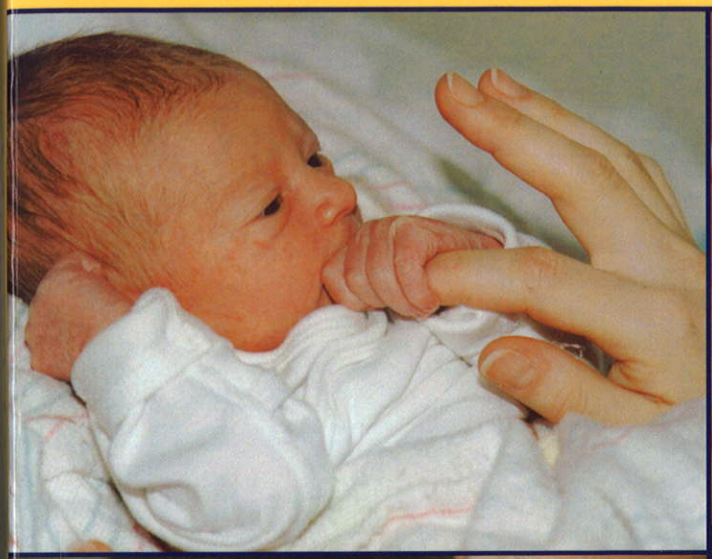
Mental Health *in Early Intervention*

ACHIEVING UNITY IN PRINCIPLES AND PRACTICE



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CHAPTER 5

Mental Health Principles, Practices, Strategies, and Dynamics Pertinent to Early Intervention Practitioners

Gerard Costa

PROMOTION OF MENTAL HEALTH

As the varied mental health professions evolved, some with shared histories and others with unique histories, an unintended consequence emerged among practitioners and the general public: the belief that mental health concerns could only be relieved by mental health practitioners. The "self-help" approaches that developed were generally applied to concerns about self-improvement or life enhancement rather than the more serious psychological or psychiatric disturbances (e.g., psychotic or serious personality disorders) or even difficult life events (e.g., death of a spouse, birth of a child with a disability). Psychology self-help books are of the same genre as home improvement manuals in that they offer the layperson a glimpse into the mysteries of specialized professions but still imply that substantive work be left to the professionals. This is not an altogether inappropriate position, and in fact, this book affirms the notion that the mental health specialist must retain core assessment, educational, and supervisory functions pertaining to the emotional and relationship disturbances.

It is clear, however, that psychological concerns are often ameliorated by a wide range of human experiences that stand outside formal psychotherapeutic or mental health treatments. Children with early disruptions in relationships are often helped immensely by a caring, consistent teacher or a loving, involved neighbor who can share the child's pain and offer him or her solace and a challenge to unfavorable beliefs about life. People who have never received psychotherapy and who suffer from anxiety or depression often discover relief and improvement through friendships or spirituality. In fact, more people with emotional problems likely do *not* enter a formal psychotherapeutic relationship but seek a variety of alternative supports. This of course can lead some to seek alluring but

unvalidated, unsupported, and even dangerous practices as has been documented in the case of certain practitioners of "attachment therapy" (Mercer, Sarner, & Rosa, 2003).

These risks notwithstanding, the position supported in this book and this chapter is that the promotion of mental health and the amelioration of emotional concerns is the *province of all disciplines*. Whether it is recognized, all practitioners influence the mental health of those they serve. What must be addressed therefore is not whether non–mental health practitioners should be involved in the business of mental health—they are and will be—but rather how the mental health field can assist those in other helping professions. Even the skeptic to such role releasing and role enhancing might be persuaded by the argument that since non–mental health practitioners influence mental health in the children and families they serve, it is better to refine and inform such practices rather than allow these influences to operate without formal grounding.

This chapter examines the ways that infant mental health principles and practices can help inform the conceptualization and interventions made by practitioners representing the range of disciplines in early intervention. This chapter describes key notions from the field of infant mental health and offers a lens through which the early intervention practitioner in a helping relationship with infants, children, and their families could provide simultaneous support and amelioration to the infant's developmental difficulties and the emotional and relationship concerns that often co-exist in the family. By way of background, consider the powerful changes that follow pregnancy and the birth of an infant.

THE PARENTING JOURNEY

The arrival of an infant—the advent of parenthood—is filled with ambivalence. This is true whether the infant is planned, is the first or last, is born to a rich or an impoverished family, or has medical or developmental problems. For all infants, life begins within the context of a relationship, and how the parent or caregiver embarks on the parenting journey depends as much on the infant as it does on the caregiver.

The field of infant mental health is concerned with the nature of this journey—the forces that influence the slow unfolding that occurs in the parent–child relationship. Infant mental health is an interdisciplinary field concerned with the optimal development of the infant across all developmental areas, within the context of his or her primary, loving relationships. The field is also concerned with the nature of the adults who care for the infant—certainly the biological parents but also siblings, grandparents, foster families, extended family, friends, physicians, pediatric therapists, and educators—the allied familial and professional community in whose context the infant begins life and grows.

Like early intervention, practitioners come from a variety of disciplines, each of which informs and enhances the work of the others.

Much has been written about this field of study (Fraiberg, 1980; Greenspan, 1992; Greenspan & Wieder, 1998; Stern, 1977, 1985, 1995; Winnicott, 1965). Elsewhere, Costa (1996) has summarized six guiding principles in infant mental health to identify core areas of interest, understanding, assessment, and intervention (see also Costa, 2003a; White-Tennant & Costa, 2002).

Guiding Principles in Infant Mental Health

1. The human infant comes into the world with remarkable capacities for human relatedness—with attachment promoting behaviors (APBs)—that help invite, inform, and regulate relationships with his or her caregiver. These APBs include the infant's large eyes, remarkable preference for faces, early recognition and preference for the parental voice, and the pleasure and regulation that occurs when held; therefore, from the earliest moments, infants require consistency, stability, predictability, availability, and attuned love.
2. The period of life from birth to 3 years is critically important for the development of "character" or "personality." The greatest period of brain development—the brain "growth spurt"—occurs from the last trimester of pregnancy through the first 18 months of life. During this period, nutritional, physical, social, and emotional satisfactions and failures will be "biologized"—actual *changes* occur in the physical and chemical structures in the brain.
3. Pregnancy and childbirth are powerful conscious and *unconscious* reminders in the parent of childhood issues, which can help or hinder the parent in responding to, caring for, and loving the infant. In every birth, the infant can serve as a powerful *transference object* for the parent—meaning that thoughts, feelings, and beliefs about other figures and events in the parental past can become associated and confused with the infant—what Fraiberg (1980) called "ghosts in the nursery" (see Chapter 10). Pregnancy, birth, and the first 2 years of maternal care require the availability of psychological resources, emotional support, and, when needed, parent–infant psychotherapy. Parenting is a relationship and not a skill, and the belief that parenting can be "taught" is not clearly supported.
4. Infant mental health practitioners have emotional histories that influence how they work with families—especially those families in which infants are not adequately cared for or are hurt. Infant mental health practitioners are not immune from the same psychological forces that influence the dyads. Infant mental health requires that these feelings be attended to. Sub-

jective feelings and responses to infants and families have a profound, but often unexamined, influence on the work that is being done. Delivery systems and child protective agencies must provide protected time for intensive and rigorous staff training and ongoing regular supervision.

