequently arouses strong personal feelings and memories of all kinds. What is your reaction to this phrase?

3. Define and discuss "parental support," as provided by an early childhood specialist or a professional engaging in work to improve a baby's emotional health. Give some examples of parental support.

4. Early intervention presumes that the first three to five years of life are critical, formative years, with lasting impact. Some people disagree with the certainty or strength of such a statement, preferring to think that all of a child's early years, from 0-17, are formative. What do you think? Why?

5. Write to the National Center for Clinical Infant Programs, 733 15th St., N.W., Suite 912, Washington, D.C. 20005, to obtain information about various early childhood, mental-health oriented programs across the country. Or, learn about a program in your area. Study this program: what is its emphasis, its staffing pattern, its clientele? How comprehensive is the program? What clinical interventions does it offer and what theoretical framework spurs its work?

6. Meet with others in the course informally to identify areas of Infant Mental Health about which you would like to learn more.

Comments and Questions:

Unit 2
The Nature of Human Attachments in Infancy

"I'm not sure the feelings of closeness can be adequately described in words. The love and caring I feel are more than I had expected—especially right away. I had thought it would take time to feel so committed, so bonded and yet I can't imagine ever being without him. The feeling sprouts irregularly—maybe when he is looking particularly sweet, like when he's sleeping or when he's being charming, like when he responds with coos and smiles."

"It feels like there is nothing more satisfying in this world. I feel most close to her when she is breastfeeding and her hand rubs back and forth against my clothes or my skin. I also feel close when she stops feeding to look up and talk to me or to explore my face with her hand. It makes me feel as if we're sharing something very special. It feels as if we're really communicating. Sometimes it feels as if there is nothing more important to me in the world than to be her mother . . ."

Introduction to Unit

Unit Objectives

1. To understand what attachment is, how it has been studied, and how it relates to overall infant development.
2. To describe some of the parental, child and family factors considered to be detrimental to the development of attachments during infancy.

Unit Overview

The study of infant attachment is one of the most well researched and carefully considered topics among the many concepts that have fascinated social scientists. Is attachment a biologically-based process? Is infant attachment an automatic outcome of early caregiving? What are the consequences of attachment, or of an attachment disorder or absence of attachment? Clinical practitioners, researchers, and theoreticians have found a common bond in their respective attempts to investigate these and many other questions about infant-parent attachment.

What seems indisputable is that infant-parent attachment is a fundamental requirement of normal child development; without it, infants fail to thrive.

Mary Ainsworth and her colleagues have pioneered an extensively employed procedure to identify and broadly classify infant attachment as secure or insecure.[1] These procedures have helped scientists and clinicians to better understand infant attachment from the earliest months through roughly the first several years. Ainsworth and those who have followed her lead throughout the past 10-15 years have shown that securely attached infants grow up to be more trustful, more creative, better adjusted in school and with peers, and more capable of problem-solving.

Although most infants who are judged as securely attached during infancy receive similar classifications when evaluated during the preschool years, Vaughn et al., recently documented that severe family or situational stress is associated with changes from secure to insecure attachments.[2] There is still a long way to go to understand the particular nature of those life events which strain the emotional bonds begun in infancy, but there has been a great deal of progress to date.

From a theoretical point of view, attachments seem to serve a socio-biological function—they keep babies in the proximity of their primary caretakers, assuring them maximum protection from harm and continuous opportunity for social learning. Among the many things infants learn from their caretakers, the most pervasive may be images and ideas about relationships, a "working model" of how people and things function and how the infant himself fits into his environment.[3]

Although there is a great deal of research about infant attachments to caregivers, there is far less empirical or theoretical work on what conditions in the environment of the infant support parents' feelings of attachment. How does a practitioner assess the quality of a mother's or father's attachment to an infant? Does parental attachment change over time? Some very recent research by Mary Main and her colleagues is helping to close this gap.[4] They have found evidence for a similarity of parents' working models of attachment established and revised during their childhood through adulthood years and those models that

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[1]Ainsworth, M., Bell, S.M., & Stayton, D.J. Individual differences in strange situation behavior of one-year olds. H.R. Schaffer (Ed.) *The Origins of Human Social Relations*. Condon: Academic Press, 1971.

[2]Vaughn, B., Egeland, B., Sroufe, L.A. and Waters, E. Individual Differences in Infant-Mother Attachment at Twelve and Eighteen Months: Stability and Change in Families Under Stress. *Child Development*, 1979, *50*, pp. 971-975.

[3]Bowlby, J. Attachment and Loss: Vol. 1. *Attachment*. New York: Basic. (Original work published 1969)

[4]Main, M., Kaplan, N., and Cassidy, J. Security in Infancy, Childhood and Adulthood: A Move to the Level of Representation. *Monographs of the Society for Research in Child Development*, Serial No. 209, Vol. 50, Nos. 1-2, pp. 66-108.

their children ultimately develop. Efforts such as these are constantly moving closer to the point where a transactional model is applied to infant-parent-family dynamics.

A study of infant-parent attachment is a study of the complex process of family building. Many facets of family relations contribute to the shape and color of the infant's early social bonds. Among the most influential is the father, his engrossment in the infant and his support of the mother. Recent research on fatherhood underscore the increasingly recognized, pivotal role of fathers as caregivers. Also important are grandparents, the extended family and the social network in general. Professionals become part of the family's social network; their sensitivity and support to the family can do a great deal to strengthen and maintain infant-parent attachments.

Unit 2 covers the study of attachment from two principal vantage points: (1) What is normal attachment and its development course? What are the factors which promote it and what are the consequences of attachment for child development? (2) What are some outcomes of problems in attachment? Can we identify sources of strain and instability, and symptoms of attachment difficulties?

Essential Concepts

attachment: the emotional tie between an infant and caregiver, evidenced by infant's strong preference for a primary caregiver, seeking proximity to and contact with that person and receiving deep enjoyment and comfort from such contact and communication; in the parent, evidenced by a strong urge to protect and nurture, enjoyment of the infant, distress at separations from the infant and at the infant's experience of pain; a lasting, mutually shared investment by parent and infant in one another.

bond: a strong, affective pull experienced by a parent during the earliest interactions with an infant; a presumably biologically-based, emotional tie that emerges during a hypothesized "critical period" shortly after birth; a concept for which there is conflicting research evidence.

signal system: a well-rehearsed collection of vocal and nonvocal messages sent by the infant and understood by the caregiver to have communicative value, i.e., to signal a need or feeling state; for example, an infant will cry to signal hunger, pain, or anger.

schemata: mental representations or images that an infant develops by integrating and organizing accumulated feelings and thoughts based on many experiences; similar to the notion of "internal working models."

differentiation: the infant's ability to discriminate; usually refers to an

ability to discern differences between strangers and familiar caretakers or between different attachment figures; to be distinguished from individuation, it is a necessary ability in the infant's development of a sense of self.

Ainsworth Strange Situation: a research procedure used to study attachment differences among one to three year olds; based on separation and reunion behaviors demonstrated by infants who experience short periods of separation from their mothers; procedure had identified four types of attachment; secure (roughly two-thirds of babies fall into this type), avoidant, resistant and distressed attachments.

separation protest (separation anxiety): the distress experienced by a young baby or child when separated from a parent; or, the anxiety felt when approached by a stranger at the peak of the attachment process, at roughly 8-10 months of age.

synchrony: the coming together of an infant's and parent's rhythms during social interaction; the ebb and flow of verbal and nonverbal communications in a mutually regulated manner, with smooth "pauses" and "bursts" of activity alternating from partner to partner.

interactive match: the likeness or similarity of style between parental and infant behaviors during interactions, e.g., when an infant initiates verbal communication or play, the mother responds with a corresponding vocalization; when an infant terminates the interaction, the mother accepts the pause and does not attempt to prolong the interaction; thought essential to healthy interactions.

interactive mismatch: an interactional state, where parental and infant behaviors are out of synchrony: e.g., the parent initiates play when the infant communicates a need for rest or the infant initiates interaction and the parent disregards these signals; partners ignore, fail to respond to signals, respond too late, or offer too much or too little stimulation to achieve a mutually satisfying interaction.

affective core: a basic feeling-orientation to life, presumably derived from one's earliest feelings in a caregiving context; e.g., a depressive affective core indicates a set of expectations that one's basic needs might not be met, that one will be unsuccessful in achieving happiness or satisfaction, that attempts to cope with problems are likely to fail; similar to the idea of a working model or to the notion of schemata.

infant coping: a set of behaviors exhibited by the infant that appear to be designed to correct or remove situations which leave the infant distressed, anxious or unhappy and/or to manage internally the emotions caused by a situation that cannot be altered, corrected or eliminated; often referred to as adaptability or resilience.

constancy: a feeling of security in the durability of another's emotional investment in one's self, despite changes in circumstance, advancing age, rageful or negative feelings or disappointments; an outgrowth of parental acceptance, consistency and environmental equilibrium.

individuation: the infant's coming to terms with the awareness that he or she is a separate person from the primary caregiver; requires a capacity to differentiate self from other; denotes the building blocks of an infant's sense of self, or personal identity, and can be associated not only with feelings of exhilaration at one's autonomy and mastery but also with feelings of insecurity and loss; an important developmental task, described and studied most extensively by Margaret Mahler and associates.[5]

practicing: the infant's first forays into independent behavior (roughly 9-12 months), exuberant action and spontaneous explorations, characterized by alternating behaviors of exploration with "refueling" or checking in with the primary caregiver for nurturance and security.

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[5]Mahler, M., Pine, F. and Bergman, A. *The Psychological Birth of the Human Infant.* New York: Basic, 1975.

Assignments and Notes

1. Read the following material in the text or elsewhere:

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Application

Overarching Themes and Central Points

1. Attachment is a two-way process between human partners.

2. Infants need primary attachment objects; while they can and do develop close ties with several people, such as siblings and relatives, they develop best in the context of a few, stable caretaking relationships.

3. Attachments develop and change over the course of the first several years due to emerging abilities of the young child; however, social and environmental stress can also have an impact on the quality of infant attachment, in some cases a negative one.

4. An infant needs to be able to feel a sense of control over his environment, to know that he can influence others; parental behaviors that are contingent upon infant behaviors are important in the development of an infant's feelings of mastery.

