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## The Infant Mental Health Specialist

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**More than a quarter-century ago**, Selma Fraiberg, one of the founding Board members of ZERO TO THREE, and her colleagues in Ann Arbor, Michigan crafted an extraordinary approach to strengthening the development and well-being of infants and young children within secure and stable parent-child relationships. Fraiberg called the practice Infant Mental Health. “Infant” referred to children under three years of age. “Mental” included social, emotional and cognitive domains. “Health” referred to the well-being of young children and families.

Fraiberg described new knowledge about early development and relationships as “a treasure that should be returned to babies and their families as a gift from science” (Fraiberg, 1980, p. 3). In the early 1970s, knowledge about the first three years of life was expanding rapidly, in the laboratories of developmental psychologists, in neonatal nurseries and pediatric clinics, and in Fraiberg’s own work with blind infants and with emotionally vulnerable infants and parents.

Under Fraiberg’s careful direction, social workers, psychologists, nurses, and psychiatrists—seasoned practitioners and student interns—worked together at the Child Development Project in Ann Arbor, Michigan to translate new knowledge into practice through the Infant Mental Health approach. Parent and infant were seen together, most frequently in their own homes, for early identification of risk and treatment to reduce the

likelihood of serious developmental failure and relationship disturbance. Each practitioner returned to “the source,” the home where an infant and parent lived, to observe, first-hand, the infant or toddler within the context of the emerging parent-child relationship. Sitting beside the parent and infant at the kitchen table or on the floor or on a sofa, the Infant Mental Health practitioner watched and listened carefully in effort to understand the capacities of the child and family, the risks they faced, and the ways in which the practitioner might be helpful to the infant or toddler and family.

Infant Mental Health represented a dramatic shift in focus in clinical practice as it existed at the time. Attention to the baby, the parent, and the early developing parent-child relationship required a comprehensive and intensive approach. Services included concrete assistance, emotional support, developmental guidance, early relationship assessment and support, infant-parent psychotherapy, and advocacy. These dimensions of service (see sidebar, page 4) continue to define Infant Mental Health practice in many settings.

### **The Infant Mental Health specialist: Beliefs, skills, and clinical strategies**

The early Infant Mental Health practitioners were social workers, psychologists, nurses, and psychiatrists. Within their various disciplines, many had been trained in a psychodynamic or relationship-based approach to

## Infant Mental Health Services

### Concrete assistance

A family's urgent and immediate need for food, formula, medical care, and housing must be met if parents are going to be able to feed, protect and nurture their young children. The Infant Mental Health specialist understands that if a family is hungry, they must be fed and if they need medical care, they must be taken care of. Parents cannot adequately meet their infants' basic needs until their own basic needs are met. Such assistance offers a powerful metaphor for the help that a specialist will be able to give to support parents in caring for their infants and in reducing risks of failure in families.

### Emotional support

An Infant Mental Health specialist offers emotional support to families who face immediate crises related to the care of their children. The specialist pays careful attention to the expressed concerns, e.g. the birth of a sick baby, the death of a child, the abandonment of a parent, the hospitalization of a baby. The specialist is observant of the parent's neediness for consistent care and thoughtful response to the care that a baby needs, the trauma of hospitalization and the adjustments required when there is a significant loss. She acknowledges the parent's needs and strengths, showing compassion for the situation and empathy in response to the crisis. The specialist's consistent presence and availability offers reassurance to the family. Words communicate reassurance and steady support, reducing the family's distress. Within the context of a therapeutic relationship, the specialist helps parents to turn their attention to the care requirements of their infants and to begin to heal.

