What is Infant Mental Health and What Does it Mean to Other Disciplines?

“Mother love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health.”

—John Bowlby

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INTRODUCTION

In 1975, Selma Fraiberg and colleagues masterminded an approach based on John Bowlby’s theory of attachment to strengthen the development and well-being of infants and young children within secure and stable caregiver-child relationships. She called the practice Infant Mental Health. Today, infant mental health (IMH) is recognized as an inclusive, interdisciplinary field of research and practice that focuses on the social-emotional development and well-being of infants and young children within the context of their early relationships, family, community, and culture.[1] The research and perspectives of many fields indicate that all domains of development—social-emotional, intellectual, language, and physical—are interdependent and supported through the dynamics of the caregiving environments. The conclusion is that the optimal, most cost-effective time to make positive interventions supporting children, caregivers*, and families is during the period from pregnancy through early childhood.[2]

Initially the workforce was comprised of social workers, psychologists, psychiatrists, and nurses. More recently, the IMH field has expanded to include the medical community, as well as the training of practitioners in other disciplines such as early childhood education, speech-language pathology, occupational therapy, and physical therapy. Essentially anyone who has contact with infants, young children and their families can recognize and support social-emotional health and well-being.

As an illustration, promotional IMH activities can be woven into multiple community programs and services including childcare centers, pediatric clinics, primary care physicians’ offices, home visitation programs, etc. IMH preventive intervention strategies can be incorporated by all specialized practitioners working in early childhood to positively impact the developmental trajectories of infants and young children whose life course is at risk due to parenting behavior or trauma. Finally, community practitioners from all disciplines can learn to recognize disturbed caregiver-child relationships and know when to refer for IMH treatment with a licensed IMH professional.

*Caregiver could include parent or other adult who provides primary care for the child.

In order to ensure that young children and caregivers have optimal relationships that nurture, protect and support social-emotional development, it may be helpful for practitioners to develop a shared lexicon, recognize core concepts, and be familiar with principles that reflect the IMH field. To start, further defining IMH and how it is synonymous with healthy social-emotional development is important.

Defining Infant Mental Health

The mental health of young children is defined as the psychological and social-emotional well-being of infants and toddlers in relationships with their caregivers, environment, and culture—with respect for each child's uniqueness.[3] Healthy social-emotional development encompasses "the developing capacity of the child from the birth through five years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture."[4] IMH also includes family functioning and caregiver-child "goodness of fit," as well as the health and development of the brain.[5]

Social development includes the ability to form relationships with others, and to understand and respond to cultural norms and expectations about interpersonal interactions and behaviors. Emotional development encompasses being able to interpret and respond to feelings expressed by others as well as to regulate and express one's own feelings.

Infants and young children rely on caregivers for social development *(I signal my needs and feelings, then my caregiver responds sensitively to my signals)* and emotional development *(I can communicate my feelings and be understood. My feelings matter. My caregivers also communicate their feelings and I can learn to understand their feelings)*. The development of self-worth, self-confidence, and self-regulation comes from this shared knowing and shared meaning between the caregiver and child that are important features of social-emotional development.

> "From early infancy, it appears that our ability to regulate emotional states depends upon the experience of feeling that a significant person in our life is simultaneously experiencing a similar state of mind."
>
> **Daniel Siegel**

IMPORTANCE OF EARLY RELATIONSHIPS

For young children, caregiver-child relationships are the most important context for early brain organization, regulation, and development and are the distinctive focus of the IMH field.[7] Children grow and develop in the context of their ongoing relationships and experiences with their caregivers and families. A young child's ability to achieve optimal social-emotional, cognitive, linguistic, and physical development is dependent upon play, exploration, interaction with others, and *falling in love* and *being in love* with a safe and nurturing adult.[8]

Attachment Relationships

Attachment theory is a cornerstone of IMH. Practitioners must be knowledgeable about the skills that infants and young children need to master for success later in life. Developing a strong attachment to one's caregiver is considered an essential component for the later ability to form healthy personal relationships.

