



# EITI Newsletter

Early Intervention Training Institute

Winter 2002 - 2003

Rose F. Kennedy Center ■ University Center for Excellence

## INFANT MENTAL HEALTH PROJECT AT THE EARLY CHILDHOOD CENTER THE BABY PROGRAM: REFLECTIONS ON THE FIRST YEAR

Anne Murphy, MEd., Rebecca King, Psy.D.,  
Susan Chinitz, Psy.D.

The Infant Mental Health Project grew out of an awareness at the Early Childhood Center of the unmet social-emotional needs of children under three years of age with exposure to trauma and severe psychosocial stresses. Similar concerns have been expressed by the Committee on Integrating the Science of Early Childhood Development of the National Research Council Institute of Medicine. In a policy statement, the committee recommended that young children's emotional, regulatory, and social development be given the same attention as pre-academic skills in early childhood settings (Shonkoff & Meisels, 2000). The Baby Program, an infant-parent psychotherapy group, was developed to address these concerns. The program utilizes the theoretical framework of attachment theory, work in reflective functioning, findings from resiliency research, and recognition of the need for social support among multi-stressed parents.

The theory guiding the Infant Mental Health Project comes from the extensive infant mental health and psychotherapy literature. Infant mental health emerges from the capacity to identify one's own feelings, develop empathy, establish positive expectations of self and other, and to constructively manage strong emotions. Parents contribute in multiple ways to the development of these abilities by playing a supportive role. The parent-child relationship itself functions as a "holding environment" that serves to validate and contain a child's emotions (Winnicott, 1953). Additionally, the lens through which a parent views a child can dramatically shape the relationship. Fraiberg's (1975) seminal work described how the "ghosts" of unresolved relationship problems in childhood can negatively influence the way a parent responds to a child. Finally, recent work by Fonagy et al. (1996) has focused attention on a mother's ability to reflect on her own childhood experience as a critical quality that helps foster sensitivity to the child's needs. This cognitive and emotional process called "reflective functioning", allows the mother to hold in her own mind the notion of her child as having distinct feelings, desires and intentions. The mother's acknowledgement and appreciation of her child's inner emotional life permits the child to understand his/her own feelings. A mother with the capacity for reflective functioning may be better equipped to overcome the "ghosts" of her past. Since both parents and children in

the program bring significant histories of trauma, which create the potential for less than optimal interactions, integrating parent and child needs is the challenge of the Infant Mental Health Project.

In addition to the using tenets of the infant mental health literature, we work to strengthen the aspects of adaptive parenting and individual child characteristics which promote resiliency (Garmezy, 2002). Many of the children who attend the Baby Program are exposed to many risk factors associated with poverty including single parenthood, teenage pregnancy, exposure to crime, parental substance abuse, domestic violence, and parental incarceration (Ososky & Thompson, 2000). The protective factors within the child found to shield infants and young children from the adverse effects of poverty include: low distress/low emotionality, an active, alert state, high vigor and drive, sociability and easy, engaged temperament, and advanced self-help skills. Protective skills within the family and community include a family size of less than four children, maternal education, maternal competence, a close bond with the primary caregiver and supportive grandparents. As children enter preschool, supportive teachers and successful school experiences serve as buffers ameliorating the adverse effects of poverty. (Werner, 2002).

Referrals to the Infant Mental Health Project come from numerous sources. Infants have been referred from preventive programs after overwhelmed parents have sought relief from the demands of their babies. Referrals have come from Early Intervention programs, where two year olds were unable, due to acting out behavior or extreme separation anxiety, to participate in center-based programs. Finally, younger siblings of children known to other units of the Children's Evaluation and Rehabilitation Center have been referred with the goal of averting later social emotional disturbances evidenced in their older siblings.

The traumas experienced by the young children and parents in the Baby Program include exposure to community violence and domestic violence. For two of our children, a close family member was murdered, and other children witnessed police activity in which family members were arrested. One child was rescued from a fire when a bomb exploded in his family's apartment building. One child moved with his mother and three older siblings from the South after severe domestic violence. Two of the children live in a homeless shelter. Of the eight children in the Baby Program, only two have a male caregiver living in the household or involved in their everyday lives. Only one father attends the Baby Program.

