
RELATIONSHIPS FOR LEARNING:

Early Head Start Infant Mental Health in Jackson, Michigan

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It is a gift to have the time and place to reflect on experiences within the rapidly expanding world of infant and family work. I began my journey decades ago as a teacher for one of the first Head Start programs in Michigan, in 1966. Thirty years later, I was asked to be a trainer and consultant to one of the first Early Head Start programs in the country. In the years in between, I had worked as a home visitor, introduced by Selma Fraiberg and Michigan colleagues to the practice of Infant Mental Health. Under their careful direction, I learned about the importance of infancy and early relationship development to one's capacity for learning and relationship experiences throughout the course of life. In the process, I developed a passionate curiosity about early development and relationship work. In my role as an Early Head Start trainer and consultant, I was uniquely challenged to integrate what I understood from my experiences as an Infant Mental Health specialist into the new arena of Early Head Start.

Infant Mental Health: The Michigan Approach

Infant Mental Health services as developed by my Michigan colleagues are intensive and comprehensive.

Parent and infant are seen together, most frequently in their own homes, for early identification of risks and treatment to support the developmental and relationship capacities of both parent and child. Returning to "the source," the home where an infant or toddler and parent live, the Infant Mental Health specialist observes, first hand, the child within the context of the emerging parent-child relationship. Sitting at the kitchen table or on the floor or on the sofa, the specialist attends to the emotional experience and needs of the infant, at the same time curious about the parent's behavior and emotional response. To the extent that

at a glance

- The EHS program in Jackson, MI is a relationship-based model that focuses on the mental health and developmental needs of children and families.
- EHS specialists (home visitors) are master's level social workers or early childhood educators.
- The model is evolving, to support families and children at home and in center-based or family child care.
- Training and regular reflective consultation for EHS specialists are essential for effectiveness.

the specialist understands, supports and sustains parents in understanding and responding sensitively to their infants' or toddlers' emotional needs, an overarching and significant goal of Infant Mental Health services is reached. Treatment strategies vary and may include concrete assistance, emotional support, developmental guidance, early relationship assessment and support, infant-parent psychotherapy, and advocacy. Fundamental to the success of these service strategies is the belief that it is the Infant Mental Health specialist's relationship with the family that becomes the instrument for growth and change (Weatherston, 1995, 1997, 2000; Weatherston & Tableman, 1989).

The Jackson, Michigan Early Head Start Program Model

The Early Head Start (EHS) Program was designed to support the parenting capacities and child development needs of families with infants and toddlers, some of whom could be expected to be highly vulnerable. As EHS was beginning in 1995, the Jackson, Michigan community was fortunate to have an established Infant Mental Health Program, one of more than 35 programs developed to provide home visiting services to children under three years of age and their parents within a statewide system of mental health care. The EHS program model proposed by planners in Jackson was designed to focus on the mental health and developmental needs of children and families enrolled for Early Head Start services. The Infant Mental Health Program provided a cornerstone for the evolution of the new relationship-based EHS model. Within this model, it was assumed that expectant parents and families with very young children would benefit greatly from well-trained practitioners who were prepared at the master's degree level with specialization in social work or early childhood education. The program model called for weekly home visiting by these EHS specialists, as well as socialization groups for interaction and play. The program model later established the option of center-based care for a small number of families with infants and toddlers.

At times, we were uncertain about how to balance developmental goals for young children with the emotional realities of parents or caregivers and the stresses that continuously threaten the stability of their lives. What follows are descriptions of this effort, with an emphasis on the evolution of a model that is dedicated to supporting the developmental capacities of infants and toddlers within the framework of emotional relationships, at home and in center-based or family child care.

Early Training Experiences

As the Region II Community Action Agency Early Head Start started up, we designed a training experience to introduce the new team of EHS specialists to Early Head Start and Infant Mental Health principles and practice. The first task was to provide a context in which the eight

EHS specialists, their supervisor, and I could think about infancy, early parenthood, home visiting work, and ourselves. New to one another and new to the practice of Early Head Start and Infant Mental Health, we very much needed 6 intensive, training days together, a total of 36 hours of training. We met once weekly for 6 weeks. The training modules included:

1. An Introduction to Home Visiting Services: Early Head Start and Infant Mental Health;
2. The Importance of Relationships and Early Relationship Development;
3. Pregnancy and Development in the First Years;
4. Observation and Informal Assessment Strategies;
5. Understanding Risks, Delays and Disabilities in Infancy and Toddlerhood; and
6. Early Head Start Families – Sharing and Responding to Home Visiting Work.

