The Handbook of Training and Practice in Infant and Preschool Mental Health
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The Handbook of Training and Practice in Infant and Preschool Mental Health
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To my daughter, Courtney, who has added immeasurable richness to my life.
Preface

The delivery of mental health services to infants, toddlers, preschoolers, and their families involves a complex interweaving of skills that straddle disciplines and test boundaries. Provision of such services is a testament to the strength of practitioners who struggle to balance the necessary knowledge base, application strategies, and self-awareness required by the work. It is a fragile dance, with the practitioner often initiating a conversation that a caregiver does not want to have, testing and retesting boundaries as the work unfolds, and maintaining a steady, yet ever adapting, view of individual children and families. The practitioner must provide constancy in an ever changing world while remaining open to new possibilities in her own work and in the lives of the families served. The dance requires the clinician to adjust her tempo across time—sometimes it is a slow dreamy waltz, at other times a spinning, whirling motion accompanying the child and family on their precious journey of developing and becoming.

In order to be effective, the infant and preschool mental health practitioner must exhibit a wide range of personality characteristics—some deep within, others at the surface—all ready to be called up at the appropriate moment. These characteristics include a sense of humor that allows the clinician to share joy with a family and to lighten dark moments. She must be able to laugh with a family, to laugh with her colleagues, and to laugh at herself. She must be patient, not only with herself and her expectations of her own work but in her expectations of families. She must be able to sit quietly and listen but not be afraid of providing advice when asked. A practitioner must also be enthusiastic and passionate about her work—the dance is different, then, than when a family encounters indifference and apathy.

Compassion must come as second nature but not overwhelm the work. Showing understanding, interest, and concern is crucial, but so is the ability to step back from the work and to maintain direction without being sidelined by overwhelming need. A practitioner must
have boundaries but be able to work in boundary-less fashion—cutting across disciplines, making decisions that are appropriate in her work with one family but not with another family. High-quality supervision is essential to this work. The good supervisor holds the clinician so that continuing progress is possible and acts as the depository for the self-doubt that inevitably arises when doing this complex work.

Infant and preschool mental health is an ever changing, evolving field. This handbook is designed to help the clinician in the journey of professional growth as she works to help young children and families realize their potentials. The handbook is intended to help training programs, agencies, and clinicians determine what skills and clinical experiences are needed to do the wide range of work that makes up this field and decide how to develop those skills and structure the clinical experiences.

The book is divided into five parts. Part One focuses on broad training areas in which a clinician interested in infant and preschool mental health practice must develop skills. Weatherston’s chapter provides a wonderful overview of current and historical issues related to training and service delivery, along with key concepts in infant mental health. Other chapters in Part One focus on developing observation skills, designing assessment training, developing diagnostic skills with very young children, providing dyadic therapy, providing (and receiving) reflective supervision, and developing self-awareness and sociocultural perspective. Finally, the chapter by Delahooke examines retraining from the perspective of the practitioner who struggles with putting together key training elements, without the benefit of a comprehensive training program. This chapter is particularly pertinent, as many practicing clinicians who decide to retrain to work with birth to five-year-olds are not able to move to another city and enroll in a comprehensive training program.

Part Two addresses specialized areas of practice, including the evaluation and decision-making process for reunification and adoption, play therapy with preschoolers, and intensive day treatment for very young, traumatized children in residential care. The last two chapters in Part Two focus on the delivery of infant and preschool mental health services outside the traditional mental health arena. Jones Harden and Lythcott look at issues in providing services in homes, schools, day-care centers, and social service agencies. Harris addresses strategies for delivering services in rural and remote areas.
Part Three explores training systems and the use of technology for training, supervision, and consultation. Included are chapters examining the development of training and practice standards within California, the Wayne State University Graduate Certificate Program in Michigan, and the development of the DIR™ Certificate program. Wajda-Johnston and her colleagues have put together a wonderful examination of the struggles they have encountered and the success they have had in developing technology for remote supervision and training.

Part Four includes several innovative models of service delivery and training that rely on collaboration between disciplines and an integrative approach to services to create system change. Finally, Part Five is a thought-provoking examination of programs in Illinois and New York that transform training and practice through the infusion of reflective process and the creation of “ripples” across systems.

As infant and preschool mental health practitioners continue to develop and expand the scope of their practices, they will find many of the chapters in this handbook particularly important to their professional development. The authors are trainers and service providers who are involved with the leading edge of infant and preschool mental health services across the United States. I hope that this book will be useful as a training guide for developing clinicians, a resource for current practitioners, and an inspiration to programs looking to expand their boundaries on behalf of very young children and their families.