Attachment is a term used to describe the dependency relationship a child develops toward his or her primary caregiver. Across all cultures studied, a process called contingent communication is observed where the signals of a child are perceived, made sense of, and responded to in a timely and effective manner by the caregiver.[9] This sensitive form of responsiveness enables the child to feel safe and understood, know that his/her needs will be met, and understand that the caregiver is a reliable source of nurturance and protection. The quality of the attachment relationship or caregiver-child relationship has a predominant role in social-emotional development and serves as a social, homeostatic regulatory system.[10]

IMH interventions and treatment focus on families who have problems providing the type of supportive and nurturing environments so important to infant and toddler attachment. Overburdened caregivers, easily overwhelmed by the demands of daily living, may have

difficulty providing sensitive and responsive caregiving necessary to develop securely attached relationships. The family environments may be chaotic and lack sensitive and responsive caregiving. The caregivers themselves may have come from adverse backgrounds. These families may benefit from the assistance of an IMH practitioner to build up the internal resources to be able to provide the nurturance and mutual regulation or co-regulation that their children will need to develop secure attachment relationships.[11]

Mutual Regulation/Co-Regulation

Mutual regulation refers to the interactive rhythm of connection and disconnection that is communicated over time in the caregiver-child relationship. Both verbally and nonverbally, infants and children communicate their needs to their caregivers. Crying, for example, tells the caregiver that her child is hungry, wet, or cold, and she then responds to that need because the cries compel her to do so.[12] When the caregiver hears a cry of distress, her own system is activated to respond to what is heard and she takes action to relieve the child's discomfort. As the mother is able to calm the child, her own nervous system is also regulated which calms her and strengthens the response system. Sometimes there are mismatches in regulation. Some caregivers get frustrated or upset when they cannot understand their child's cues. They may misread the cues and respond in a way that isn't soothing to the child; or they may feel helpless and frustrated when they are unable to understand what the child needs.[13]

When the child's needs are not met, the infant may develop coping skills to respond to prolonged interactive stress.[14] For example, if crying is activating in a way that the mother becomes frustrated, the system that is established between the caregiver and child is disrupted and might lead to a feeling of disconnection. These misinterpretations and ruptures in the caregiver response may occur even when the caregiver is being as attentive as possible and takes action to repair the interaction. The occasional experience helps the child learn to manage the conflict, misunderstandings, and miscommunications that are inevitable in life.[15] However, if the repair of the relationship is not initiated, the child may remain in a state of prolonged stress.

In healthy situations, as the relationship grows and the caregiver learns to understand the child more, the child learns to trust that his or her needs will be met. In turn, the child learns that he or she can affect the environment, including the behaviors of caregivers, through the expression of his or her needs and the contingent response from caregivers.[16] In this way, the child and caregiver are interdependent. The success of the child's ability to demonstrate self-regulation later on is related to the infant's experience of clear, consistent, and responsive mutual regulation in the early years.[17]

Early Brain Development

Infancy and early childhood are windows of opportunity for shaping development, regulation and brain function, and also a time of vulnerability. Infants need connections to caregivers in order to regulate and organize their brain's function in the moment, and to allow it to develop properly over time.[18] High levels of warmth, synchrony and reciprocal responsiveness during caregiver-child interactions shape brain architecture and are associated with enhanced infant development across all domains. Conversely, low levels of these same qualities dramatically increase the risk for a variety of adverse outcomes.[19]

These early relationships provide infants and young children with the experiences that not only shape the architecture of their brain but impact development throughout their lives. If a foundation is laid down properly, a young child will have the neurobiological structures that will allow him or her to deal with stress, self-regulate, foster curiosity, develop complex language, and motivate a capacity to learn.[20] In addition, positive relationships and interactions support the development of a child's cognitive structures which are needed to learn to self-regulate emotions and behaviors. Stable self-regulation is seen as the foundation for all social-emotional relationships, as well as for the capacity to learn. If relationships with caregivers are negative or weak, the lower brain structures become dominant and the cognitive cortical structures involved in self-regulation do not develop to their full capacity.[21]

Deepening our understanding of relational contexts and the impact of both positive and negative experiences on brain maturation is an important step towards promoting healthy early childhood development. In addition, the

knowledge and understanding enhances our ability to predict developmental trajectories. It takes less time, intensity, and repetition to organize developing neural systems in an infant than to reorganize developed neural systems in an older child.[22] The field of IMH recognizes that increased awareness of how relational contexts help to shape the connections in the brain is critical for early intervention.