5. The nature of the infant–parent relationship is best understood within the setting of the family home because the context of family events—eating, sleeping, relating, and nurturing—as well as the alternate ways parents communicate—through pictures, objects, toys, family stories, and memories—are rooted in the family home.

6. The infant–parent relationship emerges within a unique set of cultural and economic factors that provide a historical and practical context to the family and to the intervention. Infant care, expression of affect, use of health care, and relationships with interventionists are profoundly influenced by the culture and economic resources of the family.

INFANT MENTAL HEALTH AND EARLY INTERVENTION

What is the relevance of this field and these principles in understanding and working with families in which infants and children have medical needs or developmental disabilities? First, consider the impact of developmental disability on the parent.

As the third principle suggests, pregnancy is a powerful psychological event for parents, particularly the mother. Although the nature of expecting their infant varies greatly for families, certain commonalities in the mental and emotional phenomena occur in families waiting for the birth or arrival (including adoptive families) of their infants. Whether consciously, families begin to construct an image about what their infant will be like—an imagined infant—and this often (not always) reflects the idealized or "wished-for" infant. In some cases, alluded to in the fourth principle, an infant's arrival is not anticipated with joy or excitement but instead is imagined through the "lens" of unfavorable, hurtful events in a parent's life. The infant may be expected (often without awareness on the part of the parent) or viewed as an intruder, a hurtful or abandoning other, a rejecting parent, an abusive husband, a rejecting mother, or other hurtful agent—if these kinds of relationships existed in the earlier life of the parent. In describing the infant as a "transference object," Trout (1989) described the parental regard for the infant "as if" the infant were some other person(s) from the past. Although such "ghosts" (Fraiberg, Adelson, & Shapiro, 1980) may at times be benign (e.g., a child evokes feelings in the parent of a beloved figure), the child is still viewed "as if" he or she were the other figure and not as the unique infant he or she is.

This process of transference is normal and a part of all pregnancies and parenting. However, in cases in which the figures from the past cannot be relegated to the past or when the parents (or others who care for the infant) are not aware of the intrusion on their feelings and behaviors, the relationship with the infant is at risk. There are times when certain characteristics of the infant may serve to activate the transference (e.g., a young mother's 2-month-old infant looks exactly like his father, a man who was incarcerated for killing the mother's older son). At other times, the infant's neediness may stir fear and apprehension, even anger, in a parent whose own neediness was unmet as a child. Finally, a parent who was made to feel inadequate or deficient as a child may see the arrival of an infant born too soon, ill, or with a disability as "proof" of his or her own defective state—and entry into parenthood is organized through such a lens (see Chapter 1).

Infant mental health practitioners must consider a very basic question in all instances, particularly when an infant is born with a disability: Who is this infant to this family? Asking this question and letting parents teach the answers constitute significant contributions to working with families of infants with developmental disabilities. Such a line of inquiry is unfamiliar to the typical early intervention practitioner. Yet, as the practitioner forms a helping relationship with the family, informed and assisted by this knowledge, opportunities to reduce risks and enhance strengths in the infant–parent relationship are ever emerging.

The Motherhood Constellation

Daniel Stern (1995) described another dimension of parenthood, particularly in mothers, that has bearing in all families: the "motherhood constellation" (see Stern & Bruschweiler-Stern, 1998). The constellation of feelings and themes emerging around motherhood have great bearing on the unfolding parenting journey when infants have disabilities and can help interventionists help families. Stern described four themes that assume "center stage," preoccupying the mother, as her parenthood unfolds.

1. Life theme: Can she promote life and growth in her child?
2. Relatedness theme: Can she emotionally engage the infant and ensure mental/emotional development?
3. Support matrix theme: Can she create the necessary support systems to meet these themes?
4. Identity reorganization theme: Will she be able to transform her self-identity to meet these themes?

Along with these themes, Stern theorized that a new "triad" emerges as a dominant need in the life of the mother: her own mother as mother to her as a child,

herself as a new mother, and her infant. This does not mean that the father's role in the newly changed family is unimportant. It does mean that for the mother, as she changes from the *child* of a mother to the *mother* of a child, her interest in her own mother (real or wished for, whether her mother is presently available) and other mother "surrogates" becomes a central, organizing experience.

In considering the birth of an infant who is sick or has a disability, all four themes of the *motherhood constellation* might pose challenges to the mother at the very time these themes are preoccupying needs. If her child is not developing well (life) or has an impairment in social and emotional relatedness (relatedness), available resources and support systems may be stressed (support matrix) and resolution of the normal ambivalence that comes with the new identity of motherhood (identity reorganization) may be compromised. These insights are helpful when working with families because infant mental health practitioners can "learn at the feet of parents" (Trout & Foley, 1989) and see how they are doing and what they may need to feel, say, and do without judgment or criticism.

Responses Parents May Have to the Birth of a Child with Developmental Problems

Much has been written about the impact the birth of a child has on the family (e.g., Naseef, 2001; Trout, 1983; Trout & Foley, 1989). Here again, although families vary in their response and adaptation to the arrival of an infant with a disability, certain experiences emerge as common.