ACKNOWLEDGMENTS

I would like to thank Dr. Natalie Porter of Alliant International University, who encouraged me to move this handbook from concept to product. I am extremely grateful for her support and her help in connecting me to Jossey-Bass. My extraordinary home visiting program staff, whose dedication to young children and families is an ongoing inspiration, also deserve special thanks for their support while this handbook was developed and completed.

The excitement and passion for the field, passed along by visionary leaders who worked tirelessly on behalf of very young children and families long before anyone knew what infant mental health meant, continue to motivate all of us and drive our clinical work. The inspired
teaching of these visionary leaders has led us to be better clinicians, researchers, and teachers and to extend the passion for the field to others whom we train. National and international organizations dedicated to infants and young children, including Zero to Three, the International Society on Infant Studies, and the World Association for Infant Mental Health, provide continuing opportunities to share our knowledge, our work, and our dreams for improved practice, research, and training. We have all been professionally and personally enriched by our associations with these organizations and the individuals who constitute them.

Finally, this handbook would not have been possible without the considerable time and energy of the authors of each chapter. Despite heavy schedules full of service delivery, teaching, and research, these amazing authors put together stellar chapters that are thought provoking, educational, and inspiring. I cannot thank them enough for their collegiality and commitment. They are not only brilliant thinkers but are, even more important, sincere and caring individuals. The field will be forever enriched by their work.

Los Angeles, California

Karen Finello
The Handbook of Training and Practice in Infant and Preschool Mental Health
PART ONE

General Training and Practice Constructs
Imagine that you are an infant mental health practitioner and that you are sitting in a family’s kitchen. The young mother, her infant, and her toddler were referred to you by a nurse practitioner who had some concerns about the baby’s care and development following the baby’s discharge from the newborn intensive care unit. It is about 2 P.M. Dishes are piled high in the sink; food from several meals sits on the counter. It is hot. The windows are shut tight, and although the sun is shining, the shades are drawn as if to protect against the intrusion of daylight. The baby, three months old, cries in the back room. The information that you were given tells you that the baby was premature and had been separated from her mother’s care for three weeks before hospital discharge. The twenty-two-month-old toddler, a boy, brings you toys and indicates with a grunt that he wants to climb up on your lap—you, the stranger. His face is smudged with traces of chocolate. He is pale and unsmiling. There are significant developmental questions about both small children. Their mother, a single parent, twenty-four years old, is alone in caring for her children and isolated from family or friends. She seems agitated and surprised that you have come, although you spoke to her yesterday on the phone. She, too, is unsmiling, unable to pay attention to the toddler or to hear the baby’s continuing cries. She lights a cigarette, pours a cup of coffee for herself and asks you, “So . . . why are you here?”
This vignette marks the beginning of an infant mental health intervention in which the focus is on early development and relationships between a parent and her two young children. The scene is a familiar one in the world of infant mental health, challenging and complex. What is it that you, in the role of an infant mental health practitioner, will do? What core beliefs, skills, and strategies will guide you to work effectively from an infant mental health perspective? Finally, what training experiences will you need to have in order to offer this family meaningful service support? The intent of this chapter is to introduce the reader to the practice of infant mental health and the experiences that contribute to the growth and awakening of an infant mental health therapist.

WHAT IS INFANT MENTAL HEALTH?

Selma Fraiberg and her colleagues in Michigan coined the phrase *infant mental health* in the late 1960s. It is defined as the social, emotional, and cognitive well-being of a baby who is under three years of age, within the context of a caregiving relationship (Fraiberg, 1980). Fraiberg understood that early deprivation affected both development and behavior in infancy and reminded us that an infant’s capacity for love and for learning begins in those early years. She had been trained in a psychodynamic approach to mental health treatment for adults and children, which she adapted for work with parents and young children from birth to three.

Fraiberg was attuned to the power and importance of relationships and understood that how a parent cares for a very young child has a significant impact on the emotional health of that child. She also understood that parental history and past relationship experiences influence the development of relationships between parents and young children. Fraiberg referred to this new knowledge and understanding about infants and parents as “a treasure that should be returned to babies and their families as a gift from science” (1980, p. 3). She spent the remainder of her career returning that gift through training and a carefully crafted approach called *infant mental health service* (Weatherston, 2000).

Four questions are of great significance to the scope of infant mental health practice and to the training needs of infant mental health specialists: What about the baby? What about the parents who care for the baby? What about their early developing relationship and the
context for early care? What about the practitioner? These questions shape the framework for infant mental health practice and training (Weatherston, 2001).