5. Factors in the baby which can impede parent-infant attachments include: neonatal illness and anomalies, undesirable physical appearances, undesired gender, prematurity, tactile hypersensitivity, and difficulties caused by the infant's temperament, particularly if his stylistic characteristics (e.g., excitable or lethargic) are mismatched with those of his parents.

6. Factors in the parent which can impede parent-infant attachments include a history of loss of significant others, especially parents, siblings, or prior children, and unresolved childhood or adolescent conflicts.

7. Factors in the family circumstances which can impede parent-infant attachments include: traumatic pregnancy and delivery, lack of social support during pregnancy, delivery and the postpartum period, and family stress or social isolation.

8. Symptoms of emotional difficulties in infants may be indicated by chronic disturbances in bodily functions or cognitive functions, withdrawal and apathy, and extreme indications of panic, anxiety or disorganized behaviors.

9. Although the literature on infant-parent attachment has focused on mothers, most research on fathers shows that they are just as emotionally involved and sensitive with their infants; mothers and fathers do, however, tend to play different roles vis-a-vis the young child.

10. Although sensitivity and synchrony are the mainstays of healthy parent-infant interactions, normal infants and adult caretakers experience a large number of interactive mismatches.
11. The infant has abilities to cope with interactive mismatches by bringing the partner into match and creating a situation of positive emotional exchange.
12. Maternal depression appears to have an impact on the coping styles used by infants; infants of depressed mothers spend more time seemingly trying to regulate their own emotional states than trying to reengage their mothers in social interaction.
13. Parents who abuse their young children seem to demonstrate disorders of attachments, such as highly anxious attachments; they have also experienced much more abusive parenting themselves during childhood, such as frequent threats of separation from constant unavailability of, and emotional rejection by the parents.
14. Parental "unavailability," the lack of empathic interchange, is as significant an obstacle to infant mental health as are physical abuse and neglect.

Self-Study Questions

1. Think of a child you know who is between 12-18 months of age. What is the quality of attachment which you observe in this baby to his or her primary caretaker?

2. Do you know of a child who suffered some maternal separation or deprivation of good mothering in the first two years? How does this child currently function in social situations? What were the experiences of this child in the intervening years and months? (If you do not know of a child with this background, try to imagine one and think about what kinds of experiences might occur to both help and hinder the child's emotional growth.)

3. An 18-month old is about to be separated from her mother for reasons of serious neglect. The child is to enter foster care with a caretaker not known to her. What should be considered in making this placement? How could a child welfare worker assure the maximally health growth of this child?

4. Define "good mothering." Define "good fathering." Show how these are related to the development of an infant's secure attachment.

5. Observe the interactions between an infant and his parent. How in tune is the parent with the infant's level of development, state of attention and expressed interest in the environment? What "techniques" does the parent use in interacting with the infant? Do you observe a sensitive dialogue between the two?

6. Why is timing so important when it comes to interacting with a baby?

7. Think of some activities that could be initiated, or a program that could be developed to provide support for fathering activities.

8. Observe a parent and infant under 12 months of age playing and interacting. How many times do you see a mismatch occurring in 15 minutes? Take notes of the behaviors of parent and infant, noting such things as gaze aversions, signalling, withdrawal and other coping behaviors.

9. Describe the incidents where an abusive mother misinterpreted her child's age-appropriate or normal behavior as something indicating rejection or abandonment of her. How could you empathically explain to her that the child was not rejecting her?

10. What does it mean to "fall in love with your baby?" Write a 1-2 page description of how you might have felt this way in your own relationships with your baby or with a baby who is close to you (e.g., nephew, niece, etc.).

11. Have you ever taken care of an infant who cried unconsolably for more than 30 minutes? How did you feel? What did you do? Try to imagine how it must be for a mother to experience this for several days, even months? What might its impact on her be?

12. What role is played by friends during pregnancy and the postpartum period? How does their behavior help a new mother and father establish healthy attachments?

13. Think about the following situations/circumstances and write an essay about how the early postpartum period might be different and/or the same for these parents as compared to two-parent pairs of first-born children; single mother; teenage, single mother; and parents whose first child died of sudden-infant-death syndrome (SIDS).

Comments and Questions:

Unit 3
The Psychological Dimensions of Pregnancy, Labor and Delivery for Mothers and Fathers

"My pregnancy was not a complete surprise but I had expected 'getting pregnant' to be a longer process. I was overjoyed but it also didn't feel real. My husband was shocked and a little disappointed that it happened so quickly. I think it was even more intangible for him because he wasn't experiencing any physical changes. I remember feeling amazed that we had actually accomplished something so special. Several weeks later, we both went through a period of depression—reality had hit and all of a sudden, we realized how much our lives would change and we knew we were saying goodbye to a way of life."

"I learned we had been chosen from among three possible adoptive parents being considered by the biological mother about three weeks before she was to give birth. My first response was a mixture of disbelief and relief. Then an adrenalin shot of joy and excitement. I was numb, unable to even think of questions I needed answers for. It was all I could do to keep from shouting. After getting off the phone I yelled to my husband who came running and, after I told him, we just stood in the hallway holding each other and jumping up and down from the tension and giddiness."

"My immediate feeling was tenderness and an absolute sense that this was my *child. I had been concerned about holding him as I hadn't had a great deal of experience with newborns and was afraid I'd do something wrong—something disastrous (what, I don't know). . . . I couldn't wait to cuddle my child."*

Introduction to Unit

Unit Objectives

1. To understand the emotions of pregnancy and the developmental tasks it imposes on a mother and father.

2. To consider the effects of certain experiences during pregnancy on the parent's relationship to his/her child.
3. To describe some difficulties parents sometimes face during pregnancy and childbirth and the potential effects these have in the postpartum period.

Unit Overview

The transition to parenthood is one of the most profound normative experiences we face in a relatively short period of time. For the woman and the man, being able to conceive a child often marks the arrival of adulthood, and for some it connotes a sense of ultimate creativity and productivity. For others, a pregnancy carries with it a combination of every human emotion, from excitement to anxiety, from fears of the unknown to hopefulness of the future, from satisfying fullness to loss.

Pregnancy ushers in a potentially growth-producing, developmental transition for the woman. However, while pregnancy is uniquely personal, it is also an event for the family's entire social system. The father, the mother's own mother, and the network of extended family and friends all influence the mother's responses to her pregnancy. Many women take in any and all information they can about the mothering role, as they prepare for the concrete tasks of caring for a newborn. They are also coping with the complicated shifts in identity and in their relationships with their partners. The support that partners in marriage and friendship provide bolsters the woman's own inner resources, as she opens her body and her heart to a growing "inside baby."

Pregnancy is a normal developmental event. A pregnant woman often finds herself pulling inward, thinking of her relationship with her own mother, recalling childhood events and feeling particularly drawn to other pregnant women and to mothers of small children in general. Some women experience extraordinary sensitivities to world pain, such as hunger, poverty, family violence and the like, and these emotions may alternate with heightened appreciation of beauty and nature. Still other mothers brush away awareness of such emotions, finding pregnancy an awkward stage, an intrusive event beyond their control.

Fathers also have opportunity to grow to review their histories and relationships and to secure a place for their child in their lives and in the family. Men also experience many feelings during pregnancy.

In some cases, mothers and fathers are unable to master the emotional tasks of pregnancy such as accepting the pregnancy early on, identifying with the fetus and later letting go of the pregnancy. Deep-seated or unconscious conflicts can prevent the prospective mother or father from fully acknowledging the fetus or infant, or from feeling the force of their own reactions to pregnancy and childbirth. Women

whose own mothers were rejecting may harbor unconscious views of mothers as "cold," and feel afraid of repeating their own mother's style. Fathers whose own fathers were absent often feel they have no role model. Each new parent encounters his or her deepest images and ideas of what a "real parent" is. For many parents whose own parent was far from ideal, many of their memories and images invoke pain. Recognizing one's past and feeling the complicated emotions of pregnancy is an important, but at times difficult, psychological task of pregnancy.

To a degree, all parents arrive at the postpartum period feeling vulnerable and depleted, and frequently not even knowing why. It is important for the infant mental health practitioner to understand the sources of such distress. Is the distress a normal reaction to a stressful birth or a high risk pregnancy, to disappointments in medical providers or others, or is the parents' distress something deeper and more involved, possibly the surfacing of longstanding self-esteem or family relationship struggles? The clinician may be the only person in a family's significant social relationship who can help the parents identify and recover from the psychological obstacles that make the pregnancy and the early postpartum period a difficult one.

Sometimes a pregnancy is lost. Sometimes a child dies at or soon after birth. Such losses—infertility, miscarriage and stillbirth, leave deep emotional imprints. Elective abortions and surrendering a child for adoption also have major psychological consequences. Without grieving such losses, parents risk a dampening of their abilities to make optimal attachments to other children they may bring into their families.

Generally, medical and mental health clinicians need to learn more about and be more attuned to the psychology of pregnancy and early parenthood. At what point does a man or woman identify him or herself as a parent? What support can be offered to parents preparing for a baby? How can mothers be encouraged to share their concerns and questions in order for them to accept the normal ambivalences of pregnancy? If a parent's fears are based on unconscious or unexpressed sources, how can providers help to ease the most troublesome fantasies and images surrounding pregnancy and childbirth?

Whether studying high risk or normal pregnancies, the field has thought much more about the psychological birth of the infant than about the psychological birth of the parent. The process of becoming a parent begins at conception but does not end with birth; it continues for many months and perhaps years thereafter, changing in shape, theme and tone many times. The psychological dimensions of pregnancy, labor and delivery are always both real events and profound symbols. To thoroughly understand a mother and father, the provider needs to attend to actual events and to the many perceptions and affects with

which parents respond to these events.

Unit 3 deals with the psychology of pregnancy as a normal family event. But it also takes notice of the possibility and potentially negative impact of stress, unresolved conflicts and high-risk conditions and medical emergencies. Pregnancy and birth and the circumstances therein lay an important foundation to the complex and continuous developmental process of parenthood.