Children are referred primarily with externalizing behavioral problems. Parents report aggression and

severe tantrums, which include self-injurious behavior. One child with extreme separation anxiety is exposed to male family members who attempt to toughen him up by using “rough language”, fighting and wrestling. His mother seeks assistance in curtailing his aggressive behavior, preoccupation with toy guns and separation anxiety. In general, aggression is a common complaint as are sleep pattern disturbances and nightmares. Upon evaluation, parent-child relationship problems are present and contribute to these behavioral disturbances.

Eight mothers, one father, and nine children, ages four months to three years, regularly attend the Baby Program which meets twice weekly for two hours. In addition, each family receives an individual parent/child psychotherapy session with one of the two clinicians who lead the group. The Baby Program follows a structured schedule, which includes a 30-minute parent/child segment, a 60-minute parent group during which time the children are engaged in developmentally appropriate activities, and a reunion activity for parents and children.

### **THE BABY PROGRAM**

#### **Parent/Child Activities**

The routine is deliberately predictable to help children who have been exposed to trauma feel safe knowing what to expect. Upon arrival the group sits together at a long table and shares a simple breakfast. Using an everyday activity such as mealtime provides parents with a generalizable learning experience. This activity time provides an opportunity for parents to learn to set limits comfortably and appropriately, and for the children to accept limit setting. Children are guided to help clean up their place at the table, fostering “required helpfulness” (Rachman, 1979), an important protective factor. During meal time, clinicians initiate and maintain dialogue within the group. In particular, modeling and coaching adult-child conversation is used as a means of developing positive attachment representations, which can then serve as models for future relationships.

The parent/child activity time begins with the reading of a very familiar storybook, “Brown Bear, What do I See?”, which is adapted to include a refrain where the group answers, “I see Mommy looking at me” when each child’s name is substituted for “Brown Bear”. Parents now encourage each other to make sure they maintain eye contact with their child when it is his/her turn. Such an activity promotes attunement, which is one of the cornerstones that guide this program. Numerous activities are used to foster parental responsiveness, enhance development, enrich current attachment relationships and build the prerequisite skills needed for successful school experience. They include a psychoeducational component to help parents continue the process at home. The following is a sampling of activities that help foster the goals of the program:

#### 1. Reciprocity and Self-Other Distinctions:

- Mirroring, including face-to-face mirroring and parent’s imitation of the child while placed side by side in front of a mirror.
- Stimulating turn taking and engagement with play telephones.
- Teaching body parts of self and other with songs.

#### 2. Joint Attention:

- By using a simple activity such as bubble blowing, parents are encouraged to use eye contact, pointing, and verbal and facial expressions of excitement to obtain and maintain their child’s attention.
- Following the child’s lead by imitating and describing their child’s play interests and activities.

#### 3. Language:

- Parents are coached to talk to their child with greater frequency and quality. Parents are encouraged to identify and label their child’s wants and needs so that, in turn, the child may learn to do the same. Parents are also encouraged to respond to all their child’s vocalizations in order to reinforce the value of language as a means of communication, self-regulation and moderating frustration tolerance.

#### 4. Nurturance and Empathy:

- Animal figures to develop themes of cooperation and care taking and to counter schemas of aggressive interpersonal interaction that can dominate free play.
- Doctor’s kits and Band-Aids for each parent to use in order to solidify the parent-child relationship schema as one of care taking and protection.

#### 5. Self-Regulation:

- Infant massage to help relax and calm the children who are prone to dysregulation and to help develop self-soothing skills. Parents are encouraged to use this technique at home when their child has trouble settling down or falling asleep.
- Music to facilitate transition and establish a sense of predictability and routine.

#### 6. Impulse Control:

- Rolling a ball back and forth, with one side asking the other if they are ready to catch it and waiting for a response before rolling it over.
- Bubble blowing to help children become aware of their actions and to help them learn how to modulate their breath and control their impulses.

#### 7. Social Skills:

- Through developmental play, children learn social skills such as initiating interaction, sharing, asking questions, compromising, listening, and taking turns.

#### 8. Attention Span:

- Development of creative problem solving strategies to increase attention span. Parents are encouraged to note their child’s attention span and to increase it gradually by pointing out a novel use for an object, showing exaggerated enthusiasm and praising.

