Core Concepts in Infant-Family and Early Childhood Mental Health
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Our earliest recallable memories from our lives as 3- to 5-year-olds may be diffuse and not fully formed. Some of us may recollect a few high-affect, punctate memories prior to age 3, but most of our experiences from the prenatal period through age 36–48 months cannot be recalled as adults (Fivush and Haden 2003). Nevertheless, we carry within us, as somatosensory or implicit memories and representations, the memory of having been a baby and a small child: the way we were handled and talked to, the quality of important relationships we had, and whether or not we felt safe, protected, and loved during that time. Although largely out of our adult awareness, these early childhood memories and experiences significantly influence the rest of our lives through our neural anatomy, neurobiology, and inner lives as human beings. Thus, infant and early childhood mental health touches and influences all of human experience.

Infant mental health (IMH) focuses on the early experience of the child from the prenatal period through age 5, as well as children over age 5 who are developmentally or functionally younger. The definitions, focus, core concepts, and therapeutic implications of IMH are discussed in this chapter. Although it is nearly impossible in this limited space to provide an IMH foundation that is wide enough and deep enough to do justice to the field, vital core concepts will be touched upon, inviting the reader into a deeper appreciation of the importance of the early years in supporting the development of healthy children and adults, recognizing early evidence of problems, and therapeutically intervening to protect and restore wellness.

Definitions and Basics of Infant Mental Health

Mental health has been defined as the capacity to experience "the full range of life's emotions at each developmental phase of life, in a broad, comprehensive, stable, and deep manner" (Greenspan 2009, p. 5). This field of working to support the mental health of children from birth to age 5 years and their families is known by a variety of names: infant mental health, infant-parent mental health, infant and early childhood mental health, infant-family and early childhood mental health, and social-emotional wellness, among others. The first use of the term *infant mental health* is attributed to Fraiberg in the late 1970s, when she developed a program for children ages 0–3 to treat problems in the infant-parent relationship (Fraiberg 1980). For the balance of this chapter, the acronym IMH will be used to describe this field of working with children, from conception through age 5, and with their parents, families, and other important caregivers.

Currently, the World Association for Infant Mental Health (2012) defines IMH as the ability of children "to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing

environments, infant mental health involves the psychological balance of the infant-family system." Zero to Three National Center for Infants, Toddlers, and Families (2012) defines IMH as "the healthy social and emotional development of a child from birth to 3 years; and a growing field of research and practice devoted to the: promotion of healthy social and emotional development; prevention of mental health problems; and treatment of the mental health problems of very young children in the context of their families." This latter definition is particularly useful because it specifically addresses the four primary areas of service: promotion, prevention, early intervention, and treatment. Every child must be provided with five essential ingredients for optimal development in all domains, but especially mental health: 1) a safe, healthy, and low-stress pregnancy; 2) the opportunity and ability to "fall in love" and "be in love" with a safe and nurturing adult; 3) support in learning to self-regulate; 4) support in learning to mutually regulate; and 5) nurturing, contingent, and developmentally appropriate care. Without these foundational experiences, children are at high risk for developmental, relational, and behavioral difficulties and are at increased risk for mental illness (Edwards et al. 2005; Radtke et al. 2011). Conversely, if this decisive period "gets off to a good enough start, the child's and family's futures will be on track to develop their full potential" (Barnard 2010, p. 54).

The Dyad, the Moment, and Dyadic Functioning

In IMH work, emphasis is focused on the dyad (parent and child) and dyadic functioning as the primal stratum of the child's development. Dyadic reciprocal exchanges form the foundation for the development of much of what makes people human (Birss 2007; Tronick 2003). The smallest of dyadic interactions continually shape the nature of the dyadic relationship, while at the same time these small interactions are representational of the entirety of the relationship to that point. Micro patterns of interaction assemble to construct the "whole" or macro relationship. Infants and young children typically negotiate a series of dyadic relationships, creating unique and intimate patterns of interaction with important people in their lives (e.g., parents, grandparents, siblings, other relatives, teachers), and such connections contribute to the child's overall development and repertoire for relationships (Brazelton 1992).

It follows, then, that the "moment" becomes the basic element of concern in IMH such that each moment enfolds all other moments, and the content of any moment implies the whole of the dyad's experience of being together (Bohm 1980; Sander 2008). Dyadic relationships are constructed moment by moment, and they can be therapeutically addressed moment by moment. For clinicians, observing *any moment* of a dyadic interchange provides clinical information about the whole of the dyad's relationship and therapeutic opportunities to be jointly explored, in such a way that there are implications for the larger relationship and all other dyadic moments.