Essential Concepts

emotional tasks in pregnancy: the issues a mother or father needs to identify, feel, talk about and understand in order to cope with the emotional ups and downs of pregnancy and to prepare for parenthood; emotional tasks accompany all developmental stages and propel psychological growth.

binding-in: the mother's incorporation of the child into her sense of self, making the child meaningful and essential to her; an aspect of bonding and attachment that begins during pregnancy and is a task of pregnancy.

merging: during pregnancy, the mother's sense of physical and psychological oneness with the fetus, seeing the fetus as part of herself and her body.

preterm infant: infants born after fewer than 37 weeks gestation and weighing less than 2,500g.

social support: during the pregnancy and postpartum periods, the attentiveness and receptivity (and at times concrete help) provided to mother and father, facilitates parental attachment to the infant, parental tolerance of normal ambivalence, management of uncertainty and other stresses, and incorporation of the new child into the family's interpersonal world.

Assignments and Notes

1. Read the following material in the text or elsewhere:

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Application

Overarching Themes and Central Points

1. Pregnancy represents a crisis and an opportunity for maturation and identity reformulation.
2. Accomplishment of the intense emotional tasks of pregnancy prepares the mother for caring for the newborn, both physically and psychologically.
3. Men appear to experience changing emotional stages throughout their wives' pregnancies, also having an opportunity to rework earlier relationships and to achieve new levels of personality integration.
4. Complications of pregnancy, economic and family stress, religious background, family and other social supports, the strength of the marriage and the ego strengths of the prospective mother and father all affect the degree to which pregnancy will be a growth experience.
5. Parental bonding to the infant begins during pregnancy, as the parent "fantasizes" about the child to be born.
6. The processes by which the mother is able to "take-in" her child, and to bond early on include her identification of and with the child's essential characteristics, her claiming the infant as her own, and her moving away from seeing the newborn as a part of her body to coming to see the infant as a distinct person.
7. Emotional disturbances during pregnancy are related to the woman's experiences with her own mother, her personality stability, her support from others, her feelings about the pregnancy, hormonal shifts during pregnancy, and her general physical condition.
8. Though the transition to parenthood is intense, it is gradual; through successfully caring for their newborns, parents usually achieve a growing sense of mastery and competence.
9. The birth of a full-term, healthy infant can spur major family adjustments; the birth of a premature or ill child can precipitate an overwhelming personal and family crisis.
10. Preterm or ill infants and their parents suffer a disadvantage in that they each experience early threats to the development of respective confidence, due to infants' decreased alertness, greater reactivity to sights and sounds, greater irritability and the barriers to interaction posed by medical emergencies and necessary medical technology.

11. Parents and infants are generally able to compensate for early interactive stresses; for example, the differences between preterm mother-infant pairs and their full-term counterparts seem to disappear by the end of the first year.

12. Social support to new or renewed parents is critical to the adjustment of the birth of an infant.

Self-Study Questions

1. If you know well a woman who is pregnant, have a heart-to-heart discussion with her about her feelings and responses, determine if you can what stage/task of pregnancy she might be experiencing.

2. Interview a "pregnant" father and write a report of the interview: discuss his feelings about the pregnancy, his view of himself as a prospective father, his attitudes towards his wife's changing body, how he has experienced any possible changes in himself since knowledge of the conception, and other aspects of his adjustment to and experiencing of the pregnancy. How might this man's feelings affect his relationship to his infant after birth?

3. Assume that you are going to begin a support group for first-time, newly pregnant couples and there will be six sessions of 2-hours each. Create a supportive program: describe what the focus of each session will be, your objectives as a group leader, and the reasons behind your choice of topics/activities.

4. Why are subsequent pregnancies so emotionally difficult for women and men who have experienced a stillbirth, a miscarriage or other reproductive difficulty?

5. It has been reported widely that many teenage girls hide their pregnancies for as long as possible, wearing tight jeans, for example, until well into the sixth or seventh month of pregnancy. Think about maternal tasks in pregnancy and stages of adaptation to pregnancy. What might be going on in the minds and hearts of these teenagers?

6. Many young girls and boys, especially from poor backgrounds, repeatedly give birth out of wedlock; some have said that these pregnancies represent one of the few sources of "success" or "achievement" available to such young parents. Comment on this idea, with regard to the relationship between pregnancy and identity reformulation.

7. What are the problems which premature infants and their parents may have in early interactions? What factors are thought to make early interactions stressful for the premature infant and family?

8. Interview a social worker who works in a neonatal intensive care unit. What is this person's workday? What services does he/she offer to families who have given birth prematurely? What issues need to be worked through? How does the social worker feel about his/her job and what emotional supports are available to this worker?

9. We do not know a great deal about the psychology of pregnancy and childbirth. What do you think we need to understand better? What might be the psychological impact of a mother's encounter with technological procedures such as ultrasound, amniocentesis, fetal heart monitors and induction of labor?

10. Obtain permission from an instructor to attend a Lamaze or other childbirth education class. What questions do the expectant mothers and fathers ask? How do they relate to one another? Try to talk to some prospective parents about why they chose such a class and what it might mean to their experiencing of the pregnancy.

11. Were you ever pregnant or was your wife or mate pregnant with your child? Did you receive support from friends and family? What forms did the support take? How did you react to the involvement of your family and friends? Did it influence the way you responded to the birth of your child?

12. Consider the "high-risk" pregnancy, with its potential for medical complications for the mother and fetus or infant. What are the possible ways such a pregnancy could alter the parent's psychological reactions to pregnancy and childbirth?

Comments and Questions:

Unit 4
Conducting an Infant Mental Health Family Assessment

"While it's hard to know for sure, it's probably safe to assume feelings by facial expression—contentedness, consternation, unhappiness, happiness, pain or discomfort. He has a great pout, it amazes me it's so instinctual. I love walking with him from one place to another, watching him focus intently on each place, trying to imprint the memory of it in his mind. Already it seems as if he is quite aware of familiar surroundings and is more and more sensitive to new places, being somewhat hesitant and not so quick with sticking his neck out in interest."

"She has always been very alert and enjoyed staring at pictures and objects from day 1. She also started vocalizing at around 5 or 6 weeks and she loves to coo, screech, and babble endlessly. At 4 months she is starting to try and imitate sounds. She really watches my mouth as if she's trying to figure out how to do what I'm doing."

Introduction to Unit

Unit Objectives

1. To describe the knowledge base from which practitioners conduct an assessment of the infant, the young child, and the family.
2. To describe some symptoms or indicators of emotional problems during infancy and early childhood.

Unit Overview

What are the ways in which clinicians evaluate the emotional health of infants and very young children and their parents or primary caregivers? A great deal of sophistication is required to ferret out the probable causes of infant distress, seen in such behaviors as excessive crying, extreme social withdrawal, sleep disturbances, chronic illness, or non-organic failure to thrive. Older children may exhibit peer problems, behavior disturbances, language delays, anxiety or other affective

problems. Attentive parents usually come to know their children very well. Sometimes, however, circumstances stress a parent's abilities to discern or allow themselves to see problems. Professionals may need to assist them in understanding their children's behavior. The contributing factors to problems in early childhood can lie in the physical environment, the parent(s) personalities, the structure or functioning of the family, the infant's temperament, the nature of parent-infant interactions, or to a combination of factors. More often than not, there are multiple causes to emotional distress in ongoing children.

The basic components of an infant mental health assessment are the establishment of rapport with the parents, the taking of an extensive social and family history, an evaluation of the infant's cognitive, social, emotional and physical development, observation of parent-infant interactions, and exploration with the parents of their situation, feelings and needs. The clinician learns as much as possible about the parent's perception of self as a parent, his/her perceptions of the infant, and the manner in which current parenting and feelings toward the infant might derive from the parent's past relationships. The family system and ecology are also analyzed for their impact on the infant's and parental functioning. Interviews, observations, usage of tools or assessment procedures, such as testing or videotaping, and collection of reports from medical and other providers are frequently undertaken. Play sessions and separate interviews can occur with a toddler or preschooler.

There is a trend in early intervention for clinical assessments to be comprehensive. A variety of professionals representing not only the mental health fields (social work, psychiatry, psychology, psychiatric nursing) but also the fields of nutrition, education, physical and occupational therapy, speech and hearing, day care, and health, each contribute to the overall understanding of the infant's and family's strengths and limitations.

It is essential that the infant mental health clinician's focus not be one-dimensional. A clinician needs to be mindful that the young child, and also a parent, can experience emotional problems due to physical limitations or learning disabilities, such as handicaps or developmental delays. Such problems are often labeled as psychological problems of physical origin. There are also physical problems of psychological origin. Because of these complexities, infant clinicians often work closely with professionals from a variety of disciplines, each standing ready to re-assess the infant regularly in order to arrive at the most comprehensive assessment and ensuing treatment plan. If multiple services are ultimately provided, it is preferable that some *one* person assume the role of case manager to coordinate services.

At times, extended assessments are necessary for the purpose of

arriving at an in-depth understanding of the parents, who are themselves developing in complex ways during their child's first four years. As trust builds between parent and clinician, the parent is often more able to disclose important details about his or her needs, feelings and backgrounds and his observations of the young child. In actuality, assessment and treatment are each continuous, interdependent, professional activities.

The overarching goal of assessment is not just data collection and clinical analysis nor is it a determination of an intervention plan. An effective infant mental health assessment maintains a primary focus on creating a *supportive atmosphere* for the parent and infant, to work *with* the parent *on behalf* of the infant. Whether in obtaining a family history or recommending a service plan, the clinician needs to communicate empathy and respect for the complex role and authority of the parents. Searching for important information to explain behaviors and problems cannot override expression of empathy and concern, or else parents will experience a sense of loss. The clinician needs to be ever-mindful of the parents' unique ways of communicating their most intense feelings and to be respectful of the parents' defenses and coping styles. Parents are *treatment allies* and an assessment is the first stage of treatment. Unit 4 addresses several components of clinical assessment. It considers infant assessment and also assessment of the preschool child, in the content of family relationships.

Essential Concepts

clinical assessment: exploration of the psychodynamic components of an infant-parent relationship, such as the contribution made to the quality of interactions by parental personality and history, by child's temperament or by family situation; usually woven into the initial establishment of a working relationship between clinician and parent/ infant, during which time the focus of the clinical work is identified and clarified.

the language of parent-infant interaction: what a clinician hears and sees during assessment and treatment, consisting of everything the parent and infant do which communicate their feelings and relationship with one another; understood through the clinician's attention to posture, shifts in position, gaze focus or aversion, touching and movement, bodily tensions, timing of responses, expressions of pleasure and distress, special infant-parent games and rituals.