### Developmental guidance

The Infant Mental Health specialist offers information to the parent that is specific to the baby's development and needs for care. In the course of observing the infant or toddler carefully, the specialist encourages parents to notice what the child is doing and what developmental tasks might come next. The specialist invites the parent to share in the understanding of the baby, to ask questions about the baby's development, and to celebrate milestones as they are reached. The specialist offers experiences that encourage

positive interaction and playful exchange. In some instances, the specialist speaks for the baby, drawing attention to particular wants or developmental needs. Modeling may also be appropriate, guiding parents in caregiving activities or showing parents how to relate in a different way. Developmental guidance supports and strengthens parent-child interaction and response. All of the specialist's efforts reinforce what the parent is able to do for the infant to encourage mutual pleasure and purposive response. For many parents who are unprepared for the care of a baby or isolated from family and friends, the guidance of the Infant Mental Health specialist is crucial for the infant or toddler's optimal care.

### Early relationship assessment and support

Infant Mental Health specialists offer parents multiple opportunities to build and use their relationship with the practitioner to nurture, protect, steady and enhance their understanding about their babies. Specialists observe interactions of parents and infants together, noticing what is happening "in the moment," inviting parent's comments and reinforcing what is going well. The use of videotape for guided interaction is a particularly useful strategy when supporting overburdened parents in their developing relationships with young children (McDonough, 1993). As specialists and parents grow comfortable with one another, they are able to talk about the infant's contributions to the relationship, pleasurable and painful, and discuss other relationships, past and present, that make the care of the infant problematic or possible.

### Advocacy

Infant Mental Health specialists often speak for those who cannot, the infants or the parents who have not found their voices. The specialist may need to speak for the baby's need to be fed or put in a safe spot or the parent's need for a food bank or a roof over her head. Specialists may have to help families negotiate systems by finding childcare, accompanying parents to the welfare office, articulating the need for a special infant assessment. In other instances, specialists may have to

testify on behalf of a child's right to remain with a parent, the need for immediate placement in foster care or the parent's right to visit the infant weekly with full therapeutic support. It is a daunting task to know when and how to speak effectively on behalf of infants and families enrolled for Infant Mental Health services.

### Infant-parent psychotherapy

The presence of the infant is clearly vital to the practice of infant-parent psychotherapy. The infant or toddler fuels the specialist's understanding, serving as an energizing focus for the intervention. The parent's feelings in the presence of the infant or toddler are often intense and complex. Their expression within the safety of the specialist's relationship offers the possibility of thoughtful exploration about parenthood and the infant or toddler's continuing needs for care. The parent's perceptions and representations of the infant or toddler are often more available in the presence of the infant for therapeutic consideration and response. Aware that the infant or toddler evokes a myriad of thoughts and feelings, the specialist offers parents many opportunities to recover and understand the feelings that threaten to interrupt the development of a positive and enduring relationship with their child.

Negative experiences and unresolved losses may gravely affect the parent's capacity to attend to or fall in love with the baby and alter the relationship as it develops in the infant's first years. Neglectful or abusive care in infancy or childhood, interruptions or removal from the home, early trauma and broken or conflicted family relationships may deepen the pain of early parenthood and lead to another generation of failure. Parents may not be able to hold or feed their babies, talk to or offer appropriate playthings to excite or arouse their curiosity. They may not be able to set limits that are appropriate or keep their children safe. Infant-parent psychotherapy offers parents many opportunities to have and express their emotions surrounding earlier traumas, reducing the risk of repeated failure or dysfunction in this new relationship.



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mental health treatment for adults and children that they adapted to meet the needs of infants, toddlers and their parents. In recent years, attention to infancy, early relationship development and parental mental health has become part of the training of practitioners in other disciplines—for example, early childhood education, occupational therapy, and physical therapy. Consequently, it may be most helpful to define the Infant Mental Health (IMH) specialist not as a member of a particular discipline, but rather as someone with a distinct set of core beliefs, skills, training experiences, and clinical strategies who incorporates a comprehensive, intensive and relationship-based approach to working with young children and families.

In its Guidelines for Infant Mental Health Practice (Stinson, Tableman & Weatherston, 2000), the Michigan Association for Infant Mental Health recently listed the following basic beliefs that support and sustain IMH specialists as they work with infants and families. These tenets help specialists to understand their role, cherish each encounter with young children and caregivers, think deeply about the meaning that each interaction

has for the infant and the parent, and plan interventions in partnership with families. These beliefs also guide the practice of Infant Mental Health consultation to infant/family programs.