1. The birth of a child who is sick or has a disability is often experienced as a "wound"—a "narcissistic injury" or injury to oneself—in a parent, particularly the mother.
2. A subsequent pregnancy and birth can reactivate original feelings surrounding the birth of a child who is sick or has a disability, and these feelings can be expressed in intensified concerns and protectiveness toward other children.
3. Parenting is fraught with ambivalence—it is filled with enormous gratification but also great demands—and parents are often helped by the pleasure and gratification they receive from their child who can "give back" in the form of a smile, hug, loving expressions, specific and reciprocal attachments, and so forth. Parents feel disheartened when infants who have disabilities cannot "give back."
4. Parents of children with disabilities and parents whose children are dying or have died often experience continuous losses and chronic sorrow. Unlike parents whose children do not have developmental or medical compromises, parents of children with difficulties often reflect on their child's entire future, wondering about questions that most parents take for granted—questions about walking, talking, engaging in age-related activities (e.g., little league, soccer, Brownies, Boy Scouts), driving, dating, getting married, having a life partner, and planning for when the parents cannot be there to care for their child. Relatedly, parents re-experience sorrow as their child's peer group changes and makes gains in areas their child does not (see Bruce & Schultz, 2001).
5. Frequent medical crises or hospitalizations have an enormous impact on the levels of emotional stress, work and sleep requirements, and the capacity to respond to the other responsibilities of parenting. Stressors that might otherwise be managed effectively by a couple or family might create divisions and psychological distress.
6. The birth of a child who is sick, has a disability, or is dying is often experienced by the family as an event over which they have had no control. Many families feel shame and guilt and often imagine some way they are responsible for their child's disability, despite the absence of rational or empirical evidence, because it is more adaptive to imagine that some control could have been exerted over their lives.

Collectively, the six guiding principles in infant mental health, the themes that take center stage in the motherhood constellation, and the responses that families can have to a child with developmental disabilities provide a useful framework for those who work with families around the birth and care of their child with disabilities. This framework drawn from insights in mental health will serve as the foundation for ways in which early intervention practitioners can integrate mental health interventions into the work with children and families.

A MODEL TO TRAIN AND SUPPORT EARLY INTERVENTION PROVIDERS

This book does not suggest that all early intervention providers from a wide range of professional disciplines must become psychotherapists! It does assert, however, that promotion of mental health in infants and their families is the province of *all* staff from *all* disciplines in early intervention, and the field of infant mental health provides a useful framework to better understand, assess, and help families. In order to put into context the ways that infant mental health principles can serve early intervention providers, consider the various categories of help that emerge from an infant mental health perspective. These categories are derived from work in infant mental health (e.g., Fraiberg, 1980; Lieberman & Pawl, 1993; Weatherston & Tableman, 1989), but they are strategies for mental health interventions along the whole developmental spectrum through childhood and adolescence (see Costa, 2003b).

Categories of Intervention

Building an alliance is the process of engaging a family's involvement in treatment through consistent, reliable, predictable, and genuine care. This may include home visits, telephone contact, reflective listening, nonjudgmental acceptance, emotional support, and other services.

Concrete services address the everyday needs of the family (e.g., food, child care, shelter, clothing, health care, transportation). Part of this is accomplished through *systems advocacy*, or working with collateral agencies that provide services such as housing and special education services, educating families about the needs of children and advocating that those needs be adequately addressed.

Developmental/parental guidance is a helping strategy that provides information in a nondidactic way, sharing information and ideas about children's developmental changes, needs, and behavior. This may involve use of anticipatory guidance, observation, reflection, modeling, and providing materials such as toys.

Supportive counseling involves observing and empathically sharing what happens in the family, identifying and supporting feelings, and providing support and encouragement. The supportive counselor also models problem-solving strategies, provides honest and empathic impressions, and helps with links to other support services.

Dyadic (parent–child) psychotherapy is an approach that would be undertaken by a psychotherapist, psychologist, social worker, or other qualified mental health professional. Dyadic psychotherapy emerges from work with infants and their parents but also can be applied with older children. This is a specialized intervention with the primary purpose of helping the parent develop insight and a deeper understanding of experiences and emotions. There is a focus on past experiences that may be interfering with the formation of a healthy relationship with the child. In this strategy, the relationship between child and parent is seen as the "client," and a psychotherapist attempting this approach must understand fundamental notions of psychological development, including unconscious motivation, transference, defenses, and coping strategies. Within the clinical field of infant mental health, a variety of approaches offer help to families. Stern (1995) reviewed a number of these approaches and their different areas of focus or "ports of entry" into the parent–child relationship.

The largest proportion of providers of early intervention services do not have a mental health background, and when considering mental health issues of infants and their families, such staff often feel both inadequate and fearful of treading into a domain they feel neither trained in nor qualified to help. Yet, clearly the first four categories are certainly within the domain of most professional disciplines. In fact, the multidisciplinary nature of the field of infant mental

health emerged from practices that included not just mental health practitioners but others including public health nurses, pediatricians, and—as early intervention services for infants with disabilities developed—physical therapists, occupational therapists, speech-language pathologists, early childhood and special educators, and a host of other allied disciplines.

Nonetheless, such staff need better understanding of the mental health needs of infants and families. Furthermore, they would benefit from increased knowledge of the observational strategies of the infant mental health specialist, ways to enhance their skills in those helping strategies where they *can* perform, and a clearer understanding of when and how the specialized infant mental health professional is needed.

Costa, Caragol, and Calello (1998) presented a model of training and consultation based on their experiences with early intervention program staff from a variety of disciplines at the 13th National Training Institute of ZERO TO THREE. This model facilitates integration of infant mental health principles and practices into early intervention services. Steele (1998) also described approaches that integrate infant mental health practices into early intervention.

A MODEL FOR INTEGRATING INFANT MENTAL HEALTH INTO EARLY INTERVENTION

Each phase of the model (Costa et al., 1998) is examined (see Table 5.1 for an overview). Then, the focus is on categories of helping and describing a conceptual framework to consider present, ongoing, and future training needs for staff seeking enhanced levels of proficiency.

Assumptions Underlying the Model

Before examining the components of the model, three assumptions that underlie the model's effectiveness are described. These assumptions must be met for the model to succeed in creating an effective system of integrating infant mental health principles into this work.

Administrative Support

All phases of the model require the commitment of institutional resources and the creation of "protected time" for essential staff to engage in the training, consultation, and ongoing case reflection required. Ideally, administrative staff should participate in all phases of the model. This ensures that strategies of intervention that may require institutional change (e.g., creating different working relationships with other providers of social services as part of "systems advocacy") will be implemented at the appropriate administrative levels.

Table 5.1. An infant mental health training-consultation model in early intervention programs.

Phase I: Initial training for transdisciplinary team
Provides a conceptual framework and a common set of principles and language to understand infants, their families, practitioners, and the unfolding relationship.
Phase II: Case consultation model
Provides an opportunity to practice understanding and development of insights into the families and the practitioners' work with them. This is scheduled routinely and minimally on a monthly basis. The model is rooted in the notion that practitioners learn best when they discuss families they know and when they are emotionally invested in the work. Discussion always addresses "countertransference"—practioner's feelings and responses within the work.
Phase III: Reflective supervision
Initially modeled in case consultations but developed as an ongoing and integral part of the structure of the program.
Phase IV: Targeted trainings and family consultations
Provides specific trainings identified as needed by staff and administration through case consultations and supervision. May involve consultations with infants and families separately by infant mental health consultants or jointly with staff.
Phase V: Review and adjustment
Ongoing participatory review process on strengths and needs of the consultation.