Bayley Scales of Infant Development: a widely used, highly researched assessment tool which determines an infant's developmental age in the motor, social and cognitive realms and compares the infant's score to standardized norms for children of the same chronological age.

reactive attachment disorder: the absence or distortion of developmentally expected social interactions between infants and their caregivers, as related to deficits in caregiving.

infantile autism: a condition noted by distortions in a child's language and social development, such as lack of responsiveness to people, bizarre behavior, and poor or absent verbal communication skills.

failure to thrive syndrome: a serious medical condition characterized by weight and growth at or below the third percentile following an initially normal growth curve; "non-organic FTT" refers to an absence of an organic or physiological cause for the child's growth retardation.

individual differences: the notion that each child develops in a unique manner, both in comparison to other children, and in one developmental area (e.g., language) as compared to another (e.g., motor abilities); an important notion in that it suggests caution in the definition of "normality" for a given child; individual differences are observed as early as the first days of life.

normative data: an approach to assessment that consists of data comparing a given child to some accepted norm, without regard to its consequences to the child, the family or society.

social validity data: an approach to assessment that consists of the adaptability of a child's behavior or characteristic with regard to the larger society.

adjustment data: an approach to assessment that considers current and future implications in all aspects of development.

learned helplessness: an attitude developed during repeatedly unsuccessful attempts to cope with stress where a child comes to see himself as ineffective, incapable or helpless; associated with childhood depression.

ecological intervention: a comprehensive service delivery designed to meet basic needs, such as health care, nutrition, housing, social, and employment opportunities.

competence: the child's mastering of basic tasks, currently thought to be the appropriate aim of early intervention; refers to a broad measure of the child's abilities and suggests that intellectual gains can be mediated by changes in other realms such as motivation, curiosity, attention span, persistence and the like.

Assignments and Notes

1. Read the following material in the text or elsewhere.

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Application

Overarching Themes and Central Points

1. The manner in which a referral is made to a clinical infant/parent program has a great deal of impact on the initial relations between parent and clinician.
2. During a clinical assessment, it is important to set the stage for treatment by facilitating the parent's trust in the clinician.
3. A lack of trust in professionals, as well as limited understanding of the causes or depth of their feelings often inhibit parents from easily revealing to a professional the nature of their parenting difficulties.
4. Clinicians need to be sensitive to their own feelings in assessing and working with distressed infants and their parents, particularly with regard to their ambivalence to hearing about the parent's or infant's inner pain.
5. The infant mental health practitioner learns about the depth of the parent's emotional concerns through the unique language of a given parent-infant interaction.
6. At times, an extended period is necessary to complete an infant-parent assessment; home visits, observations of parent-infant interaction and attachment, developmental assessment of the infant, assessment of the play of the toddler or preschooler, assessment of parenting capacities and parental personality conflicts are some of the techniques utilized in a clinical assessment.
7. A clinical assessment of an infant's emotional status requires an understanding of the quality of the child's attachments and expression of affects.
8. A child's developmental level is a unique combination of genetic-organic characteristics and environmental factors; as a child develops, he needs multiple relationships, including those with peers.
9. Play is exceedingly important during the preschool years; through play, the clinician can observe a child's intellectual, language, and social development, as well as his orientation to caregiving situations and fantasy.
10. Diagnoses of infant psychological disorders should be made cautiously and after an extended evaluation of the infant, the caregivers and the environment.

Self-Study Questions

1. What are some of the areas which should be addressed in an initial interview of a parent with an infant known to be showing signs of emotional distress? How would you phrase your questions in order to be supportive to the parent?

2. Describe why some parents might be reluctant to openly and fully reveal their feelings and concerns to an infant mental health practitioner during the first visit.

3. Think about a situation of a depressed, reticent young mother referred to you by protective services for alleged neglect of her nine month old baby. You are the worker and are meeting this mother and baby for the first time. Take a piece of paper and write down a conversation you might imagine yourself having with this client; how would you introduce yourself? How would you introduce the presenting problem or the facts of the referral? If this woman were reluctant to give you much detail, how might you respond? Cover the first fifteen minutes of imagined interaction. Then: how are you feeling? what are your concerns?

4. Why is the manner in which someone makes a referral to an infant mental health program important? What can go "wrong?"

5. How do you feel in reading Selma Fraiberg's articles on clinical assessment in *Clinical Studies in Infant Mental Health* (1980)? What does she convey in her writing?

6. Fraiberg repetitively comments on the housekeeping of the mother in the first case she describes in her chapter on clinical assessment, noting that housekeeping is not the same as child caring. Why do you think she makes this point so often?

7. What would you consider to be a comprehensive assessment of a young child and a family? What needs to be covered? Why?

8. In play, a four-year old girl speaks the voice of a "mommy" talking to her "baby" and states, "Now, it's time to eat and I want you to eat all your food today. Then we'll go for a walk and then have a bath and go to bed. OK?" What do you observe in this fantasy play? How can a clinician use a child's fantasy-play while conducting an assessment?

9. Define "case manager." What are some dilemmas a case manager might face during an assessment phase on a case of a multiply-delayed, two year old who lives with a foster family and was two months ago removed from the home of her birth parents for severe neglect? What kind(s) of assessment might be advisable in this situation?

Comments and Questions:

Unit 5
The Newborn's Capabilities and Temperament: What He Brings to His Parents

"I would say watch a baby's face and take your cues from there. A baby's face is worth a thousand words. S/he'll tell you everything you need to know if you'll take the time to hear and see it."

"At six weeks he would sit for 20-40 minutes in a Baby Bjorn seat looking outside and amusing himself! He learned to smile at six weeks which is pretty normal but by now—10 weeks, he has learned to be quite a flirt and will bat his eyes, coo and look slightly at an angle at the person he is smiling towards. He has since his first week, had a very strong neck and at 2 months, is pushing himself into a standing position while held against the body or upright slightly away, holding his legs very straight and feet firmly planted on my legs."

Introduction to Unit

Unit Objectives

1. To become acquainted with the social, cognitive, and motor abilities of the newborn infant.
2. To understand how the considerable abilities of the newborn enable him or her to make use of the vast opportunities for social learning in just the first year of life.

Unit Overview

A newborn baby is fascinating to watch. It has been said that not even a world-class athlete can imitate a baby's body movement for more than a half a day without succumbing to exhaustion! Newborns vocalize a range of sounds, move almost constantly while awake, and studiously absorb probably more information about their environment than do their caregivers. Everything is of interest to a healthy newborn. In the first year of life, the child will learn, grow and change more than at any other time.

Researchers are continuously learning—to their amazement—how capable newborns and infants really are. Before their mothers have completed the postpartum period, they can discriminate familiar from unfamiliar objects, demonstrate preference for (perhaps recognition of) the female or high-pitched voice, indicate preference for their own rather than another mother's milk, and match what they hear on tape-recorded sounds to the mouth motions of a speaker. These and many other infant abilities are learned through fascinating research techniques that give the baby a chance to enlighten adults and forever discard the once tenaciously held notion that the infant began life as a "blank slate."

The major implication of the burgeoning knowledge of infant capabilities is for clinicians to acknowledge the infant as an *active* organizer of ideas, images, feelings and experiences. That is, what the infant sees, hears and thinks about—his basic experiences—have some impact. Early events and occurrences, then, are not without consequence.

Of what consequence are early experiences? Particularly of concern is potentially harmful stimulation. For example, if an infant experiences prolonged physical pain during a hospitalization for a sickness, how does he "make sense" of what is happening to him? If a separation from mother occurs, how long does her absence have to be before the infant comes to feel that he cannot keep a loved one near him? How can we buffer infants for inevitable stresses, such as necessary separations or medical procedures, so that they may be more resilient? Are there some infants, who by their nature, are more vulnerable to certain stresses?

Many other questions have been raised in an exciting array of responses to the infancy research of the past twenty years. The process by which infants come to develop a sense of themselves, the progression of the emergence of unmistakable emotions over the course of the first twelve months, and the infant's use of his primary social relationships as a developmental anchor are issues around which researchers and clinicians have invested a great deal of attention.

Despite the field's enthusiasm, the subject matter of infant capabilities is not without its controversies. A central point of debate, for example, has been the question of the duration of the impact of an event early in the life of a baby. If, for example, a trauma has occurred—a baby has been removed from the care of his birth mother for reasons of severe abuse and placed in foster care at age eight months—most people will accept that the trauma will have an impact. But, if the child's situation improves thereafter, if the foster mother is a sensitive caregiver and no successive traumas occur to the baby, then, how long will the effects of the original insult remain? Some researchers and theoreticians feel that the consequences of such a trauma leave a permanent mark; others state that the human being is more resilient than this,

given that basic needs are met *after* a severe trauma. Still others state that an interaction of factors, such as the child's level of intelligence, temperament, living situation, successive learning opportunities, later relationships, particular physical limitations, and the availability of social support, all mediate the impact of any adverse experience.

The debates will continue for some time, as will the inventive and productive research which has introduced us to the complex world of the newborn and young baby. Unit 5 presents some of the findings of research on infant capacities.

Essential Concepts

environment: the psychological structure of the family, but also the social, economic, and physical conditions of life facing an infant.

efficacy: an infant's competence to perform tasks, interact with others, manage a social environment; also, a parent's sense of being able to positively affect his/her baby or child and have some degree of control over what happens to the child and how the child grows; for each, a sense of efficacy is a sense of personal competence.

effectance motivation: an intrinsic urge to interact effectively with the environment; a motivation to be competent in the world.

contingency experience: experiences which are controlled by or dependent upon the infant's behavior, particularly when the infant can make the intellectual connection between his behavior and its consequences.

readability: the extent to which the infant provides clear signals and cues regarding his state of arousal, hunger, fatigue, distress, and over- or under-reaction to stimulation.

predictability: the extent to which the infant's behavior and responses to events can reliably be anticipated from contextual clues and patterns; regularity, as in sleep/wake and feeding cycles, states of arousal, and responses to stimulation.

responsiveness: the quality and duration of infant responses to such stimuli as the human voice, to being held by caregivers, or to their efforts to console, comfort, play and communicate with the infant, or reactions to the movement of toys or any objects; a responsive baby responds quickly to stimulation in an appropriate/expectable manner.