Observing and listening

Throughout each training day, there were opportunities to ask questions about development within the context of relationship, wonder about the meaning of interaction or behavior, consider strategies for effective service, and reflect on personal responses to challenging professional work. For example, while considering the emotional milestones in infancy and early childhood, we watched videotaped interactions of parents and infants at play. "What is at the heart of an infant's emotional well-being?" one specialist asked. "Capacity for relationship," replied another. Others responded: "A baby who can relate well is a baby who will thrive, play joyfully, and be ready to learn when she enters school." "You can see it in their responses to their mothers and one another. They can look and listen, get excited and invite interaction." "They draw one another in. They share their pleasure with one another so easily!"

These observations led to thoughts about other babies and parents whose emotional experiences were quite different. We watched videotaped vignettes of two families: Shana, a silent, solemn, unsmiling six-month old, who asked for very little from her mother, a passive, inattentive, and depressed woman who left Shana alone in the crib for long periods of time with little to look at or play with; and Denise, an irritable three-month-old, easily agitated and difficult to console, whose mother appeared angry and resentful of her demanding baby and overwhelmed by her needs for care. One specialist wondered what each baby was experiencing. "What is it like to be that baby?" Another asked, "What is it like for the mom to take care of her?" I asked them to think about what might be getting in the way of these mothers and babies interacting more positively with each other. Together, we explored what could explain their difficult interactions and behaviors. The specialists had many ideas: "Maybe it's the baby, Shana. She's so quiet. She may be disappointing to her mother." "Maybe her mother lost a baby before her. If she did, it might be hard to care for this one

now.” “Maybe she was premature and had to stay in the hospital for some time. There could be a worry about her development.” “Maybe the mom is lonely. Maybe no one is around to help her take care of Denise.” “Maybe it’s the baby, Denise. She’s so difficult. She’s always fussing.”

Learning how to approach and support families

Their careful observations and questions led the EHS specialists to think about ways to support an infant’s development through Early Head Start and incorporate Infant Mental Health strategies as they worked. One specialist said, “I would try to sit as quietly as I could in the first visits and learn as much as I could from the mom and baby, although it would be hard. I might ask the mom what she notices that the baby is doing this week. I might ask if she has any questions about her baby’s development and offer to bring some developmental materials out.” I suggested that it might be important to observe the baby with the parent and ask the parent what the baby is doing. “You might look for an opportunity to offer some developmental information, ‘When you talk to the baby, it help the baby learn to talk.’ Or, ‘When you smile at the baby you are teaching the baby how to smile.’ Or, ‘When you offer the baby something interesting to play with, you are helping him to practice reaching and grow curious about his world.’” I also suggested that it might also be important to invite the mom to talk about her baby by asking, “Can you tell me something about your baby – maybe what she enjoys or her routine each day? How do you know when she is hungry or tired? What do you like doing with her? What is it like for you to hold her or play with her or feed her?”

I also encouraged the specialists to think about the first weeks at home with a baby. An EHS specialist might ask a parent to talk about the early care of an infant: “What was it like for you when you brought the baby home from the hospital? Who was there to help you take care of her?” The group worked hard to understand how important it is to observe, offer developmental guidance, and ask questions that invite a parent to experience — and share — an emotional response surrounding the development and handling of a baby. The specialists understood that thoughts and feelings are more easily expressed within the context of safe, trusting working relationships. They knew that it would take time for those relationships to develop with Early Head Start families, just as their own relationships within the training group were developing.

Throughout the initial training experience, it was enormously important to consider how to approach families in ways that would lead them to accept the invitation to partic-

ipate with their infants in this new home-based program. The EHS specialists kept two Infant Mental Health assumptions in mind:

- All parents want what is best for their babies, including relationships that are stable and mutually satisfying.
- The birth of a baby into a family offers the hopefulness of a new relationship and the possibility for growth and change.

It was challenging for the EHS specialists to enter families’ homes, sit beside parents and very young children, and offer strategies for developmental and relationship support. They went carefully and with optimism, as parents allowed.