Maltreatment and ACE Studies

The early mental health of the young child lays the groundwork for future relationships, mental health, and even physical health. Conversely, children exposed to early adversity, especially those related to personal relationships and interactions, can compromise development. Indeed, the results of the Adverse Childhood Experiences (ACE) study demonstrated a strong, graded relationship between childhood trauma and level of traumatic stress with poor physical, mental, and behavioral outcomes later in life.[23] The key concept underlying the ACE study is that stressful or traumatic early childhood experiences can result in social-emotional and cognitive impairments. Fear-based childhoods disrupt neurodevelopment and can alter brain structure and function.[24] For example, fear can result from familial violence or the chronic failure to receive responsive caregiving. The conclusion is that fear during infancy and childhood has a cumulative impact on childhood development.

When children experience maltreatment they learn to modify their behavior to the environment and the caregiving they receive. An infant's or young child's adaptation to maltreatment can result in their cues and behaviors being difficult to understand. Although they develop coping strategies that help them survive in the face of adversity, the same strategies can interfere with many aspects of development. Deprivation of key developmental experiences will result in persistence of primitive, immature behavioral reactivity, and predispose a young child to flight, fright, or freeze responses which contribute to developmental disorganization.[25]

Memory

A myth has been perpetuated that infants or young children will not remember what has happened to them. The fact is that infants and young children have well-developed memories even when they cannot describe them in words—which is described as implicit memory. These memories may emerge as a response to certain stimuli such as sights and sounds which can result in a disruption in emotional status. The implicit memory surfaces without an actual sense of "remembering."[26]

Safety is paramount to healthy social-emotional development; but when infants or young children do not feel safe in their relationships or environments, the memories become embedded in sensory and body-based neural connections in the brain. The memories and earliest mental representations that young children have of the parent/caregiver consist of the ways the parent/caregiver did things with the child. If the parent/caregiver leaves or dies, the child loses the feeling of security generated by those reassuring interactions—"hidden regulators"—that helped to organize the child physiologically as well as psychologically. When a young child loses a parent or caregiver, his or her sense of self is altered. Repeated disruptions of caring relationships continually interfere with the child's ability to form a clear sense of who he or she is in relationship to others.[27]

The paradox is that for many infants and young children growing up in high-risk environments, they may be bonded with their caregivers but they do not feel safe with them. The important point is that infants and young children do not just *get over* or *forget* early maltreatment or chronic stress; the experience is embedded in their brain and bodies.

Caregivers from high-social-risk populations, especially caregivers with their own traumatic histories, are vulnerable for the development of disturbed, dysregulating caregiver-child relationships and interactions.[28] Many caregivers with negative experiences during their critical upbringing bring their own early childhood maltreatment experiences forward implicitly into their parenting in the present. Some experiences become encoded in the brain in such a way that awareness is not readily available to the individual. The caregiver may in fact not know why they behaved in a certain manner. Realizing that caregivers may be operating from implicit memory and understanding how early childhood experiences affect adult behavior, including emotional regulation, help IMH practitioners to better understand the caregivers that they are working with.

Reflective Functioning

Parental reflective functioning is a key determinant of how, within the context of the child's early social relationships, an infant or young child learns to self-organize and self-regulate. Parental reflective functioning is a caregiver's capacity to understand the infant's behavior in terms of internal states and feelings.[29] Development of self-organization is dependent on the caregiver's ability to communicate an understanding of the child's intentional stance via "marked mirroring" of facial expressions, voice, or touch.[30] For example, an infant may become fussy and the mother, face-to-face with the infant, shows a concerned affect on her face and says, "You look like you are hungry, it must be time for your bottle."