In a reflective facilitation session with a clinician working to incorporate Video Intervention Therapy in her work (see Chapter 17, "Video Intervention Therapy for Parents With Psychiatric Disturbance"), the clinician described her case before starting a video of a dyad. She cautioned that the recorded mother-child interaction was not "typical" for this dyad, saying that the mother (Eva) was usually responsive and

attentive, but in the video clip about to be seen, Eva was exasperated and upset with her older child after having been up all night with a second child, age 3 weeks. Such justifications or exceptions are often invoked by clinicians when negative affect or problematic interchanges are observed, as if these exchanges should be discounted as unimportant or are the negative exception to otherwise positive interactional patterns. However, each interaction is part of the entirety of the experience of the dyad and holds equal valence as part of their larger "whole" of being together. With the exception of harmful patterns, such as abuse or neglect, or patterns in which negative interactions predominate, the experience of navigating together a range of affects strengthens the dyad as well as both partners as individuals. From a typical positive, neutral, or negative interaction, each partner in the dyad experiences something and learns something both about himself or herself and about the other person relative to self-regulation, mutual regulation, asynchrony, and dissonance in relationships; through this process, the partners reachieve regulatory stability and move forward with a relationship that has been changed by the experience, yet can continue to achieve harmonious and reciprocally coordinated states and dyadic exchanges at a new level (Sander 1969). The ability of both partners in a dyadic exchange (child and caregiver) to coordinate their interactions, repair the frequent interactive errors that occur, and move from negative to positive affect is a key element in positive development (Tronick 1989).

Figure 1–1 shows four photos from a 7-second interaction between a 3-year-old girl and her great-grandmother. In photo 1, the child throws her arm back while laughing after blowing bubbles through a straw into her tea, and she accidentally touches the hair of her great-grandmother. In photo 2, the great-grandmother's positive affect becomes negative, and the child's affect is likewise changing just milliseconds behind the change in her greatgrandmother. In photo 3, the child makes a gestural bid for restoration of their harmonious state, a bid for repair, with a touch to the hand of her great-grandmother and presentation of her full face gaze with a positive affect. In photo 4, the harmonious state of positive matching affect is restored. Such experiences are the homeostatic pulse of the child's relational and somatosensory world and lay a foundation for lifelong interactional patterns. The child's capacity for manipulating his or her environment contributes to a growing repertoire of schemata (Sander 1969) and relational archetypes, and the inability to restore the matching state can result in the child's "protective withdrawal and defensive reactions" (Sander 1969), with relational ramifications when these essential elements of interaction cannot be effectively negotiated. Such subtle relational impairment starting early in life and left unattended or therapeutically unaddressed can remain problematic throughout life (see Chapter 16, "Developmental Psychopathology").

Identifying the Patient in Infant-Parent Mental Health Work
Key to effective IMH practice is an understanding of who the "patient" is in clinical encounters. Shortly after the Napa Infant-Parent Mental Health Fellowship Program began, the transdisciplinary practice model for infant-parent mental health was created to forward both an understanding of the clinician's focus (who the patient is) and an awareness of the level at which the clinician is working in each case (Figure 1–2). In this conceptualization, core infant mental health and well-being are seen as dependent on health and wellness in four component areas: 1) the child, 2) the parent,

3) the environment, and 4) the relationship. IMH clinicians working in component areas 1–3 would also be addressing the overall health of the fourth component: *the relationship.* For example, an occupational therapist working with a 3-month-old infant with brachial plexus would also be attending to the relationship in general, but would be particularly vigilant for any disruptions in the relationship associated with the infant's motor challenges and the related impacts on cueing and gesturing that play a key role in how the dyad partners relate to each other. Other perturbations could also manifest, such as vulnerable child syndrome (Scheiner et al. 1985) or a mother's grief or anger over her daughter's condition (McCaskill 1997). Likewise, both the obstetrician (or certified nurse-midwife) prescribing medication for the mother's postpartum depression and the psychotherapist providing psychotherapy for her depression would have the mother as their primary patient but the dyadic relationship as their shared concern; both practitioners would be attending to the relationship by promoting optimal dyadic functioning, taking appropriate therapeutic steps to prevent problems related to the relationship risks posed by maternal depression (Flykt et al. 2010), and providing various levels of direct treatment if the parent-child relationship showed evidence of problems. Such treatment might include therapeutic services provided either directly by the occupational therapist, obstetrician or certified nurse-midwife, or psychotherapist (depending on their IMH training and skills) or through referral of the dyad for particular therapy if this dyad might benefit from additional therapeutic work done by another clinician or program (e.g., Circle of Security, a therapeutic home visiting program, Video Intervention Therapy). Ideally, the occupational therapist, obstetrician or certified nurse-midwife, and psychotherapist would be meeting to discuss how best to support, safeguard, and foster the health and well-being of this dyad's relationship while each provided treatment for specific conditions within individuals in the dyad.