For most of the new team, this approach required a dramatic shift in focus — simultaneous attention to an infant, a

parent and their developing relationship; awareness of emerging developmental capacities and acknowledgement of strengths; identification of conditions that place an infant or parent at risk for developmental failures; and creation of opportunities for parent-child interaction and exchange. Furthermore, attention to the emotional experience and needs of infants and families enrolled in Early Head Start challenged each EHS specialist to remain open and emotionally available to themselves and to each other. The tasks of EHS specialists include

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- the identification of infant and toddler strengths;
- parental guidance to notice developmental capacities and changes;
- parental guidance to interact playfully and appropriately;
- shared acknowledgement of developmental milestones; and
- encouragement for success in school.

While helping parents understand and accomplish these important goals, EHS specialists must also to pay attention and respond to the realities that parents struggle with. From an IMH perspective, this is crucial to successful home visiting and developmental work with children. Balancing what parents were experiencing, thinking about and feeling with the developmental needs of their very young children often presented enormous challenges to the EHS specialists working with young children and families. In addition to poverty, they saw other risks to parents’ and children’s well being, including depression, chronic mental illness, alcoholism, substance abuse, chronic illness, joblessness, adolescent parenthood, school failure, isolation, homelessness, single parenthood, and domestic and community violence. Of equal importance, parental histories included experiences that heightened the risk — maternal or paternal abandonment, abuse or neglect; parental alcoholism, drug use, and/or chronic mental illness; the death of a parent in childhood;

A GUIDE FOR HOME VISITING WORK WITHIN THE EARLY HEAD START SYSTEM

To promote social and emotional development in infancy:

- **Sharpen the focus of each home visit by observing the infant together with the parent.** Ask the parent what she sees that the infant is doing. Support the parent's developmental awareness of the infant. Wonder with the parent what the infant may do next and think together about how the parent can encourage the infant with that developmental task.
- **Support the parent's understanding of the importance of responsive and playful interactions** to early brain development, emerging developmental capacities, and later success in school.
- **Invite the parent to ask questions** about the infant's development and offer to look for information to answer her questions.
- **Provide developmental information** (handouts, printed material, booklets) to guide parents in interacting pleasurably with the infant and responding to the infant's developmental needs.
- **Maintain your focus on the infant and the relationship** as you inform the parent about early developmental issues, using language such as: "When you talk to the baby it helps the baby learn to talk." "When you smile at the baby it teaches the baby how to smile." "When you respond to the baby's crying you are teaching the baby that he can have an effect on his world." "When you read to the baby you are helping him to listen and pay attention." "When you offer the baby something interesting to play with you are helping him to practice reaching and grow curious about his world."
- **Link/tailor your understanding of early infant development and care to the developmental level and needs of the infant and parent you are visiting** – for example, a 6-month-old baby and an 18-year-old parent with significant cognitive delays or a 10-month-old baby who is failing to thrive and a 34-year-old parent with a diagnosis of depression.
- **Suggest to parents that play activities support early growth and development.** Invite parents to show you what the infant enjoys and responds to. Offer to demonstrate new play activities that are appropriate to the infant's age for example, early baby games, nursery rhymes, songs, and finger plays.
- **Indicate that developmental information may be shared with other family members** — father, grandmother, boy friend, etc.
- **Invite the parent to try a new play interaction with the infant.** Notice the infant's response to the activity. Inquire about the parent's response to the play interaction. Reinforce the pleasure for both parent and child.

- **Guide and support positive interactions** between parent and infant through "floor play" activities during home visit.
- **Support continuing interaction between parent and infant through learning games**, saying, for example, "This is a game your baby will enjoy with you!"
- **Emphasize the importance of the parent's sensitivity and warm response to the infant's cues** as important to the development of their relationship with each other and the infant's attachment security.
- **Help parents to read the infant's cues** (for example, cries and smiles), interpret them, and anticipate what the infant needs, supporting the development of a secure and trusting attachment relationship.
- **Maintain awareness of your own emotional response to the parent and infant** as they interact (or not) and respond to one another (or not).
- **Reflect on what you see and hear with your supervisor/colleagues** during regularly scheduled meetings in effort to support your own growth, professional development and thoughtful work with infants and families.