Commitment to Multisession Training and Consultation

Many agencies are facing reductions in funding for professional development and training. This creates pressure to seek training experiences to accomplish ambitious goals without the appropriate resource and time investment. This model is clearly rooted in the notion that one-time trainings, particularly in the field of infant mental health, are insufficient. In fact, such trainings can be dangerous because they offer staff ideas and notions that can easily be misunderstood and misapplied.

Commitment to Support Reflective Practices as an Integral Part of Program Planning

This model emphasizes two important concepts that are integral to working with families guided by principles of infant mental health: *relationship-based intervention* and *reflective practices.* Relationship-based intervention considers the notion that interventionists form affective, interpersonal connections with families that require attention not only to the worker's actions and tasks but also to his or her emotional and subjective experiences. Pawl and St. John (1998) described the nature of this perspective in a publication aptly titled, *How You Are Is as Important as What You Do.* In this perspective, staff are helped to understand the profound, yet often unexamined, role their own feelings, reactions, and subjective experiences with infants and families have on their work. Accordingly, agencies must develop ways to help staff, individually and collectively, consider

the nature of their own helping relationship with families. This is accomplished through a variety of approaches collectively referred to as "reflective practices" (see Bertacchi, 1996; Fenichel, 1992; Parlakian, 2000; and Shahmoon-Shanok, 1992). Thus, in addition to the earlier question about working with families, "Who is this infant to this family?" a second question is required, "What's going on inside of you?" It is precisely this practice that is emphasized in phases II and III of the model (see Chapter 8).

Initial Training for the Transdisciplinary Team

During this initial phase, staff are provided with an overview of the principles and practices in infant mental health (see Figure 5.1). This provides staff from a variety of disciplines with a conceptual framework and a common set of principles and language to understand infants, their families, themselves, and the

This training examines the emotional life of the infant and the forces that influence the ways in which infants and their parents attach, or have difficulty in attaching, to each other.

We will begin with some understanding about our own attachments, then consider how remarkably competent the human infant is. Insights from studying other species will be presented to show that human attachment has biological roots, and we will learn about the remarkable discoveries concerning the infant brain. We will consider what the infant needs at different points in his or her development, wonder about "critical and sensitive periods" in the infant's life, and what happens when these needs are not met. We will also examine the nature of pregnancy and childbirth and consider how powerful the arrival of an infant is in the life of the parent—especially the mother. We will consider the emotional, familial, and social forces that shape how a parent regards and responds to his or her own infant-and discuss attachment as a relationship that unfolds over time. We will examine ways that infants and families communicate to us, and we will review the special circumstances around parenting a child who is ill or has a disability.

Finally, we will consider some ways of intervening in the lives of the infants and parents we work with and what goes on inside us—the helper. How we feel about the families we work with and what our own lives were like influence our interventions with families.

Topical Outline

1. Introduction: The "Attachment" Exercise
2. The Nature of Human Attachment and the Infant-Parent Relationship
3. The "Competent" Infant and the Infant Brain
4. Psychological Considerations About Pregnancy and Childbirth
5. Formal and Informal Infant–Parent Assessment
6. The Infant and Child Who Is Ill or Has Developmental Disabilities
7. Infant as Transference Object and "Ghosts in the Nursery"
8. Notions of Infant–Parent "Fit"
9. Categories of Helping and Strategies of Intervention
10. What Happens within "Us"? Helping the Helper
11. Reflective Practices and Case Consultation

Figure 5.1. Infant mental health and early intervention: Learning from the infant–parent relationship.

unfolding relationship. It is best when this occurs in a 2- or 3-day intensive seminar that permits didactic, experiential, and case material to be examined. A topical outline of selected areas that should be covered in such an initial training is also presented in Figure 5.1.

Case Consultation Model

This phase provides staff with the opportunity to apply their emerging understanding and development of insights into families and their work with them. This is scheduled routinely and minimally on a monthly basis. A sample format of how to "present" a case is provided both during the initial training and as the case consultation meetings begin. This format is provided to offer security and structure to staff who might be unfamiliar with how to begin discussion of their work with their families. Two versions of this format are presented in Figures 5.2 and 5.3. Figure 5.2 provides 11 areas of information with a sample case illustration. Figure 5.3 provides cues for these areas of information without the sample so that as staff members become more proficient, this cue sheet could be a sufficient prompt. These discussions are facilitated by an infant mental health consultant—someone who is a credentialed mental health professional with training in infant mental health. (Various models of infant mental health consultation in Head Start are described by White-Tennant and Costa, 2002.)

The practice of discussing active cases is rooted in the notion that staff will learn best when discussing families they know and in whom they are emotionally invested. Discussion always addresses "countertransference"—the feelings and responses that are activated in the work (see Chapter 1).

Reflective Supervision

Given the importance of attending to the nature of the helping relationship that is formed with families and the impact that feelings, responses, and subjective feelings can have in the work, what can be done to enhance awareness and use feelings to help families in their parenting journey? Clinical supervision has long been viewed as an essential component of training mental health professionals and an integral part of clinical work for experienced clinicians. Increasingly, the field of infant mental health has suggested that supervisory practices are equally important for professionals and staff from all disciplines who work with and form relationships with infants, children, and their families (Bertacchi, 1996; Shahmoon-Shanok, 1992).

Reflective supervision is a helping relationship for the helper in which both the client and helper's needs are being considered, which optimizes the effectiveness of the intervention. Supervision creates a partnership so that the helper never feels alone; is not overwhelmed by fear or uncertainty; feels safe to express