#### **Parent Groups**

Children initially had trouble separating from their parents during this time. The same music is played each session and children have come to expect that when this song is played, their parents will be leaving for the parent group and returning shortly. Upset children are told that “Mommy always comes back”, a mantra which is repeated as needed during this time. If a child cannot be soothed, the child is brought to his/her parent who

tries to settle the child. Parents are encouraged to tell their child what to expect in an effort to reassure safety and build the beginnings of a trusting parent/child relationship.

The parent groups are led alternately by one of the two co-therapists who lead the Baby Program and consist of either a parent support theme or a didactic session. Didactic topics include an introduction to attachment theory, responsive parenting, positive discipline, temperament and maternal depression. In an effort to bridge cultures and to reinforce didactic material taken from the infant mental health literature, we have discussed the lyrics of popular music, which share some relevant psychosocial themes.

At the start of the Baby Program, parents were asked to project ten to twelve years from now how they would like to be described by their child when he or she is a teenager. Parents in the group most often use words such as, "cool, a friend, someone who is there for them, not like my mother", phrases which are synonymous with Baumrind's (1991) description of an authoritative, flexible parent. Their projection is a key reference point because it gives us a goal or parenting model to work towards. Parents are then instructed to think of their child's mind as being like a "photo album with only a few pages full" and are reminded that they will help determine the childhood memories, mental representations (Bowlby, 1969), which will be part of their child's internal working model. Throughout the groups we strive to bring the infant mental health literature to the parents in a simple understandable manner, highlighting repeatedly the importance of a responsive parent/child relationship.

The parent groups are also adult focused, as each member struggles with her/his own individual issues. Concerns and complaints about their children present opportunities to address the challenge of raising children in the face of their own unmet needs for nurturance, lack of positive parenting models and poor impulse control. Many of the parents in the group have been traumatized and tend to deny the intensity and role that emotions have in their lives. "Get over it" or "Just stop it" are familiar refrains in response to children's crying or angry outbursts. A goal of the parent group is, thus, to provide a safe environment for the parents to address their own issues. Modeled on Fraiberg's (1975) concept of ghosts in the nursery, the group seeks to work through their painful histories that get in the way of being the parent they aspire to be.

The Infant Mental Health Project at the Early Childhood Center will expand to a second group for newborns as the demand has increased and referrals

continue. Our project is constantly evolving as we strive to meet the needs of families at high risk for adverse outcomes yet who continually impress us with their eagerness to raise resilient children. Our team shares an enormous respect for the parents in our group and their commitment to their children.

### References

- Baumrind, D. (1991).** The influence of parenting style on adolescent competence and substance abuse. *Journal of Early Adolescence, 11*, 56-95.
- Bowlby, J. (1969).** Attachment and loss. *Attachment*. New York: Basic Books.
- Fonagy, P. (1996).** The significance of the development of metacognitive control over mental representations in parenting and infant development. *Journal of Clinical Psychoanalysis, 5(1)*, 67-86.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975).** Ghosts in the nursery. *Journal of the Academy of Child Psychiatry, 14*, 387-421.
- Garmezy, N. (1985).** Stress-resistant children: The search for protective factors. In J.E. Stevenson (Ed.), *Recent Research in Developmental Psychopathology* (pp. 213-233). Oxford, England: Pergamon Press.
- Lieberman, A. F., & Pawl, J. H. (1993).** Infant-parent psychotherapy. In C. Zeanah (Ed.), *Handbook of Infant Mental Health* (pp. 427-442). New York: Guilford Press.
- Osofsky, J. D., & Thompson, D. (2000).** Adaptive and maladaptive parenting: Perspectives on risk and protective factors. In J.P. Shonkoff & S.J. Meisels, (Eds.), *Handbook of Early Childhood Intervention, 2<sup>nd</sup> edition* (pp. 54-75). Cambridge, England: Cambridge University Press.
- Rachman, S. (1979).** The concept of required helpfulness. *Behavior Research and Therapy, 12*, 1-16.
- Shonkoff, J. P., & Phillips, D. A. (2000).** *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academy Press.
- Werner, E. (2000).** Protective factors and individual resilience. In J.P. Shonkoff & S.J. Meisels, (Eds.), *Handbook of Early Childhood Intervention, 2<sup>nd</sup> edition* (pp.115-132). Cambridge, England: Cambridge University Press.
- Winnicott, D. (1953).** *Collected papers: Through Pediatrics to Psychoanalysis*. New York: Basic Books.