To promote social and emotional development in toddlerhood:

To promote social development:

- Help parents to **understand and negotiate conflict** with the growing toddler.
- Help parents **help the toddler learn to manage conflicts and disagreements.**
- Help parents to see the important relationship between managing anger or conflict successfully and the **growth of the young child's prosocial behavior and empathy.**
- **Help parents learn to set limits that are firm, reasonable and clear** for the toddler.
- Recognize and **support toddler's emerging capacities to cooperate with others.**
- Help parents to recognize and **reinforce the toddler's capacities to cooperate.**

To promote emotional development:

- Recognize and **support the toddler's developing capacity to have and express a range of emotions** – for example frustration, anger, wariness, fear, anxiety, shame, guilt, pleasure, delight, joy, pride, and love.
- Help parents to **recognize, talk about and reinforce the toddler's capacity to have and express a range of emotions.**
- **Support the toddler's developing awareness of the feelings that other people have and express.**

the death or loss of a child; exposure to domestic violence and community violence; and unresolved relationship loss.

It was not the presence of one factor, but the accumulation of risk factors, past and present, that placed some parents at risk for failure. Overburdened by their own significant social and emotional difficulties, they could not immediately or easily attend to the social and emotional needs of their infants or toddlers. Parental anger, confusion, fear and despair often explained the inability to hold, feed or nurture a young child adequately; offer appropriate playthings; notice, pay attention or read to a child; encourage the child's curiosity or wonder. In these instances, early development and relationship security appeared to be at grave risk.

The Guide for Home Visiting Work within the Early Head Start System (see sidebar, p. 54) suggests some specific strategies to use in home visits to link early development to parent-child interaction and relationship through EHS home visiting services.

Consultation: A Learning Relationship

Reflective consultation helps infant/family service providers to be more effective in their work with families. With this in mind, the supervisor of the Community Action Agency EHS program arranged for mental health consultation to take place regularly throughout each service year. This was consistent with the supervisor's experience and belief that regularly scheduled, individual supervision was fundamental to clinical competency and personal development. (The Head Start Program Performance Standards, revised in 1996, call for a regular schedule of on-site mental health consultation).

Careful observation of the infant and parent(s) together, gentle questioning and thoughtful listening are requirements for successful intervention. The same might be said for successful consultation. The EHS specialists organize an abundance of information about infants and toddlers, families, early developing relationships and the caregiving environment. As they bring the details of home visits to consultation, it becomes possible to consider infant competencies, disturbances and risks. They also think about the parent(s), their capacities to nurture and respond to the infant, their worries and their hopes. As they begin to feel trusting of the consultant and the process, they look more closely at the feelings awakened in the presence of particular parents and infants. At its best, the consultation, like supervision, is a learning relationship, (Bertacchi & Coplon, 1992) offering a place for questioning, shared understanding, guidance and support.

Emotionally present, the consultant follows the EHS spe-

cialist's lead, attending to verbal and non-verbal cues, observing carefully and offering guidance or an empathic response. Devoted and invested, the consultant serves as a continuing source of knowledge and support. She/he offers reassurance and praise as appropriate, building each specialist's confidence in observing, assessing, understanding and supporting infants and families referred to EHS.

As relationship-based services to infants and families have increased, practitioners and supervisors have written about the importance of the supervisory relationship to effective service designs. Rebecca Shamoon-Shanok (1992) writes, "When it is going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences" (p. 37). The same might be said about consultation. It is a holding environment. Safely held, the EHS specialists grow more resourceful and confident, informed about the observations they make and increasingly emotionally available to the families they serve. At the same time, they may begin to consider personal responses to the professional relationships they have

entered (Bertacchi & Coplon, 1992; Schafer, 1992). The depth and intensity of the consultation relationship vary according to individual experiences and needs. Important to Selma Fraiberg's original training model, the consultation relationship continues today to be most significant to the learning process (Fenichel & Eggbeer, 1990; Schafer, 1996).