Apgar score: the traditional and most universal measure of newborn well-being in the delivery room, having five categories: color, respiratory effort, cardiac effort, body tone, and responsiveness to aversive stimuli.

54 **Brazelton Neonatal Behavioral Assessment Scale:** an evaluation scale developed by Dr. T. Berry Brazelton to test and document the newborn infant's state of behavior and reactions to various kinds of stimulation.

Assignment and Notes

1. Read the following material in the text or elsewhere:

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Application

Overarching Themes and Central Points

1. Babies know even at birth a lot more than people used to think.
2. The infant possesses remarkable physical and cognitive abilities as well as complex social skills.
3. The infant is preadapted to be selectively attentive to the social stimulation offered by adults.
4. A prolonged period of motoric dependency in infancy allows for the development of unique styles of feeling, relating, coping, and entering into a given culture.
5. An infant is capable of attracting and guiding his parents, helping them to feel effective in their new roles, and actually relating differently to mother and father's special styles.
6. The social games of infants and parents help to provide the infant with contingency experiences, contributing to the infant's sense of effectance, or mastery.
7. Readable, predictable, and responsive infants reinforce parental confidence in themselves and in the infant's own capacity to survive and develop normally.
8. Establishing clear, understandable social and behavioral expectations is one of the most important tasks of the infants and parents.
9. An infant difficult to read or predict and slow to respond can generate feelings of helplessness in his parents.
10. Families of unpredictable, unresponsive infants need special social supports to strengthen their inner resources in order to maintain an ability to identify with the infant and sustain a sense of their own competence.
11. Professional support and positive feedback to parents about their own capacities and about their baby's abilities bolsters their self-esteem as parents and alerts them to the individual needs of their babies; this is all the more helpful to parents of babies with physiological limitations or problems.

Self-Study Questions

1. Define efficacy and explain how infants and parents come to feel a sense of efficacy.

2. Name four capabilities of newborns which are related to their abilities to quickly engage with their caregivers.

3. Observe for ten or fifteen minutes an infant between the age of one day and one month; describe your feelings in observing him or her. Is the infant easily "readable"? What feeling states did you observe in the infant? How did you come to understand the infant? What signals and cues did the baby give?

4. Interview the parent of an infant. Ask the parent to describe in detail how he or she knows when the infant is sleepy, bored, hungry or interested in some inanimate object in the environment. Then ask the parent how she or he is sure that these are the feeling states the infant is experiencing: is the parent describing a readable, predictable, responsive infant?

5. Think about the assertion that infants are biologically programmed for social engagement from the moment of birth; do you agree or disagree or would you qualify this statement? Why?

6. A mother of a three year old boy comes to your agency asking for help. The child is staging enormous, long temper tantrums lasting one to three hours. The mother states that the child was "difficult" from birth. In obtaining a developmental history on the child, what questions would you ask about the child's infancy?

7. Try to have a newborn imitate something you do, such as sticking out your tongue. Describe what you observe.

Comments and Questions:

Unit 6
Impact on the Family of the Birth of a Sick or Handicapped Infant

"They didn't know whether my son would live or die. He had severe respiratory distress and numerous complications. One doctor even told me I might want to place him in care. No one would talk about death, but I knew, I sensed something was desperately wrong with him."

"I remember the morning after she was born. I was just getting back all the sensation in my legs after the C-section. The pediatrician came in and he had a long, serious expression on his face. He began to tell me he had already ordered a blood test on my daughter and the results looked 'good.' Then came the bad news; he'd ordered the test because she had a heart defect. He said she seemed okay but we'd have to see if she gained weight to be really sure; I thought to myself, 'God, I can't take anymore' and I went numb."

"Now, he's a bright, bouncy, vibrant little boy and even though he has severe problems, he can't yet walk on his own—he has a great disposition and self-esteem as high as the ceiling. But I worry about what will happen when he enters first grade soon. Will those teachers let him thrive? Will kids make fun of him? Will all the good care now around him later evaporate? Can he take these assaults? Can I?"

Introduction to Unit

Unit Objectives

1. To describe the emotional reactions many parents and families have to the birth of a handicapped or very sick infant.
2. To describe some clinical interventions that are supportive to families as they adjust to the caregiving challenges in incorporating a handicapped or very sick infant into the family.

Unit Overview

When many parents greet an alive, squirming, breathing, hearing and seeing newborn and learn that their baby is healthy and intact, they

experience one of life's greatest feelings of relief. Unfortunately some parents encounter the opposite experience. They sense or they hear that their baby is not healthy, not intact, but "handicapped" or "defective." For these parents, such news can be shocking, and the immediate or delayed feelings which surface are often overwhelming.

Complex parental and family reactions develop around the birth of a very sick infant with a potentially life-threatening or debilitating illness or a handicapped infant whose potential is unclear. These reactions occur on multiple levels. First, there is the profound challenge to the parent's ego to mesh the previous expectations of the in utero infant with images of the real infant, whose birth they witnessed and whose characteristics they see or soon discover. The reality is jolting, and even if the parents anticipated problems, they can never be enough prepared.

Second, and related to the initial shock, is an inevitable period of grieving for the parents and their family members. After the shock come other stages of grief, including denial, intense sadness, and anger. Down the road—but not until a great deal of emotional working through has occurred—there will be some resolution and acceptance. The course of this grieving, however, cannot be predicted.

Third, parents must learn about the infant's current medical condition, his specific limitations, the procedures which might be available to manage the medical problems, the probability of survival, and the chances of healthy development. Incorporating such information on an intellectual level is extremely difficult in any situation. Where the parents feel shock, disappointment and a host of other difficult feelings, hearing and absorbing these facts might be impossible.

Fourth, parents face caregiving responsibilities in the context of an uncertain future. Even when all the medical knowledge has been communicated, many details often remain unknown. There may not be a definitive diagnosis. Treatments can be experimental and risky. Babies' stamina cannot be foreseen. Yet, the infant still needs to be fed and cared for in the most basic of ways. In many instances, special medications, equipment, caregiving procedures, clothing and other commodities are required, but parents frequently do not know this in advance. Such actual, practical, concrete challenges are superimposed on parents' emotional distress.

Fifth, difficult decisions must often be made on insufficient information and perhaps conflicting advice from unknown, and as yet untrusted, professionals.

Finally, the birth of a very sick or handicapped infant is a far less private venture than is the birth of a healthy infant. The vulnerable infant can be surrounded by pediatricians, neonatologists, family physicians, maternity nurses, public health nurses, surgeons, occupational and physical therapists, social workers, and other professionals. Coor-

dination of services can drain parents' time and energies and compound their stress. Some professionals unwittingly leave emotional scars through naive, unthinking comments, such as, "It might be better to place the baby in a nursing home; she will never be able to accomplish anything." Such statements hurt. They also belie the unique persistence of infants who somehow overcome severe obstacles and parents whose advocacy and creative problem solving rise to the challenge.

Even sensitive professionals, while so often essential to the well-being of everyone in the family, are nonetheless not part of the family. The boundaries of the family, then, change and widen, often without the parents' invitation or approval. The birth becomes a community event, the child and family entering into a subpopulation of "special needs kids and their families."

The emotional and the physical work of parenting a very sick or handicapped child is grueling. It raises issues of one's vulnerabilities, immortality, identity, basic trust, self-confidence, problem-solving capabilities, and even one's orientation to time—all at the same time it causes to surface parents' basic passions to protect, nurture and save their children. While dealing with these feelings, they still must get on with the rest of their lives, in work, with other children, in their marriage and friendships.

The families of vulnerable children are themselves vulnerable. It cannot be emphasized enough that professional work with them must be highly sensitive, respectful, patient, and ever mindful of the importance of individual differences. Professionals need to stand ready to learn from parents about their young children, to allow them a broad measure of control over what happens to their children, and to offer them continuous opportunities to refuel themselves in their own unique ways.

Unit 6 deals with the many different responses families have to the birth of a handicapped or ill infant. Central to this study is a viewpoint as to what professionals can do to support and optimize the capabilities of parents and infants, in the context of what life has brought them and what the helping network can offer.

Essential Concepts

grieving: a normal, adaptive response to significant loss, consisting of a number of physical and psychological symptoms; usually lasting from six months to one year but can be much longer; stages include shock, denial, sadness, anxiety, anger, guilt and reorganization.

denial: a parent's disbelief of a reality, avoidance or unawareness of the import of an event, such as denial of the pervasive ramifications of an infant's handicaps.

vulnerable child syndrome: a difficulty in the parent-child relationship, related to early parental expectations of the child's death and caused by actual serious illnesses, or by parental memories of the death of other loved ones or displaced fears of maternal death during pregnancy or childbirth.

narcissistic injury: in parents, an assault to parental self-esteem, the lowering of positive feelings toward the self, such as may occur with the birth of a sick, handicapped, or premature infant, or with infertility or other reproductive casualties.

parental adjustment: in the case of a family crisis surrounding childbirth or postpartum period, the parents coming to accept the child as he or she is, their incorporation of the child into their family and social relationships, resumption of marital and parenting tasks in general, and integration of the meaning of the birth experience into their lives.

parent involvement: an attitude and an activity, the increased role played by parents of handicapped children as their teachers, advisors, and advocates; the idea that parents are resources for professionals; examples of parent involvement include parent-teacher discussion groups, parents as classroom aides, parents as instructors, and peer counselors.