**INFANT MENTAL HEALTH PRACTICE**

Regarded as a unique approach to the understanding and treatment of infants, toddlers, and families, infant mental health practice embraces the belief that all babies and young children can benefit from a sustained, primary relationship that is nurturing, supportive, and protective (Stinson, Tableman, & Weatherston, 2000; Shirilla & Weatherston, 2002). The developing parent-child relationship should be placed at the center of the therapist’s work from the moment a family is referred or asks for help through the period of observation, assessment, and intervention (Liebeman & Pawl, 1993; Lieberman & Zeannah, 1999).

Parents and infants are seen together, often in the intimacy of their own homes, where the infant mental health therapist offers his or her relationship as a therapeutic context for shared observations, careful listening, and empathic response. It is most customary for an infant mental health therapist to work with a family weekly or even more frequently, for a maximum of one-and-a-half hours per visit. Some interventions may be short term or for a crisis response; others may be for assessment purposes. Most continue for three months to one year, and some sustain the work for longer periods of time, depending on the infant’s or family’s need. The goals are to support the social and emotional development of an infant or toddler, to identify and reduce the risk of disorder or delay, to nurture the emerging caregiving competencies that each parent has, and to strengthen early developing relationships in families.

The stakes are high. Babies and families in crisis cannot wait. Effective infant mental health practitioners observe infants and parents together and wonder about the nature of their interactions and developing relationships (Trout, 1982; McDonough, 1993; Cohen, Muir, & Lojkasek, 1999). Practitioners listen carefully, ask questions that are thoughtful, and gather information about the baby and early care. They may use formal developmental guides or diagnostic criteria, as appropriate. Practitioners invite parental participation throughout the assessment and treatment process, make an effort to establish warm and trusting relationships with parents, and consider parents’
feelings in response to observations and interviews (Hirshberg, 1993). Knowledgeable and skillful infant mental health practitioners organize their understanding in a meaningful and practical way. They listen carefully to parents and are not judgmental. They communicate clearly and invite a supportive partnership with parents (Hirshberg, 1996).

Core Infant Mental Health Beliefs
Core beliefs guide infant mental health practitioners to cherish each encounter with infants or toddlers and their families and to think deeply about early developing relationships (Trout, 1987; Stinson, Tableman, & Weatherston, 2000; Weatherston, 2000). These beliefs are the bedrock of infant mental health practice. They shape a practitioner’s approach to all infants or toddlers and families who are referred for early services. Some of the most fundamental beliefs are the following:

• Optimal growth and development occur within nurturing relationships.
• The birth and care of a baby offer a family the possibility of new relationships, growth, and change.
• What happens in the early years affects the course of development across the life span.
• Early developing attachment relationships may be distorted by parental histories of unresolved losses or traumatic life events.
• The therapeutic presence of an infant mental health practitioner may reduce the risk of early relationship failure and offer hopefulness for change.

Key Components of Infant Mental Health Practice
Infant mental health services include a variety of components: concrete resource assistance, emotional support, developmental guidance, advocacy, and infant-parent psychotherapy. Some or all of these components will be appropriate when working with individual infants and families (Fraiberg, 1980; Weatherston, 1997; Weatherston & Tableman, 2002). All provide opportunities to nurture early development and relationships when responding to families.
Concrete resource assistance refers to the meeting of basic needs for food, clothing, medical care, shelter, and protection. The practitioner who feeds or clothes or takes a family to the clinic assures parents and young children that he cares about them and will work to ease their burdens of care.

Emotional support is defined as compassion offered to a parent who faces a crisis during pregnancy or in caring for a new baby or toddler. Alone, or without emotional reinforcement, a parent needs someone who is emotionally available, listens carefully, asks questions sensitively, and holds the many feelings that threaten to overwhelm or confuse.

Developmental guidance is the shared understanding about the baby’s development and specific needs for care. The practitioner and parent carefully identify emerging capacities and concerns, reaching an understanding of the uniqueness of each baby through careful observation and words.

Advocacy is the offer of help to parent or infant when they cannot successfully ask for it themselves (for example, a safe place to live, assistance in finding child care, support for a special needs assessment). To speak effectively on behalf of an infant’s need for early care or a parent’s need for support is often a daunting, but critical, task.

Infant–parent psychotherapy offers a parent the opportunity to explore thoughts and feelings awakened in the presence of an infant or toddler. In the intimacy of the home visit, a parent may share stories of past experiences and significant relationships, major fears, disappointments, and unresolved losses as they affect the care of a baby and the early developing relationship between parent and child.