- 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 or disturbed by parental histories of unresolved losses and traumatic life events (“ghosts in the nursery”).
- The therapeutic presence of an Infant Mental Health specialist may reduce the risk of relationship failure and offer the hopefulness of warm and nurturing parental responses.

Qualitative summaries of Infant Mental Health home visiting services include a rich store of case study materials that describe interventions with parent(s) and infant or toddler together, for short-term or long-term work together (Fraiberg, Adelson & Shapiro, 1975; Fraiberg, Shapiro & Adelson, 1976; Fraiberg & Adelson, 1977; Fraiberg, 1980; Blos, & Davies, 1993; Pawl, 1995; Weatherston, 1995). These studies reveal basic skills and strategies that are fundamental to effective and compassionate Infant Mental Health home visiting work. Interviews with experienced IMH consultants, supervisors and practitioners in Michigan confirm the centrality of these strategies to competent and reflective practice (Weatherston, 2000). These skills and strategies include:

1. Building relationships and using them as instruments of change;
2. Meeting with the infant and parent together throughout the period of intervention;
3. Sharing in the observation of the infant’s growth and development;
4. Offering anticipatory guidance to the parent that is specific to the infant;
5. Alerting the parent to the infant’s individual accomplishments and needs;
6. Helping the parent to find pleasure in the relationship with the infant;
7. Creating opportunities for interaction and exchange between parent(s) and infant or parent(s) and practitioner;
8. Allowing the parent to take the lead in interacting with the infant or determining the “agenda” or “topic for discussion;”
9. Identifying and enhancing the capacities that each parent brings to the care of the infant;
10. Wondering about the parent’s thoughts and feelings



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related to the presence and care of the infant and the changing responsibilities of parenthood;

11. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent;

12. Listening for the past as it is expressed in the present, inquiring and talking;

13. Allowing core relational conflicts and emotions to be expressed by the parent; holding, containing and talking about them as the parent is able;

14. Attending and responding 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;

15. Attending and responding to the infant's history of early care within the developing parent-infant relationship;

16. Identifying, treating and/or collaborating with others if needed, in the treatment of disorders of infancy, delays and disabilities, parental mental illness and family dysfunction;

17. Remaining open, curious and reflective.

All of these strategies contribute to the parent's understanding of the infant, the awakening or repair of the early developing attachment relationship, and the parent's capacity to nurture and protect a young child. They form a critical conceptual base for the IMH specialist to consider and use in order to understand and work with families effectively.

The skills and strategies described in points 1-9 and 17 are not unique to the IMH specialist. Relationship building, informal and formal observation of a young child's development, guided interaction and parental support, and reflection are skills that all infant/family practitioners who work from a relationship perspective use and value. However, points 10-16 are more clearly specific to the IMH specialist and may help to distinguish IMH practice from other forms of infant and family services. These seven strategies attend to the emotional health and development of both parent and child. They focus clearly on relationships, past and present, and the complexities that many parents encounter when nurturing, protecting and responding to the emotional needs of young children. Finally, these strategies require the creation of a safe and nurturing context in which a parent and specialist may think deeply about the care of the infant, the emotional health of the parent,

the multiple challenges of early parenthood, and possibilities for growth and change.

These seven strategies characterize the work of IMH specialists across disciplines and at multiple service levels, from prevention and early identification of risks to intensive assessment and treatment of serious emotional disturbances or jeopardized relationships. The IMH specialist uses these clinical strategy as she works with infants, toddlers, and families who come to her attention because of concerns about the child's development or behavior, parental factors, situational stress, or multiple risks to child and family. The following section describes in more detail how the IMH specialist attends to emotional experience and emotional needs.