Being able to read a child's cues and anticipate their needs are important parts of parenting. In another example, a reflective caregiver can interpret her daughter's oppositional behavior as belying feelings of sadness or other feelings that are seemingly inconsistent with the behavior and help the child identify these feelings.[31] The caregiver is able to understand and reflect the "inner life of the child". This ability allows the caregiver to respond accordingly to the child's behavior and to see the behavior as an expression of the inner state of the child. On the other hand, a caregiver with reflective deficits takes the child's behavior at face value; for example, aggression is viewed as an indication of the child's "badness."[32] Lack of parental reflective functioning plays a key role in pathological functioning and problems in a parent-child relationship and may require treatment and the support of a licensed IMH therapist.

Child with Disabilities

One cannot predict the impact of a disability on a particular family without learning about their history, values, hopes and dreams, cultural context, and social environment. There is general consensus that disability presents a significant stressor. When a disability is present, fantasies and hopes for the child are significantly assaulted immediately and in painful ways. In addition to anxiety and depression, typical reactions may include bewilderment, anger, guilt, and denial.[33] These emotions can be so intense that they are overwhelming and disorganizing to a caregiver.

> "Through others we become ourselves."
>
> **Lev S. Vygotsky**

It is important to repeat that the relationships that any child has with his or her significant caregivers are vital to his or her social-emotional health. The relationship between infants with special needs and their caregivers is no different in this regard. It is vital to consider how a particular disability can affect the relationships between their child and his or her parents and other caregivers. Eye contact evokes a powerful sense of connection, yet visual impairments, for example, may make eye contact difficult or impossible. Muscle tone problems may make the usual pleasures of holding the infant less gratifying and feel like a rejection. The difficulties in social interaction that are a problem for children in the autistic spectrum can cause a caregiver to feel distressed and disconnected.[34] These examples show how the child's disability may impede central capacities used in building caregiver-child relationships.

Finally, when other developmental challenges or health needs are glaring, social and emotional development is often overlooked or facilitation of social-emotional development is neglected.[35] However, these functions cannot be ignored because the caregiver-child relationship is essential and provides the central organizing function from which all domains of development unfold.

Timing of Supports

Because the early years are so crucial to development, supportive services should begin as soon as possible and include IMH principles and practices. IMH practitioners who are in regular contact with families of young children must share the responsibility of qualitatively supporting the caregiver-child relationship and early brain development.[36] The field of IMH trains practitioners to recognize the complexity of development in the early years and to organize the multiple influences underlying the meaning of behavior as informed by child-specific issues, relationship factors, and environmental conditions.[37] In IMH, the key is to target developmental processes and utilize clinical interventions towards understanding and assisting fragile caregiver-infant or caregiver-child dyads as early as possible. IMH practitioners make an essential contribution to an early intervention team.

PRINCIPLES OF IMH PRACTICE

The IMH practice is guided by six principles, as articulated by Dr. Alicia Lieberman, an internationally renowned leader in the IMH field.

1st Principle

The most basic and widely accepted principle regarding the mental health of infants, toddlers and preschoolers is that their *mental health unfolds in the context of their close emotional relationships and moment-to-moment interactions with parents and caregivers.*[38] According to Dr. Kristie Brandt, every child must be provided with five essential ingredients for optimal mental health development: 1) a safe, healthy, and low-stress pregnancy; 2) the opportunity and ability to "fall in love" and "be in love" with a safe and nurturing adult; 3) support in learning to self-regulate; 4) support in learning to mutually regulate; and 5) nurturing, contingent, and developmentally appropriate care.[39]

A secure relationship between the caregiver and child requires maternal emotional availability and engagement. A lack of parental involvement instills insecurity in the relationship.[40] For example, when we consider a mother experiencing baby blues or postpartum depression—how does this relationship change if the mother is unable to meet the infant's gaze, offer calming support, or participate in reciprocal smiles? Such an interaction may lead to an infant who experiences his or her mother as emotionally unavailable and unable to co-regulate his or her feelings or needs. These same interactions could lead to a mother who views herself as ineffective because she gets little joy in response to her baby.[41]