Case Consultation Cue Sheet

1.	Identifying information of infant and caregiver (e.g., names, ages, genders, ethnicities). Nature of housing.	Malika is a 22-month-old (DOB: 3/16/96) African American girl, living with her 28 y/o mother, Rhonda, in a family shelter in Newark. A 6-year-old sister is in foster care in East Orange. Malika was unplanned.
2.	Date of referral and referral source	Mom/child referred on January 17, 1998, by CPS.
3.	Treatment: date begun, modalities, length and nature of participation, brief course	Date of intake: 1/24/98. EI services began 3/7/98. Home visits = 7 times. Regularly keeps appointments. Increased mutuality seen but maternal depression persists, and tendency for mom to defer to therapist.
4.	Presenting problems: infant and caregiver	Mom: Cocaine intoxication and child neglect. Drug use during pregnancy Infant: Motor/speech-language delays; inadequate care
5.	Brief family history: Infant and caregiver	Mom is third of six children. Incestual abuse at age 7 by father. Older sister and brother died. Mom unmarried. Father of child lives in South Carolina. No contact. Mom had 2 TOPs between births of 2 children.
6.	Current status: infant and caregiver: • Strengths/weaknesses • Nature/quality of attachment • Language of interaction • Developmental/medical status • Substance abuse issues • Adult psychological functioning • Psychiatric/medication needs	Mom: verbal, 11th grade education. Motivated for tx. Third attempt at recovery. Drug abuse since age 19. In relationship with father of children for 3 years before he left and moved to South Carolina. Mom has history of depression. No meds currently. Child: Small for age, delayed motor and language development. Enrolled in EI program since 3/7/98. Restricted range of affect. Has chronic ear infections and ear tubes inserted 1/98. Relationship: Periodic mutual play, but mom feels child does not "like" her and the two often remain unengaged with each other
7.	Other agencies involved	CPS and family court. Medicaid/TANF recipient Maternal history of incest and depression. Child is delayed and mother is unable to discern child's cues for interaction. Need housing.
8.	Clinical formulation	Parent and child (0–3 diagnostic system) Mom: Substance abuse and depression Child: Developmental delay and underreactive Limited reciprocity and mutual joy in relationship
9.	Clinical impressions	Consider your subjective feelings and responses to the relationship you have with the child and family.
10.	Reflection on clinical relationship	Frustration at mother's failure to follow up on suggestions; concerns and wish to protect child; feeling depressed and helpless with mother
11.	Recommendations	Refer for psychotherapy for mother and referral for medication evaluation. Dyadic psychotherapy and referral of Malika to therapeutic nursery.

Figure 5.2. Case consultation cue sheet with case illustration.

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4. Presenting problems: infant and caregiver	Mom: Cocaine intoxication and child neglect. Drug use during pregnancy Infant: Motor/speech-language delays; inadequate care
5. Brief family history: Infant and caregiver	Mom is third of six children. Incestual abuse at age 7 by father. Older sister and brother died. Mom unmarried. Father of child lives in South Carolina. No contact. Mom had 2 TOPs between births of 2 children.
6. Current status: infant and caregiver: • Strengths/weaknesses • Nature/quality of attachment • Language of interaction • Developmental/medical status • Substance abuse issues • Adult psychological functioning • Psychiatric/medication needs	Mom: verbal, 11th grade education. Motivated for tx. Third attempt at recovery. Drug abuse since age 19. In relationship with father of children for 3 years before he left and moved to South Carolina. Mom has history of depression. No meds currently. Child: Small for age, delayed motor and language development. Enrolled in EI program since 3/7/98. Restricted range of affect. Has chronic ear infections and ear tubes inserted 1/98. Relationship: Periodic mutual play, but mom feels child does not "like" her and the two often remain unengaged with each other
7. Other agencies involved	CPS and family court. Medicaid/TANF recipient Maternal history of incest and depression. Child is delayed and mother is unable to discern child's cues for interaction. Need housing.
8. Clinical formulation	Parent and child (0–3 diagnostic system) Mom: Substance abuse and depression Child: Developmental delay and underreactive Limited reciprocity and mutual joy in relationship
9. Clinical impressions	Consider your subjective feelings and responses to the relationship you have with the child and family.
10. Reflection on clinical relationship	Frustration at mother's failure to follow up on suggestions; concerns and wish to protect child; feeling depressed and helpless with mother
11. Recommendations	Refer for psychotherapy for mother and referral for medication evaluation. Dyadic psychotherapy and referral of Malika to therapeutic nursery.

Figure 5.2. Case consultation cue sheet with case illustration.

Case Consultation Cue Sheet

1. Provide identifying information about infant and caregiver: names, ages, genders, ethnicities, culture. Include information about ages, genders, and developmental status of siblings. Describe nature of housing.
2. Date of referral and referral source: age of infant and caregiver at time of referral.
3. Summary of contact: Provide the date of first contact, type of contact (e.g., center-based, home visit, mixed), number of contacts, nature of participation, and brief course of your work with the family.
4. Initial observations (strengths/concerns) of infant and caregiver.
5. Brief family history: infant and caregiver. This might include information about the parents' family or origin; status of parental relationship; and any known health, mental health, educational, or legal concerns about the family.
6. Current status: infant and caregiver and relationship
   - Strengths/weaknesses
   - Nature/quality of attachment: caregiver–child relationship
   - Language of interaction (e.g., visual, vocal, touch, movement interaction patterns)
   - Developmental/medical status
   - Substance abuse issues
   - Adult psychological functioning
   - Psychiatric/medication needs
7. Other agencies involved: Include other service providers, child protective agencies' involvement, court involvement, and so forth.
8. Formulation of need: Summarize the nature of any concerns you presently have, integrating information you have considered.
9. Impressions of parent and child and relationship.
10. The helping relationship: What are your thoughts, feelings, and ideas about your work with the family? Consider what feelings, thoughts, and ideas are activated within you and the way you understand "who" you are (or represent or remind them of) to the family and even "who" they are to you. Sometimes this is helped by questions such as, "What were you thinking, feeling when . . . ?"
11. Recommendations and next steps

Figure 5.3. Case consultation cue sheet without case illustration.

fears, uncertainties, thoughts, feelings, and reactions; and learns more about him- or herself, the client, and the work. Fenichel (1992) and the ZERO TO THREE work group on supervision and mentorship described the relationship as one in which the work's vulnerabilities are partnered and strengths are enhanced. They described three essential components of "reflective" supervision.

1. *Reflection,* meaning that there is a "stepping back," an encouragement to slow down and wonder about the family and the nature of the work.
2. *Collaboration,* meaning supervision requires a "partner" in the process of reflection. Typically, the partner is more experienced and from the same discipline, but collaboration only requires an openness to create a safe and secure environment in which the helper can explore information, activities, and feelings in the work without fear of criticism, shame, or retribution.
3. *Regularity,* meaning that supervision is not a "once in a while" event or happens only when time permits or other meetings are cancelled. Reflective supervision must occur regularly and consistently and is "protected" time.