Assignments and Notes

1. Read the following material in the text or elsewhere:

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Application

Overarching Themes and Central Points

1. The birth of a handicapped infant is an assault on parental self-esteem.
2. Parents are in great need of empathic listeners at the time of the crisis of the birth of a handicapped or sick infant.
3. Experiencing strong feelings of loss over the birth of an infant who fails to meet their fantasies or expectations, parents often go through a grieving process.
4. It is very important for parents to proceed with grieving at their own pace and style.
5. Many factors affect parental adjustment to the birth of a handicapped infant, including the manner in which they learned of the infant's problems, the type of medical interventions required, the extent and appearance of the defect, the infant's temperament, the infant's capacity to be social and to self-regulate, and the infant's ability to develop physically and cognitively.
6. Also important in a family's adjustment are the family's religious orientation, the degree of supportiveness from their extended family and friends, and the stability of their own personalities and prior family functioning.
7. Parents who experience the handicapped infant as an extension of themselves, for example, of their "badness" or "failure" have a more difficult time adjusting to the infant and forming a healthy attachment than do parents who come to see the infant as a separate individual.
8. Maladaptive, unhealthy responses to the birth of a sick or handicapped child include intense or hostile rage, prolonged denial, overidentification with the child, persistent detachment from the child, psychosomatic illness, chronic mourning, and marked overprotectiveness of the infant.
9. A parent's continuing reactions to a past, acute, life-threatening event such as a severe illness experienced by the child may have long-term, psychologically adverse consequences.
10. Over time, fearful parents unconsciously convey to their child their worry over the child's future, the child may come to take on the same worries and see himself as vulnerable, damaged, or somehow endangered.

11. The stresses of raising a handicapped or very ill child can put considerable strain on marriages and other family relationships.
12. A combination of behavioral techniques and reflective, insight-oriented psychotherapy seems to be the most helpful psychological services to parents of handicapped children.

Self-Study Questions

1. Name five helpful things which a nurse or social worker could do for a family grieving the birth of a handicapped or sick infant.

2. Why is it important that people refrain from making the following such comments to parents after the death of newborns: "It's okay, you can always have another baby." or "At least you didn't get to live with him - then you'd really be attached to him."

3. Describe some of the influences on parental reactions to the birth of a handicapped or sick infant.

4. Interview a maternity nurse about her own feelings in caring for handicapped or sick infants and their mothers during their hospital stays; what feelings does she experience and how does she handle them?

5. Define the vulnerable child syndrome. What are some of the symptoms or characteristics of these children and their parents?

6. Presume that you are establishing a support group for parents of physically handicapped infants under twelve months: describe your program design, including the way you would recruit group members, how many parents you would involve, the number of sessions, the focus of the sessions and the groups' goals and objectives.

7. Arrange to visit two programs in your community which work with handicapped young children and their families; describe these programs, contrast and compare their philosophies and approaches to working with this population, the services they provide, the children they work with, and your evaluation of their strengths and limitations.

8. What are some ways in which non-disabled siblings of the disabled might be affected, both positively and adversely, by the impact of their sibling's disabilities?

9. Consider how you personally would feel in giving birth to or fathering a handicapped, or very sick newborn. Describe what you can imagine yourself feeling. Are there any experiences involving crisis or loss in your life in the past which would affect your response to such a birth?

10. Define parental adjustment in your own terms; in the case of a parent of a handicapped or very sick infant, what would you presume to be the process by which the parent achieves a state of adjustment? What factors impede and/or further the movement toward adjustment?

11. How do you personally respond to individual differences? How do you react to young children with significant and visible handicaps?

Comments and Questions:

Unit 7
Special Issues in Infant Mental Health Practice

"I get so frustrated when I see a family that could use help from protective services, some information, support, monitoring . . . but they can't take the referral unless the child has really been harmed." (Child development worker)

"I don't feel that much is going on when I go into their home. The mother has the television on, the father and his friends are in and out, in and out, the baby is crying. It's the same, week after week. But if I have to cancel an appointment, she gets mad and disappointed; I can tell she wants me. Maybe I'm doing something *. . ." (Home visitor)*

"Terry first came to our clinic when she was a teenage mom with an 18 month old. She was sullen and resisted our help. She just delivered her second baby, 3 years later. Our nurse was her labor coach. Terry talked and felt every step of the way. The difference in her bonding to her two children is remarkable. Someone was there for her this time." (Social worker)

Introduction to Unit

Unit Objectives

1. To identify and explore some common issues faced by infant mental health practitioners.
2. To understand some of the resources available to infant mental health practitioners.

Unit Overview

Hearing the intense crying of an inconsolable infant is unsettling. The vacant stare and unexpectedly small size of a failure to thrive baby is unforgettable. A mother's remembrance of the day her own mother walked out of her life is heartbreaking. After three successive attempts to conduct a home visit, to find the family gone and the front door locked, the forebearing clinician encounters extreme frustration. These relatively common scenarios in infant mental health practice throw demanding challenges in the pathway of the clinician.

There are a number of special challenges and resources in the work of an infant mental health professional. The notion of the working alliance between the clinician and the parent, a trusting relationship revolving around a shared interest in the baby's well-being, is at the heart of many of these special issues: clinical use of the self; productive use of the parent; appropriate use of technology; interface with the child welfare and service systems; and, assurance of interdisciplinary coordination.

Clinical use of the self. In any form of psychological service, the professional who strives to learn from his or her own personal feelings and reactions is more equipped to understand the client. Why am I feeling so emotionally distant today? What am I angry about in this encounter? I am feeling discouraged and pessimistic—did something happen in the last one or two appointments? For the last ten minutes, I've been mulling over this image of a sad child in my head but the person before me is smiling; what can I make of my inner images in light of the client's messages to me? These examples of questions addressed to the self, quietly and typically right before, during or right after a session, are extraordinarily important clues to the nature of the parents' communications, struggles, and feelings about treatment.

In understanding complex reactions of clients to interventions, the clinician's ability to use the self is essential. So often, a parent will make casual statements to a worker about the baby. For example, just as the worker is leaving the home after a visit, the mother might blurt out, "She'll probably cry all night now. She does that when people leave." The worker feels a sense of dread for a long time, and then finally traces her feelings to the mother's statement. Is the worker sensing the mother's *own* feeling of dread? Was the mother talking about *herself*, implying that she felt as though she were being abandoned by the therapist? Does the worker's sense of dread indicate the possibility that the mother is preparing to abandon the therapist, or the baby, before she feels abandoned herself by one or both? Based upon these hunches, the clinician can reach out to the mother in a supportive manner and work with the mother to anticipate feelings before acting them out. The clinician also works with his or her own feelings about the situation so that personal conflicts do not obstruct an ability to hear the client and respond empathically.

Clinical use of the self also refers to sensitive and knowledgeable management of the way the clinician carries him or herself into the family's life. What questions about one's personal life ought to be answered, for example, for the sake of the beginning working alliance without transgressing necessary professional boundaries? How can the clinician be a real person and still work toward and talk about the meaning behind such questions? Clinical use of the self also means

using to clinical advantage one's personal qualities, such as warmth, sensitivity, natural interest in babies, and the urge to help others.

In infant mental health work, once called "kitchen therapy" by Selma Fraiberg, the traditional boundaries between client and professional are blurred when the office is, in fact, the kitchen or the living room. Learning to work in these often distracting settings can be a special challenge.

The best vehicles for learning to use one's self to identify indicators of transference or countertransference are supervision, consultation,, and detailed process recording. Such skills develop over time and are always refined with ongoing, professional experiences.

Clinical use of the parent. Just as the clinician uses his or her own personal qualities to inform the treatment decisions, so also must the clinician assess the *resources of the parent.* What special qualities does the parent demonstrate and how can these qualities be acknowledged respectfully and not condescendingly? How can they be reinforced and introduced into the work of parent-infant treatment? Essentially, one asks the parent to be both treatment ally and patient/client at the same time. Learning to help the parent play this dual role is a unique task of the infant mental health worker, or of anyone conducting child psychotherapy while also working with the parent.

In the past, the medical model dictated that the power, the authority, and the knowledge rested with the medical treatment provider. The preferred way to look at the patient was as a recipient of services. If the patient was to be active and organized, it was only to ask questions and to manage a schedule of medication. Over the years, those in the early intervention movement and the infant mental health field discarded such a hierarchically organized, medical model and came to see parents as *collaborators* in treatment.

In working with parents as partners, one of the guide posts for the infant clinician is to introduce one's work from the beginning as a joint endeavor, looking at the parent's needs and the infant's needs in tandem. The psychological birth of the infant is paralleled in importance to the psychological birth of the parent(s). We can support these developments only through the eyes and heart of the parent. There is no substitute for a depth and breadth of respect for the parent as a parent.

There is probably no parent who does not need and cannot use support for parenting at some time or another as parenthood is perhaps the most complex of human role relationships. Understanding the parental self-concept, how the parent views the self-as-parent, is a time-consuming and sensitive learning process for the clinician, and for parents themselves. The work of parenting calls upon unconscious elements of the personality which can best be discovered through a

solid working alliance. The resources the parent offers the clinician-parent team include the parent's personality, motivation to parent, love for the child, positive identification with the child, detailed observations of the child's behavior, and general urge to grow and develop.

Clinical use of technology. In the past 10-20 years, videotape technology has sufficiently advanced to be affordable and practical to use in a clinical setting. Videotaping is frequently undertaken to capture images that the clinician, and in some programs, the parent, can refer to for further study and review. For example, a videotape of the administration of the Bayley Scales of Infant Development allows the clinician to see in slow motion an infant's responses to objects and stimulation, to interaction with caregivers and others. With the aid of videotape playback, all aspects of a baby's functioning can be reviewed in detail. This technology can be especially helpful in understanding handicapped or multiply delayed children whose cues might not be easily read or whose problems are so involved that repeated viewing is informative.

Some programs have found that videotape technology also is useful in educating parents about their infant's special qualities or characteristics, or about the manner in which they are interacting with their infants. Parents sit with clinicians and view videotapes of their encounters with their children. The workers point out the child's response to specific parental requests or reactions and suggest to the parents alternative behaviors that are more suited to the infant's abilities or needs.

Some programs have reported clear-cut, short term gains for parent-infant interaction using videotape as teaching techniques, but the long-term changes in parent-child relationships are not clear. Since the field does not have documented research evidence of the usefulness of videotape playback in treatment, much more research needs to be conducted before clinicians can confidently use the videotape technology as a clinical intervention. As diagnostic aids, however, the technology is impressive.

Clinical use of the child welfare and other service systems. One of the hardest things for a clinician or family worker to contend with is a failed attempt to help a troubled baby or young child. More often than not, numerous interventions will be tried, including change in services, in workers, in setting or in agency, before professionals will make the necessary steps to place a child in substitute care. The decision-making process involved prior to taking these steps is often agonizing and confusing: what is the better plan for the child, to suffer separation from parent(s) or to continue in an abusive, neglectful, or maltreating situation? The choice is often viewed as the lesser of two or more evils, and there is frequently not enough corroborating information to feel totally at ease in one's recommendations. But the child's needs for protection override one's caution.