Crucial to the effectiveness of these service components is the working relationship that develops between each infant mental health practitioner and parent (Fraiberg, 1980; Lieberman & Pawl, 1993; Hirshberg, 1996). Respectful and consistent, the infant mental health practitioner must remain attentive to each parent’s strengths and needs. Within the safety of the relationship with the infant mental health practitioner, parents feel well cared for and secure, held by the therapist’s words and in her mind (Pawl, 1994). The practitioner listens carefully, follows the parent’s lead, remains attuned, sets limits, and responds with empathy. Well held, the parent experiences possibilities for growth and change through the relationship with her infant.
Infant Mental Health Skills and Strategies

Clinicians identify basic skills and strategies that are ingredients for compassionate and effective work with infants and families (Fraiberg, Adelson, & Shapiro, 1975; Blos & Davies, 1993; Pawl, 1994; Proulx, 2002; Barron, 2002; Daligga, 2002; Oleksiak, 2002; Weatherston, 2002). These contribute to the infant mental health practitioner’s understanding of the infant or toddler, the awakening or repair of the early developing parent-child relationship, and the parent’s capacity to nurture and protect her young child. They help infant mental health practitioners engage and sustain relationships with parents, as they think deeply about the social and emotional health and needs of each parent and very young child (Weatherston, 2000):

- Identify and respond to immediate concrete service needs, to the extent necessary and possible.
- Meet with the infant and parent together throughout the period of observation, assessment, and intervention, nurturing relationships and using them as instruments of change.
- Invite parents to talk and listen carefully to what each parent has to tell you.
- Sit beside the parent to observe the infant or toddler’s growth and development.
- Offer anticipatory guidance to the parent that is specific to the infant or young child, remaining sensitive to the parent’s readiness to listen.
- Alert each parent to the infant’s or toddler’s accomplishments and needs.
- Create opportunities for pleasurable interaction between parent and infant.
- Allow the parents to set the agenda and take the lead.
- Identify and enhance the capacities that each parent brings to the care of the infant or toddler.
- Speak for the infant and parent on behalf of their developmental and relationship needs.
- Wonder about the parent’s thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood.
- Listen for the past as it is expressed in the present.
Allow core relational conflicts and emotions to be expressed; hold, contain, and talk about them as the parent is able.

Attend and respond to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant, the infant’s development, the parent’s emotional health, and the early developing relationship.

Identify, treat, and collaborate with others in the treatment of disorders of infancy, delays and disabilities, parental mental illness, and family dysfunction.

Use the supervisory relationship as a context for personal and professional development.

Remain open, curious, and reflective.

All of these strategies support key tasks within infant mental health practice: to develop a trusting relationship with each infant and family referred, to identify emerging capacities and risks in infancy and early parenthood, and to construct an intervention that nurtures and sustains the parent-child relationship. Together, these approaches help define the unique specialization of infant mental health (Weatherston, 2000; Weatherston & Tableman, 2002).

### Key Tasks of Infant Mental Health Practice: Developing Relationships

Attention to relationship provides the focus for infant mental health practice. The infant mental health practitioner understands that the development of a trusting relationship with each infant and family referred offers the hopefulness for intervention and substantive change. The practitioner also understands that the relationship between parent and infant or parent and toddler provides the focus for treatment rather than the infant alone or the parent in isolation. Finally, the practitioner knows that the supervisory relationship offers multiple opportunities for learning and reflective practice. What follows is a brief discussion of each of these relationships and their importance to infant mental health practice.

**The Parent-Practitioner Relationship.** The working relationship between parent and practitioner is fundamental to growth and change within an infant mental health intervention (Lieberman & Zeanah,
A parent in treatment learns about relationships through interactions with the practitioner, who is consistently available, sensitive to the needs of the parent, and emotionally responsive (Lieberman & Pawl, 1993). Within the context of this working relationship with the infant mental health practitioner, a parent has the opportunity to feel supported, protected, nurtured, and cared for.

For some parents, the relationship offers a “corrective emotional experience” (Lieberman & Pawl, 1993, p. 430). For other parents, the relationship provides “moments of meeting” with the practitioner, helping them to discover what is intensely important about interaction and response when there is a basis for mutual trust (Morgan, 1998). The working relationship offers parents opportunities to learn about relationship and to transfer that understanding to new interactions and ways of relating to their infant or young child. It is the relationship between parent and practitioner that offers a context for growth and change between parent and infant.

The working relationship begins with the practitioner’s undivided attention to what a parent wants or needs and where the parent wants to begin. The practitioner’s invitation to a parent to talk and the practitioner’s willingness to listen are hallmarks of best practice. Reliability, consistency, and follow-through are equally important, especially as the relationship is beginning. In addition, the practitioner’s sincere interest in the infant or toddler, balanced with concern for the parent’s emotional well-being, helps the working relationship develop.

