

# **“THERE’S NO SUCH THING AS A BABY”**

by

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February 2001

Evaluation of a child with developmental delay, failure to thrive, neglect or abuse, or problems with sleep, eating, or behavior is familiar to most physicians who treat children. The idea that any of these conditions may be the presenting symptom of a child with an infant/toddler mental health problem is not as familiar. This article is written to discuss the definition and determinants of infant/toddler mental health, to provide examples of parent-infant interactions, to suggest some office observations and interventions, and to discuss referral options for treatment of disorders. Health care providers who care for infants and children have a tremendous opportunity and obligation to identify those families with potential problems in infant mental health just as they would identify a child at risk for a physical problem such as hearing loss or a bacterial infection. The lifelong results of non-treatment of mental health problems may be as serious as are those from some physical conditions. Improving awareness of infant mental health problems and increasing availability of and access to treatment has the potential to improve the lives of children and their parents as well as to prevent future behavioral, emotional, and even physical disorders.

## **What is Infant Mental Health?**

Some infant mental health professionals define the term as an infant’s ability to develop socially and emotionally in order to master the primary emotional tasks of early childhood and to set the stage for mastery of those tasks throughout life. The first emotional task for the infant is to establish a sense of basic trust that the world is a safe

place and that his/her needs will be met contingently, such as hunger results in getting fed, or tiredness results in getting to sleep. "There is someone there who understands what I need and makes it happen at the right time." The second emotional task for the infant is to develop a sense of competence or confidence in its ability to achieve a goal. Establishment of a secure basic relationship with a parent frees the child to explore and learn about his/her world.

The following are descriptions of parent-infant interactions that may reveal something about the developmental process of an infant's mental health.

Picture a mother-infant pair with the baby in an infant carrier and the mother loosely holding a bottle in the baby's mouth. The baby appears hungry and is just getting into a rhythm of drinking the bottle when the mother pulls the bottle out of his mouth and begins teasingly offering then taking the bottle away. While doing this she states, "You little pig, you're always hungry. I spend all my time just feeding you!" She continues this interaction until the baby is crying frantically and turns away when the bottle is offered. The mother says, "Ok, then don't eat!"

Picture another parent-infant pair, a former premature with nasal cannula oxygen whose father is engaging him in a game of peek-a-boo. The baby smiles and vocalizes in response to the game. When the baby yawns and begins looking away, the father stops the game and says, "That was fun, but maybe you need a rest now. Here's your pacifier". The baby takes the pacifier and seems content. The first parent insensitively disregards the needs of the infant in preference to her own needs. The second parent sensitively reads the cues of his child and changes the interaction contingently.

### **What Determines the State of an Infant's Mental Health?**

Dr. Donald Winnicott, a pediatrician and child psychiatrist made this statement several years ago: "I once risked the remark 'There is no such thing as a baby'- meaning that if you set out to describe a baby, you will find you are describing a baby and someone else. A baby cannot exist alone, but is essentially part of a relationship". An infant's mental health develops in the context of the infant-parent relationship.

Before we focus on that relationship let's step back and think about the context within which that infant-parent relationship forms. Dr. Charles Zeanah has presented a summary of the family context of infant mental health in his book *Handbook of Infant Mental Health*. (1) It reminds us that the parents come to the task of parenting with "internal working models" of relationships that were formed as they were reared by their parents. Parents may try to either emulate or overcome relationship patterns that they experienced, but all parents are influenced by their history. Parents who had abusive or neglectful parents may have a poor understanding of what a nurturing parent-infant relationship involves.

Parents and infants live in a family unit consisting of individuals with various types of legal, kindred, or social ties who experience daily family relationship issues. This family unit has a cultural background, or perhaps a multi-cultural background, with social connections that provide support to a lesser or greater degree. The community context of the family may either foster or hinder wholesome family development.

Keeping this context in mind, we return to the parent-infant relationship. Sameroff and Chandler (2) described a transactional model in which the development of the child is seen as a product of a continuous dynamic interaction between the child and his/her family and social context. The experience provided by the environment is not independent of the child. Both the child and the parent bring their unique characteristics and style to the interactions. These dynamic interactions take place hundreds of times a day between the infant and someone.

Again envision a parent-infant pair. An alert, cheerful baby looks at the parent, and the parent looks back and smiles. The baby smiles in response and vocalizes. The parent smiles, repeats and expands on the infant's vocalization, and pats the baby's cheeks. The baby responds and it goes on. Each encounter is a strand of the relationship that is being woven between the two.

Imagine how different the experience is when one of the partners responds non-contingently.

For example, the baby looks at the mother and the mother looks back with little expression, perhaps because she is clinically depressed. The baby vocalizes, but the mother continues to give no change of facial expression, no vocalization,

and no touch in response to the infant's overtures. Or consider another parent-infant pair where the infant is an easily overwhelmed, former premature who responds to a well-intentioned but overly boisterous parent by screaming or shutting its eyes and turning away.

A few such negative interactions certainly do not spell disaster, but how many of these kinds of interactions can take place before the social-emotional and perhaps physical development of the child is in jeopardy? A consistent pattern over time of disregard or non-contingent response to an infant's emotional and physical needs sets the stage for infant mental health disorders. These may present as feeding disorders, sleep problems, neglect and abuse, behavior problems such as the "toddler out of control", or other clinical conditions.

The patterns of emotional relatedness constructed during the first three years tend to persist and influence relationships throughout life. Brain research tells us that during these early years of life there is rapid neural growth and neurochemical influence on areas of the brain such as the hippocampus and amygdala, which play a significant role in control of emotion and behavior. Dr. Megan Gunnar (3) and others have evaluated the hypothalamic-pituitary axis function in maltreated children and have identified persistent abnormal neuroendocrine secretion patterns in those children who manifest behavior problems in preschool. Researchers continue to try to understand the role of environmental influences on the expression of genetically programmed functions related to behavior.

There are both parent and infant determinants of the interaction patterns that develop. Some factors that may affect parents' quality of interaction are physical illness, poverty, immaturity, drug use/abuse, a history of being poorly nurtured themselves, and parental depression or other mental illness. Several authors have written about the relatively high rate of occurrence and the pervasive detrimental effect of parental depression on young children.

Some infant factors that may affect the relationship are prematurity, illness, presence of a birth defect, temperament, and gender. These characteristics may cause the infant to act in ways different from what the parent expected. If the actual child differs significantly from the idealized child the parents had hoped for, the parents must

gradually reduce the contrast between the wished-for child and the real child. The parents may need to grieve the loss of the idealized child. This process may be so stressful for the parents that it interferes with their ability to nurture the infant.

Amazingly, even in the presence of circumstances that place the relationship at risk, most parents and infants form positive nurturing bonds. This may be due to the resilience of the child and parent and/or to the presence of protective factors in the environment such as family or community support. Risk factors in either the infant or the parent should alert us to search for evidence of relationship difficulties, but how does one recognize this evidence?

### **Office Observations and Interventions**

During even a brief office encounter one can assess the quality of the parent-infant interaction. Where is the child in relationship to the parent when you enter the room? Are they together in some interaction, or is the infant in his carrier perched on the exam table with the parent in a chair across the room reading a magazine? When the pair interacts, do you see mutuality in gaze, smile, engagement, and rhythm? Is there a matching of affect between parent and child? Does the parent respond contingently to the apparent need of the child, such as providing closeness, comfort, and security during the stress of an exam or procedure? What is the quality of touch between the pair? How intrusive is the parent in the infant's activity? For example, while the infant is exploring a toy, does the parent grab it away and try to show the infant how to play with it? Does the child look to the parent for social cues about the encounter? Can the parent describe the child's day? More information is available to the physician about these kinds of observations and assessments in *Bright Futures* and *Building Bright Futures* by Dr. Morris Green and Dr. Judith Palfrey. (4) Observations that raise concern about the parent-infant relationship should lead the health care provider to further assess the clinical situation. *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* published by the Zero to Three organization lists diagnostic categories and examples of infant/toddler mental health case studies. (5)

Signals of relationship difficulties may be evident before there is a clinical condition such as failure to thrive or abuse. Appropriate intervention may prevent progression to a more serious condition.

But what are appropriate interventions? Knowledge of the parent-infant pair in their family, social, cultural, and community setting will help determine appropriate interventions that may be possible. Parents at risk who are manifesting relationship danger signals might benefit from some well-chosen words of counsel or modeling of an appropriate interaction by the clinician. Sometimes one can point out and encourage a positive interaction such as the baby's smile and calming in response to a parent's voice. At other times one can discourage a negative interaction by saying something like, "I wonder if your baby might be thinking, 'It's scary when I hear you yell'." Another intervention might be to recommend a parenting class, or brief in-office parenting information given by a nurturing, trained office staff member. A mature mother in a secure family setting who is experiencing post-partum depression may need an antidepressant and a suggestion to obtain some extra help at home. When the physician has a concern about a child's developmental progress, referral to the *First Steps Early Intervention System* may provide additional evaluation, therapy, and supportive services. A young, substance-abusing mother may need more long-term, intensive therapy with a social worker through a mental health clinic, or intervention by child protective services. The *Mental Health Association in Indiana* as well as the Indiana State Department of Health's *Indiana Family Helpline* can help to provide additional linkages, where available, to needed mental health services throughout the state. **A summary of these intervention strategies is as follows:**

1. Counseling by the clinician during an office visit.
2. Counseling by a trained office staff member.
3. Referral to First Steps for developmental assessment and therapy.
4. Referral to a private mental health professional, or to the local mental health clinic for parenting classes or in-depth counseling.

These referral options for infant-parent relationship problems in Indiana are often limited because mental health professionals trained to work with infants or toddlers and parents are not always available. A collaborative "Integrated Services for Children with

Special Health Care Needs” SPRANS (Special Projects of Regional and National Significance) grant from the federal government to the Indiana State Department of Health and First Steps Early Intervention System has provided for the development of a team to address problems in infant mental health. Surveys of parents, early intervention providers, and mental health providers have identified concerns and potential resources to provide infant mental health services to families. Since in-home early intervention services are provided by *First Steps* to children who qualify, it seemed feasible to provide infant mental health screening through the same system since many of the children needing developmental services and infant mental health services are the same.

Training programs in infant mental health principles are being developed for early intervention providers to enable them to screen the family’s need for services, provide supportive care, or refer for more intensive therapy when needed. A survey is being designed and disseminated for mental health therapists now in practice who have experience or want to develop expertise in treating parent-infant relationship problems. A goal of the SPRANS project is to provide health care providers in each area of the state with information about available treatment resources.

A group of parents and professionals who have participated in the SPRANS grant team have established *The Indiana Association for Infant and Toddler Mental Health*. The organization is committed to promote knowledge and services in the area of infant mental health to professionals and families in the state. The state organization is a subsidiary of the *Mental Health Association in Indiana* and an affiliate of the *World Association for Infant Mental Health*. Several members of the Indiana Association have attended the World Association conference and have participated in a regional meeting with some of our neighboring states to strengthen efforts around infant mental health issues from a regional to international level. This is especially important because of the increasingly diverse social and cultural contexts in which families develop.

Increasing awareness of infant-toddler mental health issues among those who work with young children will hopefully improve access to supportive and treatment services and thereby improve outcome for the children and their families. As with many physical disorders, early treatment of mental health problems holds the prospect of avoiding the occurrence of more damaging conditions. The child and family can be

helped to develop more healthy and rewarding social and emotional relationships. Improvement in infant mental health services is a challenging but rewarding goal that will benefit many Indiana families.

To learn more about the *Indiana Association for Infant and Toddler Mental Health* you may call (317) 638-3501.

#### **About the Author**

Dr. Kardatzke was in general pediatric practice for about 18 years, completed a Fellowship in Behavioral-Developmental Pediatrics, and now works in Developmental Pediatrics at Riley Hospital for Children.

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