Keeping our balance

As our work together continued, the EHS specialists, the supervisor and I realized that we were at risk in consultation for failing to pay atten-

tion to worrisome aspects of the infant or toddler's development as we paid increasing attention to the parent's social and emotional needs. It was an astonishing parallel to the EHS specialists' experience! As was the case for some EHS families, we were also at risk for overlooking the emerging capacities and strengths of the infant as we paid increasing attention to the developmental risks and failures facing parents. Together, we struggled to find our way back to "the child," balancing present observations of the infant or toddler, the parent, and their capacities with knowledge of past realities and present risks. "What about the baby?" we asked. "What capacities does the baby bring to elicit interest and care?" "Is the baby able to woo her mother with a gurgle or smile? Or is she avoidant of her mother's face and voice, turning quickly so not to catch her stare?" "How does the baby communicate wants and needs or respond to cues?" "How curious is the toddler? What is his response to his mother's leaving him in child care? How emotionally available is he to you?"

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A format for case discussion

We developed a format for case discussions and presentations that helped us to keep our eyes on early development and relationship as we considered strategies to support both parent and child. Key points included:

- the reason for referral to EHS, the parent's understanding of why the EHS specialist is visiting;
- a description of the infant or toddler (individual characteristics, temperament, size, weight, developmental capabilities and emerging strengths);
- a description of one exchange (at play, feeding, diapering, holding, etc.) between parent and child that was meaningful, illustrating the baby's interest in the parent and the parent's capacity to respond to the child;
- the use of a 3-minute video clip of the parent and child together, if available, to observe and discuss;
- a summary of the parent's observations of the baby, what she/he sees and cherishes as well as expressed concerns;
- strategies that the EHS specialist has tried to support emerging competencies;
- consideration of infant and parent needs;
- any knowledge of early infant experiences or parental realities and history that might explain the worry about the baby, the developing relationship, or the parent's capacity to provide appropriate care.

It was also crucial to allow room during consultations for expression of thoughts and feelings awakened in the EHS specialists as they carried out their home visiting work. The format provided a structure that encouraged us to keep our eyes on the baby as the team learned to listen to the parent and at the same time to contain the intense emotions encountered in EHS work. After four years of work, we still use this format and carry a continuous awareness of the ease with which we can be pulled into the parent's realities, past and present, and lose sight of the child.

Handling emotional upheavals: Personal and professional

Several strategies that come from an Infant Mental Health approach are particularly useful in understanding and expressing emotion. For example, listening, offering a context in which very young children and parents can express themselves through their interactions and at play, accepting what the family offers to us, and "allowing feelings to be there" invite the EHS specialist to experience, understand and support development within the context of the parent-child relationship. Caught up in the emotional struggles of very difficult infant and family work, EHS specialists often feel angry, despairing, discouraged, disorganized and afraid.

Together, we have learned to allow those feelings to be there during consultation, to share them with each other, to talk about them, and to use them to better understand the parents, their struggles with their infants, and ourselves. As we have grown in our ability to do this, we are better able to attend to the child development goals of Early Head Start, incorporating the strategies that are more traditionally identified with Infant Mental Health.

Early Head Start and Infant Mental Health programs offer experiences that encourage optimal development within the context of healthy parent-child relationships. Each infant or toddler and each parent, mother and father, deserves our offer of guidance and support to reach that goal. This belief is fundamental to the work that all of us do.

Janna, Charisse, and Jared: A Year in Early Head Start

What follows is a story told through initial observations by the EHS specialist, a description of a consultation in which the EHS specialist presented her observations, and an account presented in a follow-up consultation, approximately one year later.

When she began her work with the family, the EHS specialist had recently earned her master's degree in early childhood and her social work licensure. She was new to the practice of infant mental health but had had years of developmental experience within Head Start. The summary illustrates the complexity of the work and the challenges that EHS specialists face.

The EHS specialist's observations

Come with me into the living room. It is approximately 2 o'clock in the afternoon. Dishes clutter the tabletop and the ashtray is full. The room is hot. The windows are shut and the shades are drawn as if to protect against the intrusion of daylight. The 15 month old protests. She wants to get out of the playpen she is confined to. Her mother ignores the shrieks. She finally sets the toddler free and the child begins to crawl about. She doesn't walk yet. The baby, 3 months old, restrained in his infant seat, fusses in the next room. The toddler is curious about me and comes over to take a closer look. Her face is smudged with traces of lunch. She uses no words, just tugs at my sleeve to invite my interest. I am tempted to pick her up, but refrain from doing that, knowing that her mother, distracted and anxious, also needs my attention.

A nurse made the referral several weeks ago. She was concerned about the baby's slow weight gain, the toddler's development and the mother's apparent lack of pleasure in either child. When I called to ask about the mother's interest in EHS, she agreed to let me come, but she sounded less than

It takes a great deal of courage to observe a baby or toddler closely and feel their distress.

enthusiastic. "I'll be here, but I don't know what you can do."

As I sit at the table, I see that she is easily overwhelmed by the care of two small children. She does not seem to recognize the toddler's needs for attention or stimulation. She grows impatient with her daughter as she continues to pull up to the table and reach for the ashtray. "No!" she says harshly. She reaches to take the cigarette butts from the toddler's hand, but the toddler crawls quickly away, ignoring her mother and now out of reach. The mother shouts, "Come here!" New at this job, I watch and listen ever so carefully, trying to make sense of what they are showing me, but uncertain about what to say. I wonder how often one of them has reached out only to have the other turn or move away. I wonder what explains the struggle between them. I comment quietly, "She crawls pretty quickly! How do you keep up with her and the baby, too?" The mother smiles, "She is quick. Gets away from me now." I continue to describe what I see – a young toddler who is fairly coordinated, although delayed in walking, She is curious and quick. I ask the mother what her child's name is. "Charisse," she says. I then ask if there is something she likes to do with Charisse. "Well, we used to have fun together, just her and me, until the baby came and was so sick and everything." I invite the mother to tell me more about this. As if no one has asked or listened to this story before, she begins to tell me:

The baby came too early. They had to take him from me. He wasn't breathing. He was very small, too. They held him up for me to see, but then they took him away in a hurry. I couldn't hold him for almost a day. It was really scary and for a while I didn't think that he was going to live.

The story is a difficult and painful one, but I try to remain attentive and respond by saying, "How very frightened you must have been! That was a very difficult beginning for you and for your baby."

The mother tells me a little more and I notice some relief. She glances again at Charisse, who has moved closer to her feet. She reaches out to her and this time she allows her to pull herself on to her lap. I notice that it is almost time for me to leave and say, "Our time is almost up. What has happened is very difficult and important for you to talk about. I could come back next week if you would like." The young mother agrees and before she lets me out, she sets Charisse down on the chair and goes to get the baby. "He was crying real hard. Maybe he's hungry. Hold him while I get the bottle filled," she demands and thrusts the baby into my arms.

I notice that the baby has no hair and avoids looking at me. His arms thrash about, making it difficult for me to hold him easily. He continues to cry and I call out to his mother, "He's pretty upset. He seems to be looking for you!" The mother returns with a warm bottle of milk, takes the baby and begins to feed him. They both settle down. I say qui-

etly, "That's just what he wanted, you and his bottle!" I am distracted by Charisse, who now lies quietly on the floor, slightly withdrawn, rocking side to side, and sucking her pacifier. I would like to stay, but need to go. "Bye-bye, see you next week," I tell her. "I'll come next Tuesday at 1 o'clock in the afternoon."

I leave, feeling overwhelmed, emotionally exhausted and ambivalent about going back. I'm really hungry and drive away as quickly as I can to the nearest McDonald's I can find. Once fed, I settle down and wonder about the hour's home visit. "What about the baby?" I hardly got a glimpse. He looked so tiny and distressed. "What about the toddler?" She was fussy, lively, then so quiet. I wonder if she has some significant delays. "What about their mother? Does she have family or friends around to help her? Is she caring for these children by herself? What made her so unable to understand and respond more immediately to what her children needed? Where is the baby's father?" Many questions dance around in my head.

I was also aware that I felt somewhat overwhelmed. Where would I even begin? Will I be able to support the mother's interest in her babies? Will I be able to guide her through floor play activities with either child? How overburdened is she? More importantly, will I be able to keep my eyes on everything here?

A scene from a consultation meeting

The EHS specialist brings the details of this initial visit to her supervisor and also to the next consultation group. She tells the group, "Jared (the baby boy) looked so lonely. He was strapped into his infant seat almost the whole time I was there. Janna (the mother) didn't pick him up, until the very end. She didn't seem to notice her baby's discomfort or her other child, either, for that matter!"

The consultant and EHS team listen to the poignant description and acknowledge that it takes a great deal of courage to observe a baby and toddler closely and feel their distress. The specialist describes the mother as "young, alone and frightened. She could hardly look at me when she talked!" The consultant again acknowledges how strong one has to be to experience the neediness of a mother who appears lonely and afraid. The specialist wonders how she will be able to help them. "They need so much and I am so new at this work." Her own uncertainty is clear. The consultant offers supportive comments: "You learned so much in this first visit that will be helpful in understanding what the baby and his sister and mother might need. You are such a good, careful observer and listener."

The consultant continues by inquiring about what the EHS specialist thinks the baby needs right now. "I guess he needs someone to notice that he is there, to hold or comfort him when he cries, and to offer something to eat when he is hungry." The consultant agrees and wonders about the toddler. "Well, she is pretty spunky, really. I think she could begin to walk if her mother encouraged her. She was bright-

eyed and eager at first, but then shut down when she didn't get the attention she really wanted. I think she wanted to be picked up and held, too."

The consultant asks the group how these observations might guide the specialist in planning for the next visit. "You could notice what each is doing. You know, really pay attention to the baby and the toddler and the mother, too." "They need more opportunities to look and play with things. You could bring a few toys for the mother to enjoy with each child." The consultant notes that the specialist's observation about "holding" was a very thoughtful one. "You may want to pick the baby up out of that seat and hold him or hold the toddler, too! I wonder what would happen if you didn't do those things, but responded to their need for 'holding' by holding them with your presence and also with your words. It was so important that you went. You were very attentive and emotionally present. You might invite the mother to tell you more about the baby; she seemed to respond to that. You might be the first person to have asked this. You have a very empathic style. She seems pretty overwhelmed! Your being there is really important. If her eyes wander to the toddler, ask her to talk a little more about her, what kind of a child she is, what she likes to do now or even what they once enjoyed together. Reassure her that you will come back, too."

The specialist looks more confident; the color returns to her face. Before the hour ends, the consultant wonders what it was like for the group to process the visit together. One member of the team recognizes how angry she found herself feeling, angry with a mother who overlooks her children's needs. Another realizes how hopeless she felt about the neediness of this whole family and the lack of resources to adequately meet everyone's needs. A third felt frustrated and impatient with a mother who had had two babies so close together. The group recognizes that those feelings – angry, hopeless, frustrated, and impatient – might reflect the feelings that the infant, toddler and parent shared, too. The EHS specialist might keep those in mind as she continues her work with the family and could identify those feelings at appropriate times. When the session ends, the consultant reminds the specialist, "They are so lucky to have you take an interest in the baby's development and in the toddler's care. I imagine no one else has watched or listened so intently. I'll be thinking of you."

Follow-up consultation

A year later, the EHS specialist again presents her work with the family to the consultation group. Her summary teaches us so much. During her work with the family she learned that this mother had lost an older child: "Paralyzed, she at first could not respond. She allowed her parents to care often for Charisse. She just couldn't do it. She was filled with guilt and remorse. At the time I met them, she had just brought Charisse back. She had another baby to care for then, too." The specialist went on to explain, "I helped Janna see the uniqueness of each of her children. I invited her to

describe each one, her older one too. We discussed their unique personalities as precious gifts to the family. I provided empathic listening and support to Janna, allowing her to express her grief. By acknowledging the validity of her feelings and allowing her to talk about them, she was able to pay greater attention to her children and move on."

Later, the specialist describes Jared and the relationship between him and his mother. "She clearly loves and adores her son and has described him as 'mommy's boy.' Everyday interactions are playful and offer lots of opportunities for pleasure and pride in what he can do. They played a fun game of 'peek-a-boo.' Jared engaged his mom in the game by pulling her blanket over her face and awaiting the familiar question: 'Where's Jared?' Jared pulled the blanket off and revealed his mom's face. Mom replies, 'There he is!' Both laugh joyfully together. Jared repeats the sequence. I watch with pleasure, then take the opportunity to comment on Jared's emerging cognitive and social skills at 15 months. 'He has such fun with you! He's learning that he can have some control over the game and can make it continue. He is also practicing being away from you and learning that you always come back into view!' This is useful because Janna has returned to work. She and Jared both have to learn the same lesson — that each will always 'come back.'"

Grief could have taken a terrible toll. Infant Mental Health work in the context of Early Head Start reduced the risks for this family, as the EHS specialist learned to look at and listen to the infant, the toddler, and the parent, balancing past with present, and offering her relationship as the primary tool for learning. ¶

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