Supervision is needed because the helper forms a relationship with another to bring about helpful change. This use of oneself requires rigorous and thoughtful attention. With the understanding that supervision is essential to the work, several points become clear:

1. Reflective supervision (see Chapter 15) is not considered an "add on" or secondary aspect of the work but is essential to the integrity of the work.
2. Because reflection, collaboration, and regular supervision are essential for all helping relationships, supervision is needed by both the new and experienced interventionist. Dr. David Peters, an early clinical supervisor, had a wonderful, humorous way of reminding clinicians of the need for supervision: "We need supervision to save patients from *ourselves!*"
3. Supervision is needed not only for the cases in which there is difficulty but also for those cases in which the practitioner "falls in love" with the family and is not aware of any difficulties or challenges in the clinical work. In fact, such cases can present a number of "blind spots"—aspects of the practitioner and the family that remain outside of the practitioner's awareness. David Peters had another witty admonition here: "If you overidentify with your patient, there are *two* patients and *no* doctor!"
4. Although this practice was initially modeled in the case consultation phase, special attention and training is conducted for administrative, supervisory, and direct care staff in reflective supervision. The emphasis is on the development of reflective supervision as an ongoing and integral part of the program structure. In this regard, a "parallel practice" is emphasized: The administration helps the helper, who helps the family, who helps the child. Such "intergenerational" transmission models the very relationship-based practices meant to enhance infant development and the infant–parent relationship.

Targeted Trainings and Family Consultations

During the initial training in infant mental health, and certainly during the case consultation and reflective supervision phases of this model, staff members generally identify topics of domains of knowledge that they wish to learn more about. This phase, which overlaps the prior two phases, occurs through the de-

velopment and delivery of specific trainings identified as needed by staff and administration through case consultations and supervision. Although the areas identified for learning may pertain to characteristics of the children or families being served, topics might also address areas about the intervention relationship. For example, if a case involves a history of maternal substance abuse, then a training about *in utero* effects of substance abuse on the fetus might be planned. Similarly, topics such as impact of foster care placement, parental depression and mental illness, or helping a family with grief might emerge from the clinical work. Alternatively, topics such as maintaining optimal boundaries in helping relationships, dealing with families who are difficult to engage, or discussing difficult material are examples of subjects that can be generated by the needs and responses of the intervention staff.

This phase entails an ongoing attention to areas of knowledge that are needed by staff, new domains that may emerge in the field, and aspects of the helping relationship that need further attention. Identified trainings can be provided on site by the infant mental health consultant or by other specialists, or they might be offered off site and attended by staff.

On occasion, staff might determine that a consultation by the infant mental health consultant with infants and families, either separately or jointly with staff, would be beneficial. In these cases, it is critically important that the consultation be guided by a clear purpose (e.g., assessment of an issue) and that the consultant ensure that the staff relationship not be usurped or pre-empted.

Review and Adjustment

This last phase of the model reflects the need for ongoing evaluation of the effectiveness and utility of the consultation and training model. There are both formal and informal aspects to this phase. Formally, it is recommended that staff and administrative evaluations be conducted as part of the consultation services and trainings. These meetings may take the form of a focus group with staff in which the activities of the prior period (e.g., first year of the model) be revisited. A useful model for this discussion is a SWOT analysis in which the *s*trengths, *w*eaknesses, *o*pportunities, and *t*hreats to the model's effectiveness are considered. More formal questionnaires and surveys can be constructed with the added advantage of anonymity of responses. Following the initial and subsequent targeted trainings, written evaluations can be administered to the participants regarding content, relevance, and process. Collectively, these strategies should yield a profile of the model's implementation and a road map regarding modifications and adjustments that would enhance the work. Adjustments might include decisions to plan a training for administrative and policy-making staff, include additional staff in the trainings and consultation process, alter the frequency of case consultation sessions, develop a supervisory-tier system in which supervisory staff participate in a "supervise the supervisor" track, and consider sensitivity to staff levels and local program characteristics.

As the activities under the model are conducted, the consultant should also monitor the unfolding process of training and consultation, particularly with non–mental health staff and staff for whom infant mental health is unfamiliar. This ongoing attention to the work occurs informally and becomes part of the posture and facilitation style of the consultant. This might take the form of paying particular attention to the areas that a staff member discusses or avoids. It could also take the form of looking carefully for the feelings and beliefs "behind" the discussion and supportively commenting on them. Such informal assessment of the training and consultation could also take the form of pausing periodically during the phases and encouraging a "wondering aloud" among the staff about "how is this all going?" The consultant should convey to staff a genuine interest in their feelings and thoughts about the training and consultation activities and an interest in discerning if they find it helpful. A useful approach to such a discussion is to ask if any staff member might be able to describe work with a family in which the material examined in the model activities made a clear difference in the interventions delivered and the observed outcomes. Such illustrations, which describe links between activities and interventions, often serve as supportive and affirming examples of the benefits of the infant mental health perspective.

The posture, style of inquiry, and conduct of the consultant is also an ongoing example of reflective and supportive relationship building and can serve as a model for peer and staff–family relationships. Similarly, the interest in concurrent content and process serves to illustrate the same strategies that define reflective supervision practices and the helping relationship. Collectively, these five phases represent a seamless approach to incorporating and integrating infant mental health principles and practices into early intervention services.

INFANT MENTAL HEALTH FOR NON–MENTAL HEALTH STAFF

The promotion and support of good infant and family mental health are the provinces of all disciplines, not just the traditional mental health professional staff. The categories of intervention show that psychotherapy, specifically dyadic (infant–parent) psychotherapy, is the domain of specialized mental health professionals and may require additional specialized training and supervision. However, all staff can and do have an impact on infant, family, and infant–family emotional well-being.

This perspective necessarily begins to stretch the boundaries of traditional lines of demarcation among the disciplines. A three-dimensional matrix shows

the levels of competency necessary in applying insights and strategies from infant mental health for non–mental health practitioners (see Figure 5.4; Costa, Bry, & Sullivan, 2000). This matrix considers the interplay of the practitioner's specialty (mental health versus non–mental health), the five categories of intervention, and three levels of competency (provider, supervisor, and trainer). The result is a 30-cell matrix. Using this matrix, it is possible to more carefully consider the boundaries of competency and examine what trainings are necessary for practitioners to achieve required levels of competency in infant mental health.

Each cell of the matrix contains a letter code that represents the level of training that is recommended for the intersection of the practitioner's discipline, the category of help that is being considered, and the level of competency that is expected. The matrix does contain redundancies in that certain cells could be collapsed, thus reducing the matrix size. This was not done so that each category in each dimension could be singularly considered.