The development of a working relationship takes time and energy. The practitioner needs to be patient, aware of the family’s need to move slowly and to develop courage in learning to trust and accept help. The practitioner needs to be willing to reach out, often many times. The practitioner needs to persist in face of many challenges (for example, crowded homes, intrusive visitors, severe disorganization, missed appointments). Often tentative, the relationship between parent and practitioner needs to be carefully constructed and protected.

Resistance may mean that a parent is fearful of entering into the relationship with the infant mental health practitioner. The practitioner thinks about the meaning of the parent’s resistance, addresses it with the family, and is often able to reduce the parent’s worry as they reach an agreement about their work together. Engaging parents and infants in relationship-based work requires training, practice, and continuing support.
THE PARENT-INFANT RELATIONSHIP. The working relationship between parent and practitioner provides a context in which parent and practitioner are able to consider the parent-infant relationship. Working with parent and infant together, the practitioner has multiple opportunities to observe and wonder about their developing relationship (Trout, 1987; Weatherston & Tableman, 2002). What is the nature of their interaction with each other? Is there a sense of reciprocity between them? How much pleasure does there seem to be? Are they emotionally available to each other, or are there frequently missed cues and misunderstandings? Is there a feeling of warmth or affection between them?

Sensitive inquiry might include questions about the parent’s experience of the infant, the meaning of the infant to the parent, what the parent cherishes about the infant, and what is difficult. The practitioner may use what she sees in the interaction to ask about the parent’s caregiving experience of the infant or toddler. Or the practitioner may ask questions about other babies or early care experiences that now affect the interaction with this baby. There is no script in infant mental health, only the guiding principle that it is the development of an infant or toddler within the caregiving relationship that provides the focus for the work.

THE PRACTITIONER-SUPERVISOR RELATIONSHIP. There is a third relationship that is significant to the first two: the supervisory relationship. Selma Fraiberg believed that infant mental health could be most successfully taught and explored within the supervisory relationship between a senior staff person and an individual trainee. Her unwavering belief that relationships affect relationships influenced the service that she and her staff developed to guide and support parents and infants (Fraiberg, 1980). This commitment to reflective practice influences the shape of infant mental health practice today (Schafer, 1992).

Respect, mutuality, and safety characterize what is optimal within the supervisory relationship (Shahmoon-Shanok, 1992). It is within a trusting supervisory relationship that an infant mental health practitioner grasps what is fundamental about infant mental health practice: the power and centrality of relationship. All of the work that is carried out with infants, toddlers, and families requires a belief and commitment to relationship. The practitioner’s opportunity to be in a sustaining relationship with a supervisor while providing relationship-based services to infants and families is crucial to best practice within the infant mental health field.
In sum, these three relationships form the overarching context for thinking about infant mental health practice: the relationship between parent and practitioner, the relationship between parent and infant, and the relationship between practitioner and supervisor.

Key Tasks of Infant Mental Health Practice: Identifying Capacities and Risks

The ability to identify capacities and risks in infancy and early parenthood is essential to infant mental health practice. For the purpose of this discussion, the emphasis will be on understanding risk factors generally considered in referring and enrolling infants, toddlers, and parents for infant mental health services. However, it is important to keep in mind that risk is understood within the context of capacity. The infant mental health practitioner is always balancing risk with capacity and asking this question: Where does the hopefulness lie?

Most generally, the indications of risk and need for supportive intervention are identified within the infant or toddler, the parent or caregiving figure, the developing parent-child relationship, and the context in which the infant and parent live. In some instances, the risks are constitutional and rest mainly with the infant or toddler. In other instances, the risks cluster around the parent as primary caregiver, often the mother. In many cases, there are worries about both child and parent, including constitutional and maturational factors, psychosocial indicators, and the context of relationship-care (Emde, 1989).

A trainee or practitioner new to the practice of infant mental health becomes familiar with many risk indicators, in order to observe or inquire about them, listen carefully to the parent’s concerns, and relate them all, in partnership with parents, to a meaningful service plan. At the same time, the trainee or practitioner keeps in mind the infant or toddler’s strengths, parental capacities to provide adequate care, and aspects that offer hopefulness for development and change. The last is often a challenging requirement, but it is extremely important to the early work with a family.

Identification of Risk: Focus on the Infant or Toddler. Practitioners learn to appreciate the variety of risks that encompass early development programs. The infants referred may be constitutionally vulnerable babies who cannot wait beyond the first weeks or months of life for prevention or early intervention support. They may be