2nd Principle

The second principle is that *constitutional characteristics, including temperamental predispositions, play a major role in how children register and process real life events and emotional experiences*.[42] At the same time, because of the central importance of emotional relationships, the caregiver's supportive response to the child can modulate and even transform constitutional vulnerabilities so that they do not derail the child's developmental course. For example, understanding variations in sensory reactivity plays a role in how available an infant is for social interactions. Finding ways that the interactions with the caregivers can be altered to provide a goodness of fit with the child's sensory processing responses helps to transform the feelings of inadequacy that a caregiver may feel.[43] Using an example of an 8-month-old, when the practitioner observed a generally slow response time in the infant, she then wondered with the caregiver what would happen if she were to stay with the contact and wait for the infant to process the communication using less words, requests, and movements. When the caregiver waited, the infant's delayed smile and vocalizations brought tears to her eyes as she understood that processing speed, and not interpersonal rejection, was at the root of the child's challenge.[44]

3rd Principle

The *family's cultural values and child-rearing customs form an indispensable matrix for understanding the child's behavior and developmental course* is the third principle.[43] Each child and caregiver exists in a particular cultural context that deeply affects their individual functioning. In the earliest of relationships, culture is embedded in every caregiving activity. Infants rely on their parents and other primary caregivers to help them regulate and over time, learn culturally acceptable ways to behave, and to respond to and express emotions.[46] We cannot understand and support the social and emotional development of infants and toddlers without understanding the family's cultural expectations, beliefs, and customs. Each child's relationships and shaping experiences are unique.

4th Principle

The 4th principle is that *IMH practitioners make an effort to understand how behaviors feel from the inside, and not just how they look from the outside*.[47] Within an IMH perspective, a practitioner learns how moment-to-moment interactions are shaping and shaped by the ongoing meaning-making process of both child and caregiver.[48] When the infant becomes distressed due to too much stimulation and the caregiver picks the baby up and walks the baby into a quieter space, providing eye contact, a soft voice, and gentle touch (moment-to-moment interactions), the meaning this dyad makes is that "we understand each other". The meaning that the baby makes is that "when I am upset my caregiver understands how I feel and what I need;" the meaning

the mother makes is that "I know what my baby is feeling and I am successful in calming my baby." These types of interactions that occur over and over include mutual regulation or adequate reading of and appropriate responding to the cues of the infant or young child.

Tuning into the internal world of the infant, young child, or caregiver is important to IMH practice. The quality, timing and tone of the caregiver's response to the various needs of the infant help to shape internal regulation skills. Consider a baby with severe gastrointestinal issues as expressed in poor feeding, excessive crying, and frequent reflux responses to feeding. Even a very attentive and emotionally available mother may become anxious as she approaches the infant's feeding and may withdraw from such a challenging infant, feeling like a failure because she cannot nurture her baby.[49] The infant may mirror the mother's anxiety as she approaches with the bottle and may experience his or her world as increasingly painful with little emotional or physical relief.

5th Principle

Central to IMH training is learning about *empathizing with parents and infants in a dual process which includes practitioners learning about empathizing with and listening to themselves*.[50] An intervener's own feelings and behaviors have a major impact on the intervention. Some areas of IMH focus that Lieberman recommends include:

- Becoming aware of a practitioner's own body sensations when interacting with a caregiver and infant or young child is important to intervention.
- Learning how attention to the practitioner's own felt sense can help them know how to respond to complex events in caregiver-infant interactions and relationships.[51]

6th Principle

The last principle is to intervene as early as possible. Children's brains are organized and all aspects of learning are mediated by their relationships with caregivers. When those relationships are disrupted, brain development and learning are impacted. IMH practice then becomes supporting the child through the best possible relationships and interactions as soon as possible. This means that all practitioners must:

- Be aware of the effects of maltreatment on all aspects of development.
- Learn to understand what the children are telling us they need.
- Assure/shape consistent, sensitive, nurturing and contingent caregiving responses across all relationships.
- Keep the importance of relationships central to all work and decisions.[52]