When early intervention practitioners form helping relationships with children and families, they simultaneously weave together a number of helping interventions. When a physical therapist provides treatment to an infant with low muscle tone and diminished motor planning, while empathically talking with the family about the nature of the interventions, the practitioner is not only delivering physical therapy but is at the same time building an alliance with the family, offering developmental guidance and perhaps even serving in the role of a supportive counselor. In actual practice, whether the complex nature of the in-

Professional discipline						
Category of helping	Mental health professional			Non–mental health professional		
Building an alliance	A	B	B	A	B	B
Concrete services/ system's advocacy	B	C	C	B	C	C
Developmental/ parental guidance	B	C	C	B	C	C
Supportive counseling	B	C	C	C	n/a	n/a
Infant–parent psychotherapy	C	D	D	D	n/a	n/a
	Provider	Supervisor	Trainer	Provider	Supervisor	Trainer
	Levels of competency			Building an alliance		

Figure 5.4. Three-dimensional matrix for training in infant mental health. (Key: Cells = level of training required; A = introductory/basic concepts (e.g., 2- to 3-day training, readings); B = A + advanced training in content and reflective supervision (e.g., additional multisession training including an emphasis on reflective supervision); C = A + B + regular (e.g., monthly) case conferencing/consultation led by a credentialed mental health professional with D- level training; D = A + B + C + graduation from a certificate-issuing program in infant mental health; n/a = not advisable)

tervention is recognized, all practitioners in early intervention become allies, educators, and counselors to families. This three-dimensional matrix offers a way of conceptualizing how to better prepare and support the applications of these infant mental health helping practices in the early intervention provider. The four levels of training described in the key and entered in the cells of the matrix represent a deepening commitment to training and reflective practices as the helping strategies move from forming alliances to providing advocacy and support to the role of psychotherapist. As can be seen in the matrix, no early intervention practitioner should engage in the roles of supervisor or trainer when his or her level of competency is as a provider of supportive counseling or infant–parent psychotherapy. This preserves the essential requirement and role of the mental health discipline and further directs that the early intervention practitioner interested in developing such competencies could pursue graduate education and certification or licensure in a mental health discipline. This is often what occurs when a practitioner makes a career change or becomes dually certified. The matrix offers a way of creating systems to train for and support the integration of infant mental health principles into the early interventionist's practice and acknowledges respectfully that the integration of mental health strategies into the work of non–mental health staff should not be conducted casually or unsystematically.

Benefits of Training in Infant Mental Health for the Early Interventionist

Insights from infant mental health, which can inform, extend, and expand the traditional boundaries between the mental health and non–mental health practitioners in early intervention, have been considered. This section articulates the key concepts and practices that have emerged from this discussion. Note that the benefits and risks described can also apply to staff with a mental health background, but training in the field of mental health ordinarily addresses the core concepts and practices described.

Attachment as an Organizing Concept in Understanding Infant–Parent Development

The notion that an infant's first attachments serve as organizers of mental, emotional, and neural development offers the early intervention provider a framework for assessment and intervention. An infant mental health perspective emphasizes the mutual and reciprocal influences that the infant and family have on each other and the "co-constructive" process that underlies development. Greenspan and Wieder (1998) and Wieder and Greenspan (2001) have offered a model of assessment and treatment, the Developmental, Individual-

Difference, Relationship-Based (DIR) approach (see Chapter 7), that significantly deepens the understanding of the forces that shape development and the power of the earliest relationships.

Relationship-Based Framework and the "Use of Self"

Infant mental health interventions emphasize the importance of the helping relationship. Characteristics of helping relationships, the importance of attending to the subjective and evoked affect of the interventionist, and the need for reflective practices all emerge from clinical work in the field of infant mental health. The affective and subjective reactions experienced by the interventionist are not to be dismissed as irrelevant but rather are to be examined and understood because of their potential value in discerning aspects of the infant and family life. Simply stated: The feelings and beliefs that are engendered in the helper can serve as a guide for empathy, inquiry, and intervention with the family. The helper's use of these experiences—the "self"—is critically important to this work.

View Parenting as a Relationship, Not a Skill

Parenting is more properly viewed as a relationship, not simply a skill. Parental adequacy is most challenged under stress, and it is under stress that humans rely on their emotional resources as much as their skills to function. Parents' ability to apply "skills" may be seriously compromised under serious stress such as dealing with a child's illness or disability. *The single most important factor in child emotional well-being is the parent's emotional well-being.*

The Notion of "Optimal Distance" in the Therapeutic Zone

When helping relationships are formed, particularly when the services provided occur in homes, community settings, and other nonclinical environments, risks to appropriate boundaries can emerge. Although home visits often resemble "social" events, they must nonetheless be viewed as clinical services in which the helper's respectful boundaries are maintained as well as the clinical neutrality and objectivity. This is often a difficult distinction to make. Staff often view themselves as friends, and in a real way this is correct because caring relationships are formed and, in turn, are often treated reciprocally by the families that are helped. However, interventionists must balance the risks of becoming too close to families, feeling responsible for meeting their needs, or beginning to ignore their personal needs. Interventionists must also avoid becoming too distant and aloof—providing a service, ending promptly, and leaving clients' homes and lives. This does not mean that the work is absent of warmth, emotion, and genuine caring. Rather, it reminds interventionists that their responsibility *to* the family is to use their relationship and their skills to help the family. This is best done when the helper maintains an optimal distance or boundary in the relationship (see Chapters 1 and 8).

The Existence of Unconscious Processes

The field of infant mental health concerns preverbal and early affective development organized around the nature of early relationships. In accordance with the field's psychoanalytic traditions, the existence of unconscious processes is a core concept. In fact, considering the notion of infant as a transference object and "ghosts in the nursery," it is apparent that such processes, in which the infant is treated "as if" he or she were another, largely develop and operate outside of the parent's awareness. Unconscious processes are not restricted to the treatment of the infant and to the parent alone. The role of repetition, reenactment, and unconscious motivation in the parent and practitioner must also be considered. "Repetition" and "reenactment" mean that certain earlier experiences can guide one's behavior and affective experiences and can be repeated at later developmental and psychological periods, with different people and different settings. For example, patterns that characterized the parent's treatment when he or she was a child can be replayed through the parent's behavior, affective states, and reactions with and treatment of his or her own child. This "intergenerational transmission" of behaviors and characteristics occurs largely at the unconscious level, leading the infant mental health specialist to show interest in the parent's earliest development and to recognize that the nature of parent–child interactions can serve as an alternative way that families communicate about their history and the nature of their present relationship.

These unconscious processes apply to the practitioners as well because practitioners are not immune to the same psychological forces that influence the families they seek to help. Infant mental health reminds practitioners that their interpretations, attitudes, and beliefs about families must always be the object of examination and self-reflection, as noted previously, so that the practitioner's own emotional histories are better understood and become useful rather than disruptive projective forces in the therapeutic process.

