

Training in Infant Mental Health

Educating the Reflective Practitioner

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Training approaches in the arena of infant mental health are evolving, demand for training experiences is growing, and recognition of challenges to building the infant-family workforce is improving understanding of training needs. The diversity in the prospective workforce creates challenges for training programs, for example, how to clearly define appropriate training objectives, how to define relevant knowledge base and skills, how to structure training approaches for such a heterogeneous population as the infant-family workforce, and how to provide training experiences that facilitate ongoing professional development for individual practitioners. Workforce diversity is not the only or even the most important challenge however. Work with infants, toddlers, and their families is made up of a great variety of problematic situations, each unique to a baby and its family, each requiring *naming and framing*. Thus, the complexity of training in infant mental health can be construed as the twin challenges of acquiring needed knowledge bases and also gaining the skills of naming and framing, or of problem setting, which are necessary for effective and reflective practice. The challenges for educators in infant mental health are not only to transmit appropriate knowledge bases in the training process but also to prepare the trainee to work within an ongoing relationship with each family. These training issues will be addressed through an attempt to characterize the work of infant mental health using Schön's framework of reflective practice to further develop the tasks of problem setting in the indeterminate swampy zone of infant mental health practice. **Key words:** *infant-family workforce, infant mental health, problem setting, reflective practice*

Reflection means continuing conceptualization of what one is observing and doing.
—Fenichel, 1992

TRAINING approaches in the arena of infant mental health are evolving, demand for training experiences is growing, and recognition of challenges to building the infant-family workforce is improving understanding of training needs. The majority of training to date is postprofessional, or postgraduate, meaning it is undertaken by individuals who already have professional backgrounds in fields such as social work, psychology, psychiatry, nursing, early childhood education, special education, or other disci-

plines. A wonderfully broad diversity of individuals, groups or stakeholders, care contexts, and professional helping models is involved in efforts to support the development of infants, toddlers, preschoolers, and their families; the work itself sometimes brings together practitioners who are unfamiliar with each other's specialty. This diversity in the prospective workforce creates challenges for training programs, for example, how to clearly define appropriate training objectives, how to define relevant knowledge bases, how to structure training approaches for such a heterogeneous population as the infant-family workforce, and how to provide training experiences that facilitate ongoing professional development for individual practitioners.

Workforce diversity is not the only or even the most important challenge however. Educators of the infant-family workforce face another set of issues embedded in the task of

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defining infant-family practice, issues that are reminiscent of those that Schön (1987) linked to problems with epistemology of practice. In his analysis of professional knowledge (1983) and proposals for rethinking education for reflective practice (1987), Schön argues that the problems of real-world practice do not present themselves as well-formed structures, that is, as clearly articulated problems. Instead, in practice, situations are encountered that are messy and indeterminate. Schön suggests that the prevailing epistemology of practice in our society is derived from the positivist philosophy that holds that practitioners are instrumental problem solvers who select technical means best suited to particular purposes. In this positivist view, rigorous professional practitioners are technical experts who solve well-formed instrumental problems by applying theory and technique derived from systematic, preferably scientific, knowledge. Schön, himself, presents a starkly contrasting perspective saying:

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern. (1987, p. 3)

Recognition of this gap between educational emphasis on acquiring knowledge of theory and technique and the “indeterminate, swampy zones of practice” led Schön to focus on the “problem of problem setting” for the practitioner:

When a practitioner sets a problem, he chooses and names the things he will notice . . . Depending on our disciplinary backgrounds, organizational roles, past histories, interests, and political/economic perspectives, we frame problematic situations in different ways . . . It is not by technical problem solving that we convert problematic situations to

well-formed problems; rather it is through the *naming and framing* [italics added] that technical problem solving becomes possible. (1987, p. 4)

DISTINGUISHING KNOWLEDGE BASE FROM PRACTICE

Clarifying differences between technical professional knowledge relevant to infants, toddlers, and their families and the tasks of problem setting in the work of infant mental health will help educators better articulate training challenges. Better understanding of this differentiation will facilitate development of training strategies that help practitioners learn to understand “problem setting” and to work with the issues of naming and framing in infant mental health practice. Work with infants, toddlers, and their families is made up of a great variety of problematic situations, each unique to a baby and its family, each requiring *naming and framing*. Thus, the complexity of becoming competent in infant mental health practice can be construed as *the twin challenges of acquiring needed knowledge bases and also becoming competent in the processes of naming and framing, that is, of problem setting*, both of which are necessary for effective and reflective practice. Schön further develops the idea of problem setting for situations encountered in real-world practice by identifying 3 broad types of problems, *problems of the unique case, problems of conflict among values, and problems of uncertainty about the presenting situation*.

Schön’s notion of the unique case acknowledges uniqueness as a powerful and definitive challenge to problem setting. In infant mental health practice, acknowledging not just the heterogeneity among babies and their families but also the uniqueness of each infant-parent dyad highlights that training must embrace both the professional knowledge base and the practitioner’s competence with “problem setting.” Every baby is unique, every family is unique, every parent-infant relationship is made up of its own flavors of

interaction, representations, and meanings. In Schön's analysis of factors undermining the relevance of professional knowledge bases, unique cases are among the most challenging because these cases fall outside the frame of existing knowledge: "the case is not in the book." Problem setting includes selecting among relevant knowledge base material then applying the information in a unique family situation. In the health sciences, this is a particularly salient issue because our science is conducted on large groups of individuals, or research samples. But infant mental health practice, like practice in other human services, requires practitioners to apply the knowledge bases not as expressed in group averages but to understanding of an individual, unique baby, and his family.

The issue of differences in perspectives, attitudes, values, and beliefs is also central to infant mental health practice. For example, true respect for cultural meanings is essential to effective work with individual families. Uncertainty about the presenting situation involves recognizing the unfamiliarity that accompanies unique cases and an ability to tolerate that things are initially not clear. Thus, a significant dimension of infant mental health practice, across disciplines, is Schön's "setting the problem," a process in which the practitioner chooses the things she will notice, name, and frame. From this perspective, much of the learning in infant mental health training involves gaining abilities for "naming and framing" in direct work seeking to understand the situation of a particular baby and her family from the perspective of their context with all its unknowns. The challenges for educators in infant mental health are not only to transmit appropriate knowledge bases in the training process but also to prepare the trainee to attempt make to sense out of the uncertain situations and uniqueness that are encountered in real-world work with individual families while remaining aware of and alert to differences of perspective or values. This recognition helps to guide our thinking about training in infant mental health and helps us to focus on the pro-

cesses of educating the reflective infant-family practitioner.

ESTABLISHING A COMMON LANGUAGE

The infant mental health field has been described as including a developmental perspective, as interdisciplinary, as having a multigenerational perspective, and as being prevention-oriented (Emde, Bingham, & Harmon, 1993). A discussion of training in infant mental health has as its first challenge establishing a framework for communication about the arena of infant mental health. What is infant mental health? What is training as an infant mental health specialist or an infant-family practitioner? Both these terms and others are used to express who is doing the work and, to some extent, what the work is. What is a practitioner prepared to do once trained as an infant-family practitioner, developmental specialist, infant specialist, or infant mental health specialist? Three uses of the term infant mental health can be identified. The first is a general reference to a state of well-being in infants. A second use of the term is a discipline-specific reference to clinicians trained in infant-parent psychotherapy in order to provide treatment for at-risk or already troubled infants, toddlers, and their families. The third use indicates a global orientation to infant mental health practice as the work of supporting young children and their families. Each of these uses has a slightly different meaning, but there are 2 commonalities; each term identifies an aspect of specialization and each emphasizes the well-being of the infant and caregiver and their relationship. A discussion of these different uses of the term infant mental health can help to establish a common language for both practice and for training.

Infant mental health or the well-being of a baby is defined as "the developing capacity of the child from birth to three to: experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn—all in the context of family, community, and

cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development" (Zero To Three, 2002). This definition acknowledges the necessity of a developmental perspective that recognizes the active, constructivist infant held in the context of important relationships that mediate the baby's experience of the world around him.

The term infant mental health specialist was originally introduced by Shapiro, Adelson, and Tableman (1978, 1980) to describe clinicians who began with basic clinical training in their fields, then needed "education specifically concerned with the parent-infant relations in the first three years of life and the application of clinical skill to a population not yet served in mental health clinics, at-risk infants and their parents." Weatherston (2000) describes the "extraordinary approach" crafted by Fraiberg and colleagues, and christened Infant Mental Health, this way: "Sitting beside the infant and parent at the kitchen table or on the floor or on a sofa, the Infant Mental Health practitioner watched or listened carefully in effort to understand the capacities of child and family, the risks they faced, and the ways in which the practitioner might be helpful to the infant or toddler and family."^(p.3) Infant mental health specialist services include concrete assistance, emotional support, developmental guidance, early relationship assessment and support, advocacy, and infant-parent psychotherapy (Lieberman, Silverman, & Pawl, 2000; Weatherston, 2000).

Emde (2001) characterized infant mental health as an integrative arena bridging across levels of knowledge, new discoveries of science, and the practice of interventions. He described the practice of infant mental health as typically involving (*a*) systems' sensitivity and responsiveness to a variety of biological and contextual factors, (*b*) an appreciation that interventions work through the influence of relationships on relationships, (*c*) appreciation that interventions address problems of regulation within individuals and within relationships, and (*d*) recognition that intervention

goals are to relieve both current and future suffering in children and parents.

There has been confusion in the use of the term infant mental health specialist, in part, because "mental health" also identifies several discipline-specific areas of expertise, most commonly, psychiatry, social work, psychiatric nursing, and psychology. It is important to acknowledge though that training in a mental health profession does not necessarily include emphasis on those areas that define infant mental health: a developmental perspective, an interdisciplinary approach, a multigenerational perspective, and an emphasis on risk, resilience, and prevention. To establish a common language, it does seem sensible to maintain the original meaning of the term infant mental health specialist introduced by Shapiro and colleagues (1980) as a clinician with training in a mental health discipline and additional specialized training for work with troubled infant-parent relationships. Weatherston (2000) suggests that infant mental health represented a dramatic shift in clinical practice in its attention to the baby, the parent, and their early developing relationship. In its original meaning, infant mental health practice is distinguished from other forms of infant and family services by a set of skills and strategies that go beyond relationship building, observation, supporting child development, and providing parent and family support. This specialist clinician an infant mental health therapist (D. Weatherston, personal communication, December 4, 2004) also has strategies for attending to emotional health and development, relationships past as well as present, and the complexities parents may encounter in their development and functioning as parents, nurturing, protecting, and responding to the emotional needs of their young child.

The third use of the term infant mental health indicates an encompassing orientation to all work that involves supporting infants, toddlers, and families. The term infant-family practitioner is increasingly used to include the full range of competencies within the global orientation of all work promoting wellness for

infants, caregivers, and their relationships. In the words of Eggbeer, Mann, and Gilkerson (2003), the infant-family workforce “individually and collectively possesses the knowledge, skills, and personal qualities to partner with parents during the first three years of a child’s life.”

Especially given this breadth of views about the meaning of infant mental health, training designed for preparing practitioners from many different disciplines to work with infants, toddlers, preschoolers, and their families is a complex initiative. One type of training may be designed for awareness-raising, that is, informing participants about infant and toddler characteristics, emotional development, needs of infants, toddlers, and their families, and risk factors that threaten their well-being. In a second focus for educators, training programs may emphasize interdisciplinary preparation for support and intervention, including a developmental perspective about infants, toddlers, and families and development of “relationship-based” intervention skills. Relationship-based intervention is distinguished by an appreciation that interventions work through the influence of relationships on relationships, and by simultaneous emphasis on relationships at several levels, especially the parent-child relationship and the practitioner-parent (family) relationships (Heffron, 2000; Weston, Ivins, Heffron, & Sweet, 1997). A training program may be highly focused on infant mental health with discipline-specific competences for treatment, such as treatment of mental health and relationship problems, communication disorders, problems with motor development, medical problems, etc. This is not an exhaustive description of possible ways to target training initiatives; training may also include details of system-level knowledge, attention to program-level competence, and preparation for infant mental health consultation in the many different settings where services may be offered.

Returning to the original questions, what is a practitioner prepared to do once trained as an infant-family practitioner, developmen-

tal specialist, infant specialist, or infant mental health specialist? The disciplines themselves may best confront the questions of specifying acquired competencies for infancy specialization and naming of the specialization within a discipline. In doing so, disciplines will contribute to establishment of a common language that will facilitate effective communication. Real-world issues of problem setting are embodied in this discussion of the meaning of these terms, including issues of scope of professional competence, issues of professional certification and licensing, and issues of implementing legislative mandates for training.

POLICY IMPACT ON PERSONNEL PREPARATION

Services and service delivery have gone through some important changes as a result of legislation and other forces that have placed priority on services for the birth to 3 age range. Public Law 99-457 of 1986 included components that mandated a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for children birth to 3 (Meisels, 1989; Poulson, 1996). The law requires that services to infants and toddlers with disabilities be provided by multidisciplinary teams composed of qualified personnel from the 10 disciplines recognized in Part H: special education, speech-language pathology, audiology, occupational therapy, physical therapy, psychology, nutrition, social work, nursing, and medicine. The law also specifies that states establish procedures to ensure that these personnel are appropriately and adequately trained.

With the reauthorization of the Head Start Act in 1994, Congress established a new program, Early Head Start, to provide services to low-income families with children from birth to age 3 and to pregnant women. The program mission centers on encouraging healthy prenatal outcomes, enhancing the overall developmental progress of the young child, increasing parents’ skills and knowledge of child

development, strengthening the family unit, and promoting community building and staff development. According to the Program Performance Standards, if Early Head Start teachers are not otherwise qualified, staff members working as teachers with infants and toddlers are required to obtain a Child Development Associate credential for Infant and Toddler Caregivers or an equivalent credential. The Child Development Associate was initiated as part of a national effort to improve the quality of child care and is now a national credentialing program administered by the Washington-based Council for Early Childhood Professional Recognition. Mandates for including infant mental health services brought questions from Early Head Start program staff and members of the technical assistance network including inquiries about the meaning of the term "infant mental health." The Administration for Children & Families convened an Infant Mental Health Forum in October 2000 for discussion and input about these questions (Administration for Children & Families, 2000). These legislative initiatives have introduced new areas of service emphasis: (1) a shift to family-centered services, (2) an emphasis on interdisciplinary collaboration in services, and (3) changes in the location of services from office or center to home or other natural environments (Beckman et al., 1996; Stayton & Bruder, 1999). The focus on personnel standards has stimulated much discussion, both within and across disciplines, about specialization for work with infants, toddlers, and their families (Bruder, Klosowski, & Daguio, 1991; McCollum & Thorp, 1988).

A number of other policy-level activities have emerged in this legislative context. For example, advocacy groups in a number of states have been engaged in strategic planning activities to promote infant mental health involving a broad range of stakeholders throughout the state. Several states have developed strategic plans, for example, Florida, New Mexico, Arizona, and other states have active workgroups considering early childhood mental health issues, for example, Nebraska,

Washington. Recently, the American Academy of Psychiatry held a series of regional conferences on system of care issues that included a focus on infant mental health. Illinois has a statewide early intervention infant mental health initiative for building training and consultation (see Gilkerson & Kopel, 2005, this issue). These types of activities have both broadened the demand for training and increased accessibility to some types of training.

INFANCY SPECIALIZATION AND CONSENSUS ABOUT THE INFANT-TODDLER KNOWLEDGE BASE

Considerable attention has been given to reforming personnel preparation for early intervention in higher education settings (eg, Winton, McCollum, & Catlett, 1997) and for specific disciplines such as psychology, nursing, communication, or pediatrics (eg, Bailey, Simeonsson, Yoder