These principles offer a roadmap of skills and training opportunities for IMH practitioners of all disciplines to develop a shared language and to be able to see the same baby and family. The IMH practitioner is not only viewed as a member of a particular discipline, but also as someone with a distinct set of IMH core beliefs, skills, training experiences, and clinical strategies who incorporates a comprehensive, intensive, and relationship-based approach to working with young children and families.[53]

> "Do not mistake a child for his symptom."
> **Erik Erikson**

CONTINUUM OF SERVICES

Continuum

IMH supports an infant and young child's social-emotional well-being by encouraging positive relationships between babies and their families. IMH supports, approaches and services are seen as a continuum. The continuum includes:

Promotion: Services and supports that recognize the central importance of early relationships on brain development, learning, and the social-emotional well-being of all young children promote IMH principles. These services include a focus on positive caregiver-child and primary caregiver relationships within the home, childcare, medical, and other service settings for young children and their families.[54]

Preventive Intervention: Services that mitigate effects of risk and stress and that address potential early relationship challenges or vulnerabilities that have a documented impact on early development are preventive interventions. When there isn't a shared relationship between the parent's caregiving and interaction style and the needs of the baby, specific interventions may be needed. Specific intervention strategies are designed to nurture mutually satisfying caregiver-child relationships and prevent the progression of further difficulties.[55] These types of interventions can be provided by a range of trained early interventionists providing the opportunity to infuse IMH practices within several different interventions into their particular discipline.

Treatment: Services that target children in distress or with clear symptoms indicating a mental health disorder are considered treatment. The services address attachment and relationship disturbances and the interplay between the child, parent, and other significant caregivers that jeopardize achieving early mental health and social-emotional development. Specialized early mental health treatment services focus on the caregiver-child dyad and are designed to improve child and family functioning and the mental health of the child, the parents, and other primary caregivers.[56] This level of care must be provided by licensed mental health therapists trained in IMH.

Across this continuum, IMH services seek to facilitate a child's neurobiological and social-emotional development while focusing on early relationships and the "goodness of fit" among the child, the parents, and other significant caregivers.[57]

When to Make A Referral

Early neglect, trauma, and maltreatment have long-term pathogenic effects, including effects on brain dysfunction and related psychosocial difficulties. Problems in infant emotional development often involve parents' difficulties managing their own inner worlds—difficulties that impair their ability to care for their babies. These individuals' parenting difficulties can range from explicit repetition of early abuse to quite subtle distortions and deficits in parenting.[58] When the practitioner observes over time that the caregiver-child dyad has significant difficulty in maintaining regulation, recovering from distress, or managing intense affect, and that these observed difficulties are hampering developmental success, a referral to a licensed mental health therapist trained in IMH may be appropriate.

> "If we value our children, we must cherish their parents."
>
> **John Bowlby**

APPROACH TO SERVICES

The IMH field advocates approaches to assessment and intervention that are interdisciplinary, preventive, trauma-informed, developmentally-informed, and relationship-based. Today, practitioners recognize that in order to understand the unfolding of developmental processes, one must look at the infant and young child in the context of his or her environment and most particularly, in the context of his or her relationships with the caregivers in his life. However, there can be differences between approaches and targets of service delivery by those working with young children and families. The more we can understand the differences, the more we can understand how to collaborate in the child's and family's best interest by employing IMH principles.