The Powerful Role of the Infant as a Transference Object—"Ghosts in the Nursery"

Few notions have been more compelling to the infant mental health specialist than Fraiberg's (1980) notion of "ghosts in the nursery." This idea, however, applies equally to the capacity that infants and families have in eliciting thoughts and feelings in the helping professionals as well so that the interventionist is compelled to wonder about not only "who is this infant to this family" but also

"what's going on inside of me" and "whom might I represent to the family and they to me?"

Recognition of the Influence of the Helper's Personal Life and Subjective Experiences

Accordingly, the final benefit is the powerful but often unexamined role that the interventionist's own life and subjective experiences in the work can play in influencing all aspects of the clinical relationship from engagement to interpretation, to process of the work, and even to termination—how they say "goodbye" to the children and families. In an article marking the growth of the field of infant mental health, Michael Trout (1988) spoke of the need for "more rigorous self-monitoring of our clinical and our research efforts, and recogniz[ing] the extraordinary risk for bias in all of our work" (p. 191).

This need for rigorous self-monitoring can take many forms, including infant mental health consultation, case consultation, peer discussions, planned trainings, and consistent and planned reflective supervision. This requirement for self-monitoring and supervision is needed not only for the cases in which practitioners experience some difficulty in engaging or working with a family but also for cases in which practitioners feel good about the work and their feelings about the family are quite positive. Personal psychological histories and subjective experiences, as well as responses to the ways families are with practitioners (i.e., countertransferential feelings), are powerful organizers and filters of assessment and intervention activities. These experiences create "blind spots" that must be attended to. Steele (1998) spoke of the process of helping early intervention staff "acclimate to a new paradigm" (p. 73) in referring to the shift in thinking that an infant mental health perspective requires.

Risks of Training in Infant Mental Health

Along with the benefits that infant mental health training can have for the early interventionist are risks.

Infants and Families Become "Objects," Not "Subjects"

One concern is that the knowledge and concepts from infant mental health can become "boxes" or categories into which practitioners might tend to fit "their" families, who are then viewed as "having" certain problems or characteristics rather than "being" who they are in their journey of growth and adaptation. This shift in perspective away from experiencing families as "subjects" can interfere with the necessary empathic posture that enables interventionists, regardless of their professional background, to engage in more effective interventions.

The Dangers of Knowing Too Little

When practitioners objectify people or consider them as if they were primarily the problem (e.g., that mother who is depressed, that child who has autism), they simplify matters that must be considered more complexly. This often happens when an interventionist is new to the work or to the field of infant mental health or when the work with the family poses significant challenges to the helper. In part, this risk is similar to the old adage that "a little knowledge is a dangerous thing." Every medical student can attest to the fact that early in training, as each disease is reviewed for the first time, every student is convinced they have it. In cases in which the work poses challenges, the limited knowledge about infant mental health can be used as a tool to create emotional distance from the difficulty by labeling or assigning qualities to the family and not rigorously examining the relationship-based work. Frances Stott (1997) wrote about such concerns in the training of students in infant mental health.

Pathologizing, Labeling, and Confirming: Understanding Is Not Diagnosing

Another variant of the risk of objectifying families and applying limited knowledge is the inappropriate use of diagnostic labels and prematurely "fixing" on a way of understanding families so that interventionists draw conclusions without all of the information that is needed. The struggle to understand may often take the form of wondering about the nature of certain problems (e.g., Is there a more serious psychiatric illness in a family?) or even leading interventionists to quickly develop some beliefs about the family (e.g., "The mother is *noncompliant* or *in denial*"). But practitioners must always subject these considerations to more rigorous scrutiny. The need to better understand must not lead practitioners to the diagnosis of problems, particularly when such tendencies can distort the clinical work.

The Dangers of Feeling Too Much

Michael Trout (1989) made a memorable comment about his teacher, Selma Fraiberg, at his summer course in infant mental health at the Infant-Parent Institute in Champaign, Illinois: "Professor Fraiberg opened our eyes and we couldn't close them again." Studies in infant mental health draw the student into a new way of understanding the nature of infant development, parenting, infant–parent attachment, and the formation of the helping relationship. This is particularly true as the nature of the early emotional life of the child is more clearly understood. Experiences that might have otherwise been minimized or not considered carefully (e.g., a hospital stay, foster care placement) suddenly assume more power and impact in the life of an infant. Study in infant mental health does in-

deed open the student's eyes to a new way of looking, understanding, and intervening. This can lead to powerful and sometimes disturbing feelings. This new growth in feeling requires supervision to discern how best to understand and use such experiences in the work.

Boundaries of Competency and Scope of Practice: Distinction between Psychotherapy and "Relating Therapeutically"

A fear voiced by many non–mental health practitioners who learn about infant mental health is that they are being asked to become psychotherapists. Although the interdisciplinary nature of the field of infant mental health reveals that the promotion of good mental health in infants and families is the province of *all* disciplines, it must be emphasized that the unique and specialized type of mental health interventions, such as infant–parent (dyadic) psychotherapy, is reserved for the licensed or certified mental health professional with specialized training in this field.

CONCLUSION

Training in the principles and practices of infant mental health can inform all those who work with infants and families in early intervention. Those helpers who have the most impact on supporting capacities and reducing risks in families—the basis of good mental health in infants and families—are often not mental health practitioners. A deeper understanding of the field of infant mental health offers greater understanding of the nature of human attachment, the powerful forces of transference and countertransference, the alternative ways that families communicate to practitioners about how they and the practitioners are doing, and the various ways practitioners can help. Such a perspective can offer practitioners, as Foley and Hochman (1998) have described, a way to distinguish how to "relat[e] therapeutically" and differentiate that capacity from psychotherapy (p. 15).

Practitioners who can be helped to integrate insights from infant mental health into their professional domains and who can with training, support, and supervision learn to understand and utilize the powerful emotional forces at play within them and among them and the family members can achieve the "optimal distance" (Foley, Hochman, & Miller, 1994) in the helping relationship that is the hallmark of effective relationships with families (see Chapter 1).

This chapter presents a model for integrating infant mental health principles and practices in early intervention services. It offers a series of steps that programs can take, in alliance with trained consultants, and presents a model that will inform unfamiliar staff and assist staff with discussing their relationship-based cases and seeking reflective supervision, guided by an infant mental health

perspective. The chapter considers some risks associated with training in infant mental health, especially for non–mental health staff but emphasizes the enormous benefits to the family and staff that this perspective provides.

Early intervention programs that establish and implement a plan to instill infant mental health training and consultation services into their system will discover what Selma Fraiberg did for many of her students—opening eyes that cannot be closed again. Understanding and practicing the work of infant mental health will forever change. This is both a gift and a burden that must be accepted in order to enhance the lives of the families and infants whom practitioners serve as they struggle to adapt and grow with each other.

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