## **Attending to the emotional experience and needs of infants, toddlers, and families**

### *The emotional experience*

IMH specialists pay attention to the emotional experience of each infant or toddler and each parent. They ask, "What is it like to be this baby? What is it like to be this parent?" In the course of intervention, the IMH specialist pays attention to the infant's expression of rage or flattened affect or the failure to cry out when hungry or tired or wet. The IMH specialist wonders what the baby's experience is of a particular caregiving interaction or relationship. Carefully attuned to the infant's expression of emotion, the IMH specialist works at understanding the meaning of the infant's communications and guides the parent in understanding this, too.

Similarly, the IMH specialist is very attentive to the parent's emotional state. She notices the parent's rough handling of her baby when he needs a diaper changed. She notices shifts in the parent's affect, the disgust she cannot hide, or the absence of affection. The specialist watches quietly and wonders, to herself, what makes the handling of the baby so difficult. She allows herself to connect with the parent's intense and conflicted emotion. She is both repelled and filled with empathy for the parent's pain. The specialist keeps a very sharp eye on her own emotional responses as a guide to what is happening in the moment between parent and child. She may speak to what she sees and feels, and wonder what the parent is experiencing. She may notice and address the parent's change in mood, the struggle around caring for the baby, and her wish to run away. She may empathize with the parent's difficulty in having to care for the baby alone. She may ask the parent what she is experiencing as she holds or feeds or diapers her child. She may inquire about the care of other babies or the loss of an older child. She may offer empathy in abundance and acknowledge the painful struggle she feels as she sits beside the mother and her child. There are many possible responses and there is of course never "a script." What the IMH specialist understands is the importance of remaining open to the emotion expressed

in the parent's handling of her infant or toddler and the challenge to remain emotionally available as she frames her response.

### *Relationships present*

The IMH specialist who is able to recognize, hold and tolerate the emotions expressed by both infant and parent offers a context in which a parent may talk openly about the infant's care. As the specialist makes it possible for the parent to feel and also express a range of emotions in her presence, she will invite the parent to talk, and she will listen intently. Parents offer stories about the pregnancy, labor and delivery, the feelings encountered in the early care of the baby, and their early relationship. Mothers offer stories about boyfriends who have abandoned them or husbands who have left them. They offer stories about family members who are abusive and friends who disappoint them. The IMH specialist is careful to follow the parent's lead, not deepening the pain, but allowing the emotion surrounding these events and relationships to be expressed as a parent is able to.

The infant or toddler, dependent on a parent for protection and nurturing, is a powerful participant within an Infant Mental Health intervention. The infant shows the specialist what life is like in this particular household—what is going well for the family as well as the risks. The specialist observes how the infant seeks attention or makes needs and wants known. The specialist watches who cares for or plays with or responds to the baby. Of equal interest is the infant's behavior and response. "Why is the care of this baby so difficult? What is the role of the infant in the difficulties or the parent's despair?" These, and questions like these, guide the specialist who sits at the kitchen table and observes parent and child together, listening as stories of caregiving, past and present, unfold.

Indeed, it is the infant who allows a story to be told. The way in which a parent handles the baby, gestures of care, and playful interactions (or the absence of interaction) suggest to the specialist what the capacities are and what some of the conflicts might be. For example, the parent may cuddle the baby comfortably and stroke his arm as he falls asleep. The specialist sees how easily the parent responds to the baby's need for a nap and comments on the parent's ability to read the baby's cues correctly. Alternatively, the parent may leave the baby to cry in a darkened room while she cleans the kitchen. She responds at last, fixing a bottle and propping it. The baby sucks greedily and the parent observes angrily, "She'll eat me out of house and home if I let her." The specialist wonders what has happened to put such distance between the two. What demands does the baby make? What does the baby contribute to the difficulty between them? The specialist also wonders how lonely and hungry the parent is. How many of her own needs are met and by whom? The specialist asks, "What have

the first weeks with the baby at home been like for you? Who has been here to help you? Would it be helpful to talk about this?" Their relationship begins.

### *Relationships past*

The Infant Mental Health specialist may wonder who the baby represents to the parent—for example, an abusive father, an abandoning mother, or a sister who required attention and care. In the example above, the specialist wondered if the parent had cared for other young children. "Have you ever taken care of a baby before?" she asked. The young mother had. "I was the 'mother' to three younger brothers by the time I was 8 years old," she said, tearfully. An important story of another mother and other babies began to be told.