Family-Centered

A focus on relationships is harmonious with the family-centered perspective that regards caregivers as full partners in all aspects of service delivery. The family, not just the child, is the focus of intervention in a family-centered approach. The characteristics of family-centered practices and effective help-giving include respect for the family member, presumption of competence, and promotion of their strengths and abilities rather than limiting them by their presumed deficits.[59] An emphasis is placed on family choice, family strengths, and the nature of the relationship between the practitioners and the family. A physical therapist, for example, might model how to stretch the child and coaches the caregiver as she practices the stretches. They discuss natural opportunities when the child could be stretched during the day, such as

while changing a diaper, then the caregiver practices the stretches at the changing table. They identify that this is a good routine in which to embed stretches. The physical therapist, as coach, and caregiver work together in a reciprocal interaction to share ideas, problem-solve, and practice potential solutions and strategies.[60]

Relationship-Based

While a family-centered intervention defines who is the focus of intervention and provides guidelines regarding how to focus on the family, principles of relationship-based care provide specifics regarding the relationship inherent in family-centered care. When we use the term "relationship-based approaches," we are referring to intervention approaches that rely on the context of relationships as central to the focus of intervention. An IMH relationship-based approach addresses the expected and unexpected stress, coping and adjustment reactions, and general well-being of families.[61]

Intervention that is relationship-based assumes a family-centered perspective, but takes it one step further by focusing on the social-emotional health of both the young child and the caregiver. The approach requires the creation of a safe and nurturing context in which a caregiver and practitioner may think deeply about the care of the infant, the emotional health of the caregiver, the multiple challenges of early parenthood, and possibilities for growth and change.[62] Questions that might be asked in a relationship-oriented way include, "How do the practitioner and caregiver see the same baby?" "Who is this infant or young child to this family?"[63]

For a child with a disability, assessment and intervention would include not only the child's symptoms and functioning but risk and protective factors within the caregiver-child relationship. These could include: 1) the caregivers' beliefs about the cause of the developmental delay; 2) the way the child's condition affects the different family members, including their emotional responses; 3) caregivers' mental representations of the child and his/her capacity; 4) caregivers' representations of themselves and their role as parents; and 5) caregivers' coping mechanisms.[64]

Reflective Supervision

Reflective supervision is recommended for all IMH practitioners due to the evocative nature of working with young children and families. Providing practitioners opportunities to recognize the potential stress of providing relationship-based practice and allowing time for adequate reflection is strongly encouraged for all engaged in IMH work.[65]

Practitioners' best work with families happens when they are reflectively aware of their own reactions, judgments and assumptions, whether positive or negative, and are able to talk about them in reflective supervision.[66] Within the reflective process, the practitioner continually uses internal knowledge and external knowledge to examine and advance practice both in supervision and in clinical work.[67] Regular reflective supervision is critical to effective IMH practice.

> "Do unto others as you would have others do unto others."
>
> **Jeree Pawl**

INTEGRATING IMH AND EARLY INTERVENTION

Shared Lexicon and Core Beliefs

It is helpful to define an IMH practitioner not as a member of a particular discipline, but rather as someone with a distinct set of core beliefs, principles, training experiences, and clinical strategies, who incorporates a comprehensive, relationship-based approach to working with young children and families.[68] However, certain skills may distinguish an IMH-trained practitioner from an early intervention service provider. For providers who are not IMH therapists, but who are interested in integrating early intervention with IMH practice, some additional training may be warranted. Having a shared lexicon, core training, and adherence to IMH principles would assure the best success for families.

Training and Strategies

As IMH approaches are integrated into the work of early intervention, Dr. Deborah Weatherston asserts that the following skills and strategies may warrant further training:

1. Recognizing the caregiver-child relationship as the unit of development and, therefore, learning new methods of observation, assessment, and intervention.
2. Learning to be comfortable with holding multiple views.
3. Looking at parenting behavior and not skills.
4. Wondering about the caregiver's thoughts and feelings related to the presence and care of the infant or young child and the changing responsibilities of parenthood.
5. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving adult.
6. Listening for the past as it is expressed in the present; inquiring and talking.
7. Allowing core relational conflicts and emotions to be expressed by the caregiver; holding, containing, and talking about them as the caregiver is able.
8. Attending and responding to parental histories of abandonment, separation, and unresolved loss or trauma as they affect the care of the infant, the infant's development, the caregiver's emotional health, and the early developing relationship.
9. Attending and responding to the infant's history of early care within the developing caregiver-infant relationship.
10. Identifying, referring, and/or collaborating with others if needed, in the treatment of disorders of infancy, delays and disabilities, parental mental illness, and family dysfunction.
11. Remaining open, curious, and reflective.
12. Receiving reflective supervision to encourage the ability to work in a relationship-based model regardless of discipline.[69]

Example of Collaboration

The following vignette from Pawl and Milburn (2006) illustrates how mental health and relationship issues can be difficult to distinguish from medical and developmental issues and how collaboration between practitioners can help alleviate the parent's confusion.