The child welfare system is a major resource in infant mental health work with the population of severely abused and neglected infants and, at times, also with highly overwhelmed parents in need of a respite. The infant mental health practitioner can be an important consultant to protective workers on issues such as how the separation from the parent should be made, whether visitations occur and how often, or how the substitute caregiver can manage the special needs of the infant, including making the transition to a new home and coping with the loss of the parent.

In protective work, the professional team widens. After removal of an infant from his/her home, the team can include foster parents, protective and substitute care workers, attorneys, day care providers, medical care providers, judges and others. Coordination of services and effective case management are essential for the well-being of the child. This is no easy task for the infant mental health practitioner to either accomplish or to facilitate and support.

The social service system in general is not only a resource for abused and neglected infants, it is also there for the benefit of all young children. The service network includes pediatricians, nurses and other medical specialists, speech, physical and occupational therapists, nutritionists, early childhood educators, day care providers, clergy, social workers, psychologists, and any other helping persons involved in the care of the infant or family. Where referrals are necessary, coordination, follow through, and mutual respect for one another's discipline are mandatory. Special care needs to be taken to assure that in a complex web of multiple services for multiple needs that the parents are not forgotten or set aside.

Interdisciplinary Coordination. True collaboration in treatment with other service providers involves more than effecting a referral of a young child or family to other services. It involves sharing cases and sharing perspectives. Too often clinicians feel they must manage a health problem case entirely on their own. Since a family's multiple problems can often incorporate medical, economic, housing, protective, social *and* psychological issues, it is a great benefit to the family to receive help from several different sources. But these services need to be coordinated for maximum benefit.

A primary coordinator or case manager needs to facilitate team meetings, making sure that all service providers understand one another's recommendations for treatment and the manner in which the family is responding to interventions. If each professional can communicate his or her discipline's basic orientation to diagnosis and treatment, it will be far more likely that all intervenors will reinforce the family's follow through on services. Without adequate team conferencing and case management, however, feelings of defensiveness or

territoriality, mutual suspicion, and competition for the family's approval can surface. Such concerns often lead to mixed messages to the family, whereby some parents split the team into "good" and "not good" helpers, thereby confounding problems and concerns for everyone. This can happen on any case, but when protective issues are involved, effective case management is a mandatory service for the family as well as for the service providers.

The five challenges presented in Unit 7 are only some of the issues facing clinicians who work in the infant mental health field. The field's excitement and complexity grow out of multidisciplinary constituency, each discipline combining separate theoretical and practice strengths. Its biggest challenge continues to be primary prevention on behalf of very young children and their families. Those who work with these families are awed by the richness of the lives they enter and by the depth of the issues they seek to understand.

Essential Concepts

treatment alliance: a trusting, primarily positive relationship between client and therapist, making use of the client's basic capacity for insight and self-observation, tolerance for conflict and a joint orientation towards a shared goal, all of which enable therapeutic change to take place.

countertransference: the emotional reactions of a therapist to the client or to encounters with the client which relate to unresolved issues in the therapist's own life, as opposed to realistic, expectable reactions; it often very broadly refers to the whole gamut of reactions and feelings which emerge in conducting therapy or providing service to a client.

outreach: services provided to a family outside of the traditional ones, such as home visits, telephone calls in between visits, letters with a specific clinical purpose, provision of concrete services such as transportation to medical appointments and the like: often called outreach to denote the special reaching out to hard to hold clients whose inclination is to let go of the services before they or the child have achieved any tangible gains.

parent as a resource: the idea that a parent with a problem or a parent who would function as a peer-helper each have something to teach to professionals engaged in working with a child; counters the commonly occurring attitude that it is only the professional who is in charge and equipped with answers; supports the notion that early intervention is most effective when the parent and professional form a *team* on behalf of the child.

parent involver: a person engaged by a program specifically to work with parents to increase their involvement in their children's learning and experiences while under the care of a therapist or enrolled in a specific program.

Assignments and Notes

1. Read the following material in the text or elsewhere:

2. Instructor's comments on this Unit:

3. Personal goals for this Unit:

Unit Review and Applications

Overarching Themes and Central Points

1. In infant mental health work, outreach to the parents is often necessary to sustain contact and continue the therapeutic work on behalf of the infant.

2. The infant mental health professional must take special care to hear out the parents, including their complaints against other service providers; parents' prior experiences with professionals around their sick or distressed infant may have been disheartening, judgmental or generally negative.

3. Keeping the baby's needs and well-being at the center of the clinical work can often help to alleviate parental anxiety, confusion, and ambivalence over seeking professional help.

4. The clinician needs to be aware of the possibility that any clinical interventions, be they concrete services or verbal interpretations, can increase negative transference reactions; the therapist needs to be ready to help the parent understand the nature of his/her responses to the therapy.

5. The possibilities of countertransference reactions on the part of the infant-parent clinician are intensified in situations where the infant is at risk, the parents slow to change, and/or the family's crises frequent.

6. When a parent does not have the capacity to adequately care for a child, a referral must be made to protective services; in some instances, the emotional well-being and development of a child hinges on the child's being cared for by others.

7. When a child must be removed from the home of his/her parents, or when a child dies, the helping persons grieve the loss to all concerned. This loss exerts a tremendous emotional toll; it is helpful for professionals to be willing to seek out and accept comfort and support from peers and colleagues.

8. When a family is unable to properly care for an infant but is thought eager and able to learn, educational methodologies that facilitate parental sensitivity to infant's special characteristics and needs are recommended.

9. Videotape playback can often be a useful learning tool, supporting the therapist's work and serving as a vehicle for parental self-awareness.

10. Parents who are perceived by the therapist as resources are more likely to be involved in their children's programs and more likely to work with the professional on behalf of the child.

Self-Study Questions

1. You have just received an intake form, on which is described a case of a mother who lives in a remote, rural area with a child once diagnosed as a non-organic failure to thrive baby, now discharged from the hospital. The doctor requests some "outreach services" for the family. As someone knowledgeable about infant mental health, how would you initially approach this family? What would you want to say to the parents? What would you anticipate finding?

2. You have gone to do a home visit and for the third time, no one is at home, despite your having called the mother three hours before your arrival. You know this to be "resistance." How might you understand the parent's behavior? What would you consider doing?

3. Interview someone who works with parents and babies. Ask them to talk with you about how it feels when a newborn has died. How do they cope with their feelings? Does such an experience affect their subsequent work and if so, how and for how long? What kinds of supports are available to them?

4. Define a variety of reproductive losses. How might clinicians and service providers respond to such events?

5. Consider some programs using videotape feedback, where parents are taught to better interact with their babies. What is the learning process by which mothers come to change their parenting behaviors, based on observing themselves with their infants on videotape playback? How does this learning occur?

6. What is your perspective on the short and long-term effectiveness of programs designed to teach or train parents to interact and communicate with their babies? How does a "teaching" perspective compare with a longer-term, "developmental" perspective on working with parents?

7. Give an example of a parent who has been or is very involved in his or her child's developmental or learning programs: what did this parent do? How did she or he facilitate the child's learning or use of the program? How did he or she make the program staff feel?

8. Investigate some parent support programs in your community or state. Choose two and compare them on the following: philosophy regarding parent work; target population; special needs given priority, if any; staff size; program history and funding stability; comprehensiveness of services offered. Does your area need more such parenting programs? If so why, and with regard to which client subgroups?

9. After four months of attempting to facilitate change in a parent who insufficiently attends to her healthy but delayed fifteen month old, a community health nurse is feeling discouraged. The child is beginning to walk and the home is not yet made safe for her explorations. The nurse wonders what to do next. Using a model of interdisciplinary collaboration, what kinds of service might she want to consider? How could she effect adequate case management? How would she want to involve the parent? What would be appropriate goals for this family?

10. Some people believe that clinical work with infants and very young children is much harder emotionally than is work with older children or with adults. What is your position on this?

Comments and Questions:

Suggested Readings

Unit 1: Introduction to Infant Mental Health Practice

Highly Recommended Readings

Crittenden, A. (1983). New Insights into infancy. *New York Times Magazine,* November, 84-96.

Fraiberg, S., Shapiro, V., & Cherniss, D. (1980). Treatment modalities. In S. Fraiberg (Ed), *Clinical studies in infant mental health.* New York: Basic Books Publishers, 56-93.

Bromwich, R. (1978). Goals and guidelines of an intervention program: The interaction model. In R. Bromwich, *Working with parents and infants: An interaction approach.* Texas: PRO-ED, 15-24.

Levine, L. & Nash, J. (1982). Parent-toddler education and guidance group. *Infant Mental Health Journal, 3*(1), 43-50.

Recommended Readings

Fraiberg, S. (1980). *Clinical studies in infant mental health.* New York: Basic Books.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of American Academy of Child Psychiatry, 14*(3), 387-421.

Zeanah, C. & Conger, C. (1983). The mental health professional in the intensive care nursery. *Zero to three, 4*(2), 1-6.

Tablemen, B. (1982). Infant mental health: A new frontier. *Infant Mental Health Journal, 3*(2), 72-76.

Unit 2: The Nature of Human Attachments in Infancy

Highly Recommended Readings

Maccoby, E. (1983). How children differ in their attachments. In E. Maccoby, *Social development.* California: Harcourt, Brace and Jovanovich, 81-112.

Tronick, E. & Gianino, A. (1986). Interactive mismatch and repair: Challenges to the coping infant. *Zero to Three,* 1-6.

Parke, R.D., Power, T.G., Tinsley, B.R., & Hymel, S. (1980). The father's role in the family system. In P. Taylor (Ed.), *Parent-infant relationships.* Florida: Grune and Stratton, 117-133.

DeLozier, P. (1982). Attachment theory and child Abuse. In C. Murray-Parkes and J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior.* New York: Basic Books.

Trout, M. (1981). Potential stresses during infancy: The growth of human bonds. In S. Tackett and M. Hunsberger (Eds.), *Family-centered care of children adolescents.* Pennsylvania: W.B. Saunders Company, 471-482.

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Bowlby, J. (1969). *Attachment.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss. Vol. 3: Loss.* New York: Basic Books.