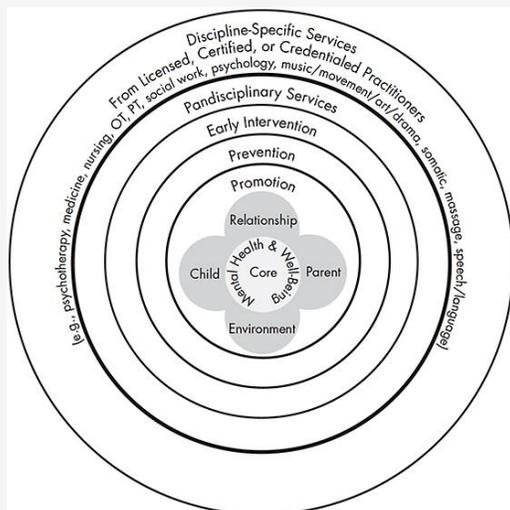The concentric rings in Figure 1–2 delineate the various therapeutic levels in the field:

FIGURE 1–2. Transdisciplinary practice model for infant-parent mental health.
Note. OP=occupational therapy; PT=physical therapy.
Source. K. Brandt and E. Tronick 2003.

Promotion—Services focused on supporting the early development of safe, functional, nurturing, and loving relationships between infants, their parents, and other caregivers.

Promotion services may occur at the policy level through public campaigns and training, be population based, or occur at a program level, but are most effective when delivered at the individual level. Mental health promotion is related to "improving the quality of life and potential for health rather than amelioration of symptoms and deficits" (World Health Organization 2002). With breastfeeding increasingly being shown to be associated with positive dyadic interactional patterns, maternal sensitivity, and attachment security, and with child advantages in cognitive, motor, and behavioral health and early neural development (Bernard 2013; Deonia et al. 2013; Herba et al. 2013; Oddly et al 2010; Tharner et al. 2012), IMH promotion strategies include programs that support initiation and continuation of breastfeeding to at least the duration recommended by the American Academy of Pediatrics (2012).

Prevention—Services that mitigate effects of risks and stress, and address potential early relationship challenges or vulnerabilities that impact early development. Intervention strategies are designed to nurture mutually satisfying parent-child relationships and prevent the progression of further difficulties (California's Infant, Preschool, and Family Mental Health Initiative 2003).

Early Intervention—Services that endeavor to clarify a concern about an infant and/or parent, observe for the emergence of infant-parent challenges, or provide initial services after a specific challenge or delay is suspected or has been identified (Zeanah et al. 2000, p. 551).

Pandisciplinary Services—Assessment, diagnosis, consultation, and/or therapy aimed at optimizing individual and/or parent-child dyadic functioning, as well as functioning within other important relationships, in the presence of serious health and mental health conditions, histories, and/or risks that are known or suspected. Providing therapy within this sphere requires practitioners to have specialized training, skills, and experience, but is not limited to a specific license, credential, or certificate. Examples of useful models include Developmental, Individual Difference, Relationship-based (DIR/Floortime), Circle of Security, Video Intervention Therapy, and Healthy Families America home visiting; although specialized training is required, training and use of these approaches are not limited to one discipline or classification of providers, and each approach can be used with fidelity across many disciplines.

Discipline-Specific Services—Assessment, diagnosis, consultation, and/or treatment aimed at optimizing overall individual and/or dyadic functioning, and functioning within other important relationships, in the presence of serious health and mental health conditions, histories, and/or risks that are known or suspected. Work within this sphere requires that practitioners have specialized training, skills, and experience, and *requires* the possession of a license, certificate, or credential to perform the discipline-specific scope of work necessary to address the needs of the infant, the parent, and/or the relationship. Examples include Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy, for which training and practice are limited to psychotherapists; Nurse-Family Partnership, for which training and service delivery are limited to registered nurses with a PHN certificate; and prescribing

medication for disorders such as depression, attention-deficit/hyperactivity disorder, and anxiety, which is typically limited to physicians, nurse practitioners, nurse-midwives, and physician assistants.

Lifelong Impact of Infancy and Early Childhood

The enduring effects of the first 5 years are both astonishing and disquieting, yet somehow completely intuitive. The current state of science is sufficient to mark these early years as the most pivotal for human development in terms of lifelong health and well-being, learning, neural development, and healthy relationships throughout life. The Adverse Childhood Experiences Study has produced scores of publications demonstrating the range, nature, and lifelong impacts of adverse childhood experiences (ACEs) (Felitti et al. 1998). Experiencing six or more childhood ACEs has been correlated with 1) the development of a number of serious, even life-threatening, health conditions, behavioral health issues, and psychiatric disorders in childhood, adolescence, or adulthood; and 2) a lifespan shortened by an average of nearly 20 years relative to the life expectancy of individuals without ACEs (60.6 years vs. 79.1 years) (Felitti et al. 1998; Hillis et al. 2004).