> Marta, a 12-month old, had developmental delays and microencephaly but had not been given a more specific diagnosis. Her mother, Erika, spoke only a little English, so understanding what the English-speaking doctors said to her about Marta was very difficult for her. From the beginning, Marta had been difficult to feed, and weight gain had been a major problem. The pediatrician believed that the feeding problems were organic in origin, but he had not been able to identify a cause. He had explained to Erika that microencephaly often resulted in mental retardation.
>
> Carol, an IMH practitioner, who was referred by an occupational therapist working with the family, began making weekly visits to support Erika, who had become very depressed. She watched the feeding interaction and saw that Erika forced food into Marta's mouth, ignoring all of her protests that she did not want to eat.
>
> Carol sat patiently with Marta and Erika, commenting on what an ordeal it was for both of them. She listened to Erika's despair and frustration, and gradually she began to understand what had happened. As an infant, Marta had not been a vigorous eater. Nursing was not possible, and even with a bottle, she was not strong enough to suck efficiently. When the pediatrician had explained to Erika that Marta had microencephaly, Erika had understood him to mean that Marta must eat more so that her brain would grow. In Erika's mind, feeding Marta became synonymous with preventing mental retardation. Also in her attempt to understand Erika's perceptions of mental retardation, Carol found out that Erika's younger brother had been labeled mentally retarded and many of the children in her childhood neighborhood used to make fun of him.
>
> It was not difficult to understand Erika's desperation. With Erika's permission and in collaboration with the

occupational therapist, Carol called the pediatrician and said she would like to work with Erika and Marta along with the occupational therapist, to change the feeding dynamic. She needed his approval that it would be safe to let Marta get hungry enough to eat on her own. Erika was enthusiastic in theory but her anxiety about Marta not eating was overwhelming, and she wasn't able to stop herself from force-feeding. At that point Carol and the occupational therapist discussed how to proceed and it was agreed that Carol would ask the pediatrician to allow Erika to bring Marta in daily for a weight and health check to minimize her anxiety. Gradually, Marta began to nibble food on her own, and Erika's anxiety began to decrease.[70]

In this example, it was the collaboration that eventually brought a solution to both a medical problem—lack of weight gain and a relationship problem—the force-feeding dynamic. It took collaboration and a mutual understanding about this dyad's meaning-making in order to reduce Erika's anxiety and to allow Marta to learn to eat on her own. Once this dyad felt 'held' through the collaborative relationships between the pediatrician, occupational therapist, and IMH therapist, their interactions in other areas began to improve.

> "The essence of creativity is figuring out how to use what you already know in order to go beyond what you already think."
>
> **Jerome Bruner**

CONCLUSION

The field of IMH has come a long way since Fraiberg coined the term, and it continues to grow. Understanding how emotional well-being can be strengthened or disrupted in early childhood can help all systems promote the kinds of environments and experiences that prevent problems and remediate early difficulties so they do not destabilize the developmental process. Regardless of the origin of mental health concerns, research clearly indicates that IMH approaches can have a positive impact on the trajectory of common emotional or behavioral problems as well as outcomes for children with serious disorders.

As an interdisciplinary field, it is recommended that attention must extend beyond one's area of professional training in communication, cognition, sensory regulation, or motor development to an interest in feelings, including one's own relations, in supporting the quality of the caregiver-child intervention relationship.[71] This may require additional training that includes the IMH principles in order to create a therapeutic web and broaden the continuum of practitioners working to strengthen the development and well-being of infants and young children within secure and stable caregiver-child relationships.

> The single most common factor for children who develop resilience is at least one stable and committed relationship with a supportive caregiver or other adult.[72]

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