Maccoby, E. (1980). The development of attachment. In E. Maccoby, *Social development,* Ch. 2. New York: Harcourt, Brace and Jovanovich.

Stern, D. (1985). *The interpersonal world of the infant.* New York: Basic Books.

Stern, D. (1977). *The first relationship.* Massachusetts: Harvard University Press.

Goldberg, S.,(1983). Parent-infant bonding: Another look. *Child Development,* 1355-1382.

Main. M. & Weston, D. (1982). Avoidance of the attachment figure in infancy: Descriptions and interpretations. In C. Murray-Parkes and J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior.* New York: Basic Books.

Main. M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: A move to the level of representation. In *Monographs of the society for research in child development*, Serial No. 209, 50(1-2), 66-106.

Pruett, K. (1986). Infants of primary nurturing fathers. *Psychoanalytic Study of the Child, 40*, 257-277.

Klaus, M.H. & Kennell, J.H. (1982). *Parent-infant bonding*, 2nd Edition. St. Louis: C.V. Mosby.

Lieberman, A., & Paul, J. (1984). Searching for the best interests of the child: Intervention with an abusive mother and her toddler. *Psychoanalytic Study of the Child, 39*, 527-548.

Unit 3: The Psychological Dimensions of Pregnancy, Labor and Delivery for Mothers and Fathers

Highly Recommended Readings

Rubin, R. (1976). Maternal tasks in pregnancy. *Nursing Digest*, 91-93.

Rubin, R. (1977). Binding in the postpartum period. *Maternal & Child Nursing Journal, 6*, 67-75.

Osofsky, H. & Osofsky, J. (1980). Normal adaptation to pregnancy and new parenthood. In P. Taylor (Ed.), *Parent-infant relationship*. Connecticut: Grune and Stratton, Inc., 25-48.

Goldberg, S. (1979). Premature birth: Consequences for the parent-infant relationship. *American Scientist, 67*(2), 214-220.

Recommended Readings

Klaus, M. & Kennell, J. (1982). The family during pregnancy. In M. Klaus & J. Kennell (Eds.), *Parent-Infant bonding*. St. Louis, C.V. Mosby, 1-21.

Benedek, T. (1970). The psychobiology of pregnancy. In T. Benedek and E.J. Anthony (Eds.), *Parenthood: Its psychology and psychopathology*. Boston: Little, Brown and Co., 137-152.

Bibring, G.L. (1959). Some considerations of the psychological processes in pregnancy. *Psychoanalytic Study of the Child, 14*, 113-121.

Colman, A., and Colman, L. (1971). *Pregnancy: The psychological experience.* New York: Seabury.

Gerson, M.J., Alpert, J.L., & Richardson, M.S. (1984). Mothering: The view from psychological research. *Signs: Journal of Women in Culture and Society, 9*(3), 434-453.

Guttman, H.A. (1983). Autonomy and motherhood. *Psychiatry, 46*(3), 230-235.

Lederman, R.P. (1984). *Psychosocial adaptation in pregnancy.* Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Valentine, D.P. (1982). The experience of pregnancy: A developmental process. *Family relations, 31,* 243-248.

Unit 4: Conducting an Infant Mental Health Family Assessment

Highly Recommended Readings

Trout, M. (1981). Potential stresses during infancy: The growth of human bonds. In S. Tackett and M. Hunsberger (Ed.), *Family-centered care of children and adolescents.* Pennsylvania: W.B. Saunders Co., 482-492.

Fraiberg, S. (1980). Clinical assessment of the infant and his family. In S. Fraiberg (Ed.), *Clinical studies in infant mental health.* New York: Basic Books Publishers, 23-48.

Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanalytic Quarterly, LI,* 612-634.

Goldberg, S. & Minde, K. (1983). Infant Psychiatry. In P. Steinhauer & Q. Rae-Grant (Eds.), *Psychological problems of the child in the family.* New York: Basic Books Publishers, 153-167.

Schroeder, C., Gordon, B., & Hawk, B. (1983). Clinical problems of the preschool child. In C. Walker and M. Roberts (Eds.), *Handbook of clinical child psychiatry.* New York: John Wiley and Sons Publishers, 296-334.

Recommended Readings

Magrab, P.R., & Sostek, A.M. (1983). Clinical problems of birth, the neonate and infant. In C.E. Walker & M. Roberts (Eds.),

Handbook of clinical child psychiatry. New York: Wiley & Sons, 280-295.

Steinhauer, P.D. (1983). Assessing for parenting capacity. *American Journal of Orthopsychiatry,* 468-481.

Broder, E. & Hood, E. (1983). A guide to the assessment of child and family. In P. Steinhauer and Q. Rae-Grant (Eds.), *Psychological problems of the child in the family.* New York: Basic Books, 130-152.

Greenspan, S. & Greenspan, N.T. (1985). *First Feelings.* New York: Penguin.

Greenspan, S. & Porges, S. (1984). Psychopathology in infancy and early childhood: Clinical perspectives on the organization of sensory and affective theoretic experience. *Child Development, 55,* 49-70.

Provence, S. (1983). Depression in infancy? *Zero to Three, 3*(4), 1-4.

Newberger, C. (1980). The cognitive structure of parenthood: Designing a descriptive measure. *New Directions for Child Development, 7,* 45-67.

Unit 5: The Newborn's Capabilities and Temperament: What He Brings to his Parents

Highly Recommended Readings

Brazelton, T. (1979). Behavioral competence of the newborn infant. *Seminars in Perinatology, 3*(1), 35-44.

Friedrich, O. (1983). What do babies know? *Time Magazine,* 52-59.

Goldberg, S. (1977). Social competence in infancy: A model of parent-infant interaction. *Merrill-Palmer Quarterly, 23*(3), 163-177.

Recommended Readings

Tronick, E. & Adamson, L. (1980). *Babies as people: New findings on our social beginnings.* New York: Collier.

Kaplan, L. (1978). *Oneness and separateness from infant to individual.* New York: Simon and Schuster.

Fraiberg, S. (1977). *The magic years.* New York: Charles Scribner.

Unit 6: Impact on the Family of the Birth of a Sick or Handicapped Infant

Highly Recommended Readings

Oehler, J. (1981). Parental reaction to adverse neonatal events. In J. Oehler (Ed.), *Family-centered neonatal nursing care.* Pennsylvania: J.B. Lippincott, 134-155.

Green, M. & Solnit, A. (1964). Reactions to the threatened loss of a child: A vulnerable child syndrome, pediatric management of the dying child, Part III. *Pediatrics,* 58-66.

Mintzer, D. Als, H., Tronick, E.Z., & Brazelton, T.B. (1984). Parenting an infant with a birth defect. *Psychoanalytic Study of the Child, 39,* 561-589.

Canino, F. & Reeve, R. (1980). General issues in working with parents of handicapped children. In R. Abidin (Ed.), *Parent education and intervention handbook.* Illinois: Charles Thomas Publisher, 82-106.

Recommended Readings

Caplan, G., Mason, Ed., & Kaplan, D. (1965). Four studies of crisis in parents of prematures. *Community Mental Health Journal, 1,* 149-161.

Poznanski, E. (1984). Emotional issues in raising handicapped children. *Rehabilitation Literature, 45*(7-8), 214-219.

Unit 7: Special Issues in Infant Mental Health Practice

Highly Recommended Readings

Shapiro, V. & Tuta, K. (1982). Developing a working alliance with parents of infants at risk. In J. Stack (Ed.), *The special infant.* New York: Human Sciences Press, 231-241.

Naylor, A. (1982). Results of a mismatch. *Zero to Three, 2*(3), 8-11.

Honig, A.S. (1980). Working with parents of preschool children. In R. Abidin (Ed.), *Parent education and intervention handbook.* Illinois: Charles C. Thomas Publisher, 385-431.

Clark, G. and Seifer, R. (1983). Facilitating mother-infant communications: A treatment model for high-risk and developmentally delayed infants. *Infant Mental Health Journal, 4*(2), 67-82.

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Recommended Readings

Steinhauer, P. (1983). Issues of attachment and separation: Foster care and adoption. In P. Steinhauer and Q. Rae-Grant (Eds.), *Psychological problems of the child in the family.* New York: Basic Books, 69-101.

Bolton, F. (1983). *When Bonding Fails.* California: Sage Publications, Inc.

Sadler, L. & Catrona, C. (1983). The adolescent parent: A dual developmental crisis. *Journal of Adolescent Health Care, 4,* 100-105.

Greenspan, S. & Wieder, S. (1984). Dimensions and levels of the therapeutic process. *Psychotherapy, 21*(1), 5-23.

Child and Family Institute

The mission of the Institute is to serve families and those who work with children by providing leadership and promoting excellence through a comprehensive delivery of educational programs, consultation services, library resources, research, networking, model program development, and advocacy.

Born in 1968, the Child and Family Institute in the Division of Human Resources at the University of Southern Maine has grown to become one of the most comprehensive statewide early childhood training and resource centers in the country.

The Institute is multiply funded, including grants from the Maine Department of Educational and Cultural Services, Maine Department of Human Services, Head Start agencies, The Maine Division of Community Services, and the Maine Department of Mental Health and Retardation to develop a graduate level course in infant mental health based on the work of Michael Trout, a nationally known infant mental health specialist.

In addition to permanent staff members, including child development specialists, others are employed part-time to teach university courses in child development, and special needs, and to conduct symposia, workshops, and seminars. The Institute provides university courses which may be applied toward an associate of art and/or bachelor of science degree through the University of Maine at Farmington. The Institute also provides workshops, technical assistance, and consultation to early childhood staff as well as staff working with young children with special needs and parents of these children.

The Institute has one of the most comprehensive collections of early childhood materials in northern New England, housing over 5,000 books, pamphlets, periodicals, children's books, filmstrips, slides, films, records, and videocassettes. Among others, subject areas include child development, parenting skills, research publications, and administration. Materials are circulated via a "mailbag" approach. Audio-visual equipment is also available. The Institute houses private collections including the Leah Rubinoff Memorial Collection focusing on family day care materials, and more recently the Dr. Dorothy Gross Memorial Collection of child development, parenting, families, abuse and neglect, and infancy. Earlier collections include materials from Project Help Me in Waterville, and from the Audubon Society.

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