The neuroscience and epigenetic literature has demonstrated the negative impacts on neuroanatomy and neurofunction resulting from early adversity, such as exposure to maternal stress in utero, child neglect, child maltreatment, and otherwise impoverished environments (Currie and Widom 2010; McCrory et al. 2011; also see Chapter 2, "The Neurosequential Model of Therapeutics," and Chapter 10, "Behavioral Epigenetics and the Developmental Origins of Child Mental Health Disorders"). Certain brain structures, including the corpus callosum, hippocampus, amygdala, and hypothalamus, as well as the related functions of memory and stress arousal regulation, are particularly sensitive to the caregiving environment (Teicher et al. 2003; Zhang et al. 2013). Longitudinal studies show the strong relationship of early childhood attachment to later development and functioning in areas that include adult attachment status, adult relational competence, communication styles, psychopathology, posttraumatic stress disorder, and reliance on the help of others when distressed (Grossmann et al. 2006; Sroufe 2005; Steele et al. 2008).

Multiple disciplines are contributing to an understanding of the lifelong impacts of this complex and susceptible period spanning from pregnancy through age 5 years, but these associations are not the sole basis for supporting children in thriving. Infants and young children deserve to be safe, loved, and happy regardless of later sequelae—they deserve it as human beings—so studies related to later poor outcomes from adversity in childhood do not become the basis for IMH work; they confirm the urgency.

Developmental Process and Context

In sub-Saharan Africa, a giraffe gives birth to a calf that falls 10 feet to the ground, lands on his back, and quickly sits up. Within minutes he will stand and within hours be able to run alongside his mother. A calf that is unable to accomplish the developmental

motor tasks of standing, walking, and running so quickly after birth (something the typical human infant will not accomplish until age 10–14 months) will die by predation or starvation.

The human infant is born, breathes on his own, and is placed in his mother's arms. He, too, must accomplish a crucial developmental task or agenda, or he will not survive: the newborn must attract a caregiver who is competent and willing to invest in his survival. He must attract someone willing to keep him safe, feed him, and fall in love with him. Fortunately, he has come well equipped for this task, appearing vulnerable and small, but possessing myriad compelling capacities for undertaking the task at hand, such as the ability to move in rhythm to his mother's voice (Condon and Sander 1974); facial imitation abilities (Moore and Meltzoff 1999); attracting pheromones (Kaitz et al. 1987); reflexes and capacities that can be interpreted by the parent as demonstrations of strength, health, connection, and so forth (Brazelton 1973; Klaus and Kennell 1976; Nugent et al. 2007); and countless other characteristics and abilities.

For both infant and parent, the nascent dyadic relationship is evolving within systems that are sensitized and/or destabilized by the bio-psycho-social valence of this period. These open systems are dynamically and inextricably interrelated and interacting and include the 1) Attachment System: safety, security, and love; 2) Meaning-Making System; 3) Behavioral System: cueing, gesturing, reflexes, and communicating; 4) Regulatory System: self and interactive regulation; 5) Relational System: engagement, responsivity, attunement, and contingency; 6) Somato-Sensory System: the body, affect, and senses; 7) Neurodevelopmental/Neuroendocrine System including hormonal, stress/arousal, and epigenetic elements; 8) Memory System: implicit, explicit, procedural, autobiographical; 9) Mentalizing System: reflection on the state of self and others; and 10) Intersubjective System of shared dyadic mental states and attention (Beebe and Lachmann 1998; Beebe and Stern 1977; Brazelton et al. 1974; Charles 2001; Bowlby 1953, 1958; Fonagy et al. 2004; Given 1978; The Human Memory 2013; Perry 1999; Stern 1985; Trevarthen 1979; Tronick 1989; see also the balance of chapters in this book). These open and activated systems expose the global system's core, and, whether rigid, flexible, or chaotic, the potential for change—functionally adaptive and maturational, or maladaptive and derailing—exists such that "intervention at this early stage is one of the best chances we have for prevention of child psychopathology" (Brazelton and Cramer 1990. p. xviii).

Starting at birth, and even to some extent in pregnancy, a series of thematic movements in the parent-child relationship and within the family constellation is now set in motion. Often viewed as the stepping-stones of development, *developmental milestones* might be conceptualized as hallmark events in the life of the child and family that are potent but brief rungs on a ladder of development. Each milestone is embedded in a transactional process of meaning making by the child, parents, family system, providers, and others. To illustrate this, I will briefly depart from our discussion of early childhood and use the metaphor of high school graduation, where receiving a diploma is the milestone, but as such it has implicit and explicit, emotional and concrete, real and imagined antecedents and reverberations within the life of the child and family. For both parent and child, hopes and dreams have been fused to this milestone, as have the processes of autonomy

and individuation, independence and dependence, self-agency, grief, loss, separation, joy, pride, the "empty nest," and so forth. As a result, the *intra*personal or inner lives of the parent and the child have been destabilized, causing their *inter*personal interchanges to shift in ways that may range from barely perceptible to massively disruptive for the dyad. Perhaps parent and child are unaware of why something has shifted between them, and the "something" that has shifted now echoes within each person and their relationship. This process is embedded in their patterns of interaction and the representations held within themselves and within the relationship, and these in turn are embedded in family systems with their own gravitational pull. So the disequilibrium in the individuals and the relationship holds the potential for positive and negative impacts at all levels (individuals, relationships, and family system) and on the functional navigation through the developmental stage. Thus, the milestone, while symbolic, is embedded in and characterized by individuals, systems, relationships, and their past expectations, experiences, and meaning making—a complex and dynamic substrate in which the milestone rests, exerting its own multidirectional influence (e.g., advancing independence, loss of control, separation, success).

To appreciate the complexity of the individual, dyadic, and family experience in the child's first 5 years, one need only replace the above example of high school graduation with any number of developmental processes under way in early childhood, including sleeping through the night, thumb sucking, attachment, language acquisition, crawling, walking, toilet training, sibling rivalry, affect regulation, peer interaction, fine motor development, and problem-solving skills, to name just a few. Brazelton (1992) calls these thematic times *Touchpoints,* during which disorganization and functional regression can occur, relationships are pervious, systems may rigidify in their homeostatic pull or become chaotic when long-standing patterns are disrupted, and the potential exists for an optimal developmental trajectory or developmental derailment within the parent, child, dyad, or system (see Chapter 4, "Brazelton's Neurodevelopmental and Relational Touchpoints and Infant Mental Health"). In these thematic movements, IMH clinicians can not only observe and appreciate family dynamics and functioning but also find points in these processes for forging therapeutic alliances, entering into the family's system of care, and providing scaffolding in vulnerable periods.

Serve and Return

Babies develop a sense of themselves and a desire to reach the "other" through communicative exchanges that ideally are supported by delight on the part of each member of the dyad—the baby in seeing the parent's smile, warm affect, change in porosity of speech, gestures, and engagement, and the parent in hearing the baby's intonations and seeing and feeling the baby's engagement—and through inferring from this that each is important to the other. With time (again, ideally), these back-and-forth exchanges become more robust, expanding in duration, frequency, affect, and content. Before neuroscience could demonstrate much about such seemingly mundane relational moments, Bronfenbrenner (1994) wrote, "Human development takes place in the context of an escalating psychological ping-pong game between two people who are crazy about each other" (pp. 118–119). Described in many ways, including "mother-infant reciprocity" (Brazelton et al. 1975) and "two-way interchanges" (Greenspan and

Greenspan 1989), this "serve and return" between a child and an important adult in his or her life is now considered fundamentally necessary for neural wiring and "the most essential experience in shaping the architecture of the developing brain" (Center on the Developing Child, Harvard University 2012). Assessment of the quality of a dyad's serve and return is within the purview of *all* providers working with a family, and it is vital to provide therapeutic support or an appropriate referral when this dyadic process appears to be impaired.

Transdisciplinary Practice

As discussed by Zeanah et al. (2000), Emde, Bingham, and Harmon described the field of IMH as having four basic characteristics: 1) multidisciplinary nature, 2) developmental orientation, 3) multigenerational perspective, and 4) preventive emphasis. However, moving beyond multidisciplinary to bona fide transdisciplinary work has challenges. To embrace transdisciplinary therapeutic approaches, providers are compelled to suspend their belief that their approach or disciplinary perspective is superior to others and to embrace the belief that coordinated and intersecting service delivery is coactive and synergistic. Providers working to preserve or restore health and well-being are all "therapists," with only the preceding adjective (e.g., *occupational* therapist, *psycho*therapist, *developmental* therapist) specifying the provider's perspective or expertise. Having a shared lexicon, philosophical approach, and core training supports transdisciplinary work. At a minimum, core training for all IMH providers, regardless of discipline or function, should include Touchpoints (Chapter 4), the Neurosequential Model of Therapeutics (Chapter 2), the NCAST Parent-Child Interaction Feeding and Teaching Scales (Barnard 1994), and the Newborn Behavioral Observations (NBO), the Neurorelational Framework (Chapter 5, "The Neurorelational Framework in Infant and Early Childhood Mental Health"), the Fussy Baby Network (Chapter 12, "Fussy Babies"), Video Intervention Therapy (Chapter 17), and Reflective Practice (see Chapter 19, "Transforming Clinical Practice Through Reflection Work"), and other core concepts found in the balance of this book that are categorically essential for all IMH providers, regardless of their discipline, primary therapeutic focus (e.g., cognitive-behavioral therapy, psychopharmacology, assessment, literacy, child health), or principal mode of service (e.g., home visiting, clinic-based work, private practice, early care setting). Baseline and shared fundamentals support providers in coordinating and expanding therapeutic work, and families in experiencing a seamless approach and perspective from service providers, agencies, and the community at large.

Therapeutic Approach Model

Consciously or unconsciously, therapeutic work emerges from the therapist's *theory of change*—operating to influence both micro and macro decisions, such as what is attended to, what is said, and what therapeutic strategies or directions are chosen—and is influenced by the clinician's conceptualization of the *process of change* (how someone changes). Ideally, therapeutic work is derived from and grounded in theoretical constructs, research evidence, and the logical construction of strategies or approaches where work is improvisational and contextual—and optimally this process is guided by an explicit therapeutic model. Some disciplines or approaches provide such conceptual

guidance, but for those providers without a guiding framework, a basic therapeutic model is offered here (Figure 1–3). This model supports recognition of therapeutic gateways and pathways, in tandem with elements of the explicit, implicit, and plane of transformation (or zone of reflection) that are active in therapeutic work. From various disciplines, there may be different names for the parts of this model, but the elements remain constant.
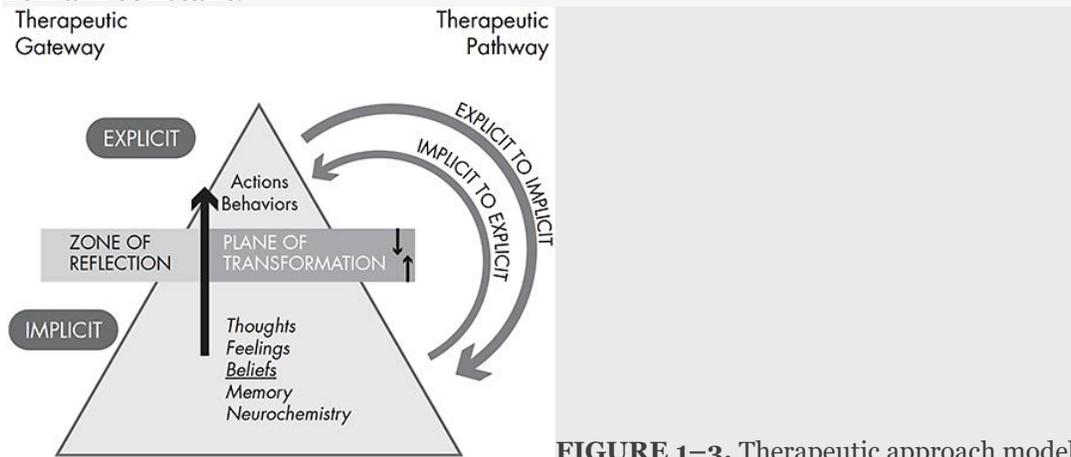

FIGURE 1–3. Therapeutic approach model.

Therapeutic Gateways: Implicit and Explicit

Clinicians are afforded opportunities for therapeutic work through explicit or implicit portals, when either the client offers an invitation (e.g., "I don't know why I get so angry when he acts like that. I just lose it!") or the clinician observes a portal of entry (e.g., during a home visit, a parent swats the child's hand when she reaches for a crayon on the table). The former invites the clinician through the *implicit gateway,* where work can begin with the exploration of thoughts and feelings, and the latter through the *explicit gateway,* where actions and behaviors can initiate the work. Brazelton often uses the explicit gateway as he holds the newborn infant and asks the parent to talk to the infant as he, too, talks to the infant. As the infant orients to the parent's voice and turns toward the caregiver, the parent may exclaim, "You know me already!" Brazelton nearly always asks about what meaning the parent makes of the infant's capacities. He enters the system through the explicit gateway by focusing on the baby's behavior, then skillfully moves to the implicit by asking about the parent's meaning making.

Effective clinicians are aware of the realm in which they are working with a client—in the implicit or the explicit—and whether the therapeutic goal is one that addresses the behavior and actions or addresses the underlying feelings, thoughts, meaning, and so forth. Some therapeutic work remains only in the explicit realm. For instance, home visiting programs that address early literacy and encourage nightly reading to the child, or work to ensure that the infant has home health care and attends well-child appointments, may remain exclusively in the explicit realm, because actions and behaviors are required of the parent (i.e., reading regularly to the child or taking the child to well-child pediatric appointments). Although it might be agreed that such efforts could be more efficacious if the implicit (e.g., thoughts, feeling, beliefs) was part

of this work with the parent, as it very often is, such implicit work may not always be within the clinician's capacities or inclination, within the scope of the provider's work, or consistent with agency policies.

Therapeutic Pathway

Therapeutic work originating in either domain—explicit or implicit—inevitably influences the other. Video Intervention Therapy (Chapter 17) is a useful mode of using actions and behaviors to therapeutically influence the implicit.

The following case illustrates working from explicit to implicit.

> An 18-year-old mother, Eva, has had her 6-month-old baby, Olivia, removed from the home for severe neglect. In supervised reunification visits, the clinician notes that Olivia is hypersensitive to sounds (auditory), movement (vestibular), and proximity. Eva swings the baby up to her face, close to her nose, saying loudly, "Oh, I missed you sooo much!" Olivia freezes, then turns her head laterally to gaze away from her mom. Eva jiggles Olivia, pleading stridently, "Olivia, look at your mommy. I missed you." As Olivia begins to scream and arch back in distress, the clinician reflects in action [see Chapter 19, "Transforming Clinical Practice Through Reflection Work"] on what portal of entry is being offered and the therapeutic pathway that may work in this moment. There are many choices, but in this recorded encounter, the clinician says, "What distance have you noticed works best for Olivia to be able to see your whole face? She's probably so excited by seeing you. I wonder what distance will work for her today." Eva moves her crying baby back several inches and shifts arms to better support Olivia, who stops crying but is only slightly turned toward Eva. Eva asks Olivia loudly if that is better, and the baby's face puckers into a cry face. The clinician says, "Looks like you found just the right distance for her today. I wonder if talking softly might help her deal with all her excitement in seeing you."

Skillfully, the clinician is working in the explicit domain to support mom and baby to interact, mom to help her baby regulate, mom to feel competent, and both to find some mutual delight in their time together—not only today but into the future. Notice, too, that the clinician used the word *excitement,* a word with complex meaning, in reference to the child's arousal level. The temptation for this clinician might be to launch into "telling" the mother information about regulation, sensory stimulation, signs of sensory overload or dysregulation, and so on, but "telling" has limited influence on deeply held beliefs, thoughts, and feelings. Eva may feel that a baby who loves her mother looks at her mother, and that turning away and crying means that Olivia does not love her or that Eva is not a good mother. Eva might believe that Olivia is a "bad" baby, irritable or hard to soothe. As Eva tries strategies to support Olivia, she is experiencing "something" and operating from a belief system. It is tempting to speculate on her experience and beliefs in the moment, but such speculation may tell clinicians more about their own projections than about Eva. The clinician can only know what is in the implicit if Eva shares that information. The clinician believed that providing didactic information on regulation, sensory stimulation, and so forth, in this high-arousal moment for Eva, would likely not be helpful or heard, and could even be further dysregulating for the mother, so the clinician chose behavioral observation and exploration as the path.

Plane of Transformation or Zone of Reflection

In IMH, clinicians encounter implicit thoughts, feelings, and beliefs that are underpinned by neurochemistry and memory and made manifest through behavioral patterns interlocked with procedural memories of infancy and early childhood. These can present as automatic or reflexive behaviors for which the origins may be wholly or partly out of awareness. Thoughts, feelings, and beliefs in the implicit manifest into actions and behaviors in a plane of transformation where strategies are chosen to carry out, align with, or achieve the implicit in a process that can be conscious or unconscious, deliberate or impulsive. Likewise, in this plane of transformation, actions and behaviors can be reflected on and sense or meaning made of the explicit, often with the surfacing of emotions evoked by the congruence between the implicit and the explicit, or the lack thereof—a mismatch between what one believes or thinks and what one does, or vice versa.

What Is Therapy?

Length constraints prevent much elaboration on therapeutic strategies in this chapter, but the balance of this book is directed at that purpose. As new research and scientific findings inform the field, both seasoned and novice clinicians may deliberate about how to translate these findings into clinical strategies. The chasms between and among researchers, theoreticians, and clinicians are worthy of discussion in another volume, and their related work has been compartmentalized and apportioned in ways that make transdisciplinary therapy challenging. Research and theoretical publications rarely include clinical implications, and clinicians caring to enhance their practice with new findings typically must derive and construct clinical inferences and strategies independently. To address this, the IMH field must identify strategies for more effectively moving research findings into clinical practice; for examining and disseminating clinically derived knowledge to other clinicians, researchers, and theoreticians; and for constructing new transdisciplinary therapeutic models to advance the field and better meet the needs of children and families.

After the obvious first objective of securing a safe passage for the mother and infant through the pregnancy and delivery (Rubin 1984), the next most important objective is to scaffold, support, and foster the process of the parent and child falling in love with one another (Brandt 2009). Bronfenbrenner's (2005) celebrated words should guide therapeutic work: "In order to develop intellectually, emotionally, socially, and morally—a child requires...progressively more complex reciprocal activities, on a regular basis over an extended period of time in the child's life, with one or more other persons with whom the child develops a strong, mutual, emotional attachment, and who are committed to the child's well-being and development, preferably for life" (p. 9). Following Bronfenbrenner's notion, therapeutic work should commence with identifying, securing, or reinforcing such a relationship for every child, and evaluating the child's attachment status within important relationships relative to presenting behaviors or concerns. To some, no doubt, this does not sound like therapy; however, no lasting improvement or conservation of wellness can be realized for a child in the

absence of a relationship that provides the safety, protection, and nurturance of such a human connection.

IMH therapeutic work may be ascribed by some to certain disciplines (e.g., psychiatrists or psychotherapists) or limited to specific treatments (e.g., Parent-Child Interaction Therapy, Nurse-Family Partnership), but expansive transdisciplinary therapy is necessary to address the often complex and multifactorial challenges experienced and exhibited by clients, and to construct novel therapeutic approaches derived through evidence-based practice (see Chapter 18). The transdisciplinary cache of therapeutic approaches must be expansive enough to meet families where they are, literally and figuratively, and provide therapeutic work in a fashion tailored to address their needs, not the deliverables in a grant or the needs of an agency with only one approach to offer. Some families may be supported by working with a provider once a week, while comprehensive therapy addressing every hour of the day must be considered for children and families already exhibiting severe challenges. Mobius Care With a Tile and Grout Approach (Brandt 2011) is one such model that I developed in a blend of Brazelton's (1992) Touchpoints concepts (see Chapter 4) and Perry's (2006) Neurosequential Model of Therapeutics (see Chapter 2). This approach crafts hour-by-hour therapy for a child and parent that scaffolds their developmental progress within the context of the child's chronological, developmental, and functional age, through enlisting the unique resources their environment affords.

Therapeutic work must address the needs of the child and family, and come with a full measure of respect for families and passion for the work. Some forms of parental or dyadic therapy can be too slow to meet the needs of the rapidly developing child who, moment by moment, is making meaning of experiences, crafting internal representations and templates, shaping perception, and integrating new capacities, like layer upon layer of developmental "bricks being laid." A clinician's work with a parent must realize change in dyadic interactions quickly enough to support the child's development before the developmental sequences of multiple domains are delayed, derailed, or too significantly harmed. This compounding effect must motivate the clinician to approach therapy with a sense of urgency and fervor but also caution. Facilitating other safe and nurturing adults spending engaged time with the child can act as a buffer when parental or dyadic treatment is progressing too slowly to support the child's healthy developmental progress. Every provider at every contact with a young family should provide as much therapeutic support as possible to foster a strong parent-child relationship while also identifying and mobilizing resources in the environment to scaffold the child's specific developmental needs when these needs cannot be fully met by the caregiver(s) due to any of a variety of causes.

Conclusion

IMH is a dynamic and comprehensive transdisciplinary field that is on the leading edge of neuroscience. No longer are pregnancy and early childhood envisioned as a custodial phase before learning begins or before harm from impoverished caregiving occurs.

Clinicians, however, are tasked with creating therapy that safeguards and leverages the capacities of the child and family while simultaneously addressing the vulnerabilities and risks—all within the rapidly advancing atmosphere of the developing child and family. Unlike any other field, IMH work reaches far into the future, touching the lives of the next generation or more with transgenerational transfer both through epigenetic mechanisms and through the awakening of procedural caregiving memories when the children served today embrace their own children.

William James (1890/1950) once described the infant's world as "one great blooming, buzzing confusion" (p. 462), but a contemporary view suggests that infancy is much more, and perhaps the most influential period of dyadic construction and neural development in one's life. IMH work endeavors to have all babies and young children experience safety, predictable patterns of caregiving from nurturing adults, mutual delight in the presence of their caregivers, and manageable and recoverable stress mediated by an attuned caregiver, all of which contribute to a lifetime of optimal development with healthy well-being, satisfying relationships, and unlimited opportunity.

KEY POINTS

- Every child must be provided with five essential ingredients for optimal mental health development: 1) a safe, healthy, and low-stress pregnancy; 2) the opportunity and ability to "fall in love" and "be in love" with a safe and nurturing adult; 3) support in learning to self-regulate; 4) support in learning to mutually regulate; and 5) nurturing, contingent, and developmentally appropriate care.
- The core of mental health and well-being is embedded in the nexus of what the child brings, what the parent brings, what the environment offers, and the quality of relationships. Mental health services can be generally organized into five levels: promotion, prevention, early intervention, pandisciplinary therapies, and discipline-specific treatment.
- The current state of science is sufficient to mark the first 5 years as the most pivotal for human development in terms of lifelong health and well-being, learning, neural development, and healthy relationships throughout life.
- Infants and young children have developmental tasks or agendas that create thematic shifts and disequilibrium in individuals, relationships, and family systems, holding the potential for positive and negative impacts at all levels and on navigation through the developmental stage.
- Each provider working to restore or maintain wellness is a therapist, and therapeutic work with parents is rooted in the clinician's theory of change (why people change) and beliefs about the process of change (how people change). A therapeutic model can guide awareness of the therapeutic gateways for entering the work, pathways for change, strategies chosen, and congruence or alignment with beliefs and actions.

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