The infant may also represent the parent as a small child. Faced with the neediness of a very small infant, the parent may feel all over again her own helplessness and re-enact, quite unconsciously, neglectful or inconsistent or teasing patterns representative of her own early care. Alert to the struggle, the IMH specialist wonders what other baby may have been neglected or hurt, abandoned or teased. The earlier traumas may never have been spoken about before. Within the context of the relationship with the IMH specialist, aspects of early care may be more safely re-experienced, feelings attached to them expressed, and memories shared. By separating the past from the present, the specialist and parent try hard to reach an understanding that will protect against repeating a hurtful cycle of care. Both will be alert to the possibility of a new relationship between parent and infant that is positive and secure.

To the extent that the IMH specialist understands a parent's history of relationship and care, she will understand the parent's ability (or inability) to nurture and protect her child. Parents who have had many negative life experiences and disturbed or unresolved relationship losses may not respond to their infants or toddlers with sensitivity, consistency or warmth. It is the IMH specialist's task to attend and respond to parental histories of abandonment, neglect, separation, and loss. The IMH specialist offers a safe place for the experience and expression of emotions surrounding intensely painful events and relationship experiences. For many parents, the experience with the IMH specialist is the first time they have shared their confusion or anger, disappointment or grief with someone who has a capacity for compassionate response.

The IMH specialist learns to be strong and compassionate as she listens to many difficult stories. It is not unusual for parents to disclose details of early and continuous abuse, neglectful parental care, abandonment by a parent, removal to foster care, the death of an older child, the birth of a baby with special needs. Parents who are able to mourn their losses or express their anger and despair within the context of a nurturing and responsive relationship with the IMH specialist may

become clearer about their early history and, as a consequence, more emotionally available and appropriately responsive to their infant—less angry, less depressed.

### *Reflective functioning*

The IMH specialist who attends to the emotional needs of infants and families must remain alert to his or her own emotional health. Most IMH specialists learn to use the supervisory relationship to reflect on the complex emotional realities of overburdened families and infants at risk. In the process, the IMH specialist grows increasingly aware of personal responses, too. Longings for relationship, memories, hopes and wishes, are continuously evoked in the presence of infants and parents who are negotiating early and conflicted relationships. The IMH specialist may be affected deeply by individual infants and families enrolled; she needs to have time to discuss what is seen and heard.

### *Commitment to emotional health*

A unique and powerful focus that an Infant Mental Health specialist brings to the intervention experience is the commitment to the emotional health of infants and parents as they develop in relationship to one another in the first years of life. Why is this so important? As William Schafer, a seasoned Infant Mental Health practitioner and training consultant observes:

*... During the first eighteen months of life a child constructs a lasting internal vision of what human relationships are, how they work, what to expect from them, and what to offer in return. . . . What gets set in early life is one's deepest beliefs about human relationships. These determine how a person goes about learning, profiting from experience, using help, and parenting one's own children.* Schafer, 1991, p. 120.

To the extent that an IMH specialist is able to understand, support and sustain parents in interacting and responding sensitively to their infants' or toddlers' emotional needs, an overarching and significant goal will have been reached.

### **Beyond infant and parent: Infant Mental Health consultation to birth-to-three and family programs**

Infant Mental Health specialists are often called upon to provide developmental and clinical consultation to individuals and agencies working with children from birth to three and their families. As consultants, IMH specialists bring knowledge about infancy, early parenthood relationship development, and strategies for change. They have experience in carrying out developmental observations and assessments with sensitivity and regard for the uniqueness of each infant or toddler and parent referred. They have experience in providing clinical services to a variety of infants and families, and understand the strategies required when responding to families at multiple risk. In addition to the skills and



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clinical strategies of Infant Mental Health practice, the IMH consultant needs:

1. An ability to observe and listen carefully
2. A willingness to work hard at establishing and strengthening strong and meaningful relationships with individuals and consulting groups
3. A respect for continuity and predictability, sensitivity and responsiveness as integral to effective consultation with early intervention practitioners/groups
4. An ability to invite another person to tell you what they saw/heard/felt/experienced when caring for an infant or toddler, talking with a parent, going on a home visit, working with a parent and infant together, determining eligibility for services, running a teen parent-infant group, etc.
5. An ability to provide a context in which people feel safe and secure, able to think about their work with families and to reflect on their own emotional responses as appropriate.

The IMH consultant may be asked to meet with an individual practitioner to discuss a particular developmental or clinical concern. In this instance, the consultation may be limited to one or two meetings or until the questions are resolved. The consultant may be asked to

meet regularly with a group of child and family practitioners for training and case discussion for the year. Regardless of the group size, frequency of meetings or length of service to the individual or group, Infant Mental Health consultants understand the importance of relationship building to enhance each practitioner's developmental and clinical skills. They work hard at establishing and strengthening meaningful relationships with individuals and consultation groups. They know that practitioners—newly developing and experienced—need opportunities to ask questions and talk about the infants, toddlers and families with whom they work. The consultant provides a context within the consultant-practitioner relationship where it is safe to do this.

Consultants encourage practitioners to bring the details of their observations about a particular baby, alone or in interaction with someone, and to talk about what they see. In the process, they are invited to think about the capacities of an infant or toddler, the uniqueness of a particular infant-parent pair, or the intricacies of relationship work. The consultant may ask questions to guide the consultation process. For example, "What did you notice about the baby's developmental capacities? What did you see him do?" "What does the baby bring to the newly developing relationship with his mother? What kind of care does the toddler demand?" "What about the parent? How interested or responsive does she seem to be? How able is the parent to pay attention to the toddler's needs?" "How do they interact with one another? How satisfying does the interaction seem to be?" As practitioners learn to observe and listen more closely, they grow more sensitive to a range of risks (Wright, 1986). At the same time, they grow more aware of their own emotions and responses to the very difficult work that they do.

The consultant is challenged to keep an eye on the affective experience of each practitioner throughout each consultation and give permission to talk within the group. The consultant might ask what practitioners are thinking about as they present their work. Many thoughts and feelings may wash over them as they begin to reflect more deeply, often for the first time, on what they see in a particular family, what they experience as they are present with the family and what they are feeling now. Aware of the emotion that the practitioner offers or silently shares, the consultant may ask if this is something a practitioner would like to talk more about. This approach invites the practitioner to connect with the emotion, yet allows the practitioner to remain in control. In addition to supporting the practitioner, this offers an example of thoughtful responding when working with parents, too.

In the process of discussing a particular infant or parent or home visit, the Infant Mental Health specialist often reflects on her own thoughts about infancy and early parenthood, relationships past or present, and her

own emotional response to complex and challenging work. Infant Mental Health consultation invites practitioners to be reflective about the services they provide to infants and families, and about themselves.

Infant Mental Health consultation brings many rewards. Practitioners from multiple disciplines and agencies learn to sit quietly, to watch the baby and follow the infant and parent's lead. They learn to listen more carefully in order to hear what a parent wants to say. They learn about each infant or toddler's contribution to the relationship and the importance of each parent's emotional response. They learn about the power and importance of emotional expression within the context of trusting relationships, in their work with families and within the consultation experience. They grow increasingly confident in understanding infants and parents, appreciating the dynamics of interaction, and containing the feelings expressed or aroused.

### The training of an Infant Mental Health specialist

As we have seen, Infant Mental Health is a field dedicated to understanding and treating children from birth to three years of age within the context of family, caregiving and community relationships. The field is broad and interdisciplinary, embracing professionals from many disciplines, including social work, child welfare, education, speech and language, occupational and physical therapy, child and family development, psychology, nursing, pediatrics, and psychiatry. Infant Mental Health specialists may be trained at the bachelor's, master's, doctoral and/or post-doctoral levels. Training programs may include academic or community in-service programs of specialized study.

Each specialist develops knowledge and skills that are specific to the discipline in which they are prepared—for example, developmental assessment protocols, techniques for clinical interviews, referral and collaboration, treatment planning. In addition, Infant Mental Health professionals develop a knowledge base and competencies that are quite specific to the optimal development of infants and toddlers within the context of nurturing relationships—for example, knowledge of attachment and early development, infant and family observation for the purpose of early assessment and care, the identification of disorders in infancy, and strategies for intervention with parent and child. It is the overlay of specialized studies, opportunities for skill-building, and supervised service experiences with children birth to three and their families that contribute to the optimal development of an Infant Mental Health professional (Eggbeer & Fenichel, 1990)

In sum, Infant Mental Health practice as originally developed by Selma Fraiberg and her young staff is indeed a gift returned to parents and infants in the form of thoughtful observation, careful listening and empathic response. The strategies that characterize the

work of an Infant Mental Health specialist are embedded in the belief that development occurs within the context of relationships, past and present. To the extent that the Infant Mental Health practitioner and consultant offer opportunities for relationships to flourish, the gift is multiplied, ten-fold.

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### References

- Blos, P. & Davies, D. (1993). Extending the intervention process; A report of a distressed family with a damaged newborn and a vulnerable preschooler. In E. Fenichel & S. Provence (Eds.), *Development in jeopardy*. Madison, CT: International Universities Press, Inc.
- Cramer, B. (1998). Mother-infant psychotherapy: A widening scope in technique. *Infant Mental Health Journal*, 19 (2).
- Eggbeer, L. & Fenichel, E. (1990). *Preparing practitioners to work with infants, toddlers and their families*. Arlington, VA: National Center for Clinical Infant Programs.
- Fraiberg, S. (1980). *Clinical studies in Infant Mental Health*. New York: Basic Books.
- Fraiberg, S. & Adelson, E. (1977). An abandoned mother, an abandoned baby. *Bulletin of the Menninger Clinic*, 41, pp. 162-180.
- Fraiberg, S., Adelson, E. & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *J. Amer. Acad. Child Psychiat.*, 14, 397-421.
- Fraiberg, S., Shapiro, V., & Adelson, E. (1976). Infant-parent psychotherapy on behalf of a child in a critical nutritional state. *Psychoanalytic study of the child*, 31, pp.461-491.
- Lieberman, A. & Pawl, J. (1993). Infant-parent psychotherapy. In C. Zeanah (Ed.), *Handbook of Infant Mental Health* (pp. 427-442). New York: Guilford Press.
- Lieberman, A. & Zeanah, C. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment*. (pp. 555-574). New York: Guilford Press.
- McDonough, S. (1993). Interaction guidance: Understanding and treating early infant-caregiver relationship disturbances. In C. Zeanah, Jr. (Ed.), *Handbook of infant mental health*. (pp. 414-426). New York: Guilford Press.
- Pawl, J. (1995). The therapeutic relationship as human connectedness: Being held in another's mind. *Zero to Three*, 15, 4 (pp. 3-5).
- Schafer, W. (1991). Planning as an attachment experience. *The Infant Crier*. East Lansing: Michigan Association for Infant Mental Health.
- Stinson, S., Tableman, B. & Weatherston, D. (2000). *Guidelines for infant mental health practice*. East Lansing: Michigan Association for Infant Mental Health.
- Weatherston, D. (1995). She does love me, doesn't she? *Zero to Three*, 15, 4 (pp. 6-10).
- Weatherston, D. (2000). Infant mental health practice: Parents' and practitioners' voices. Unpublished doctoral dissertation, Wayne State University, Detroit, MI.
- Weatherston, D. & Tableman, B. (1989). *Infant mental health services: Supporting competencies/reducing risks*. Department of Mental Health: Lansing, Michigan.
- Wright, B. (1986). An approach to infant-parent psychotherapy. *Infant Mental Health Journal*, 7 (4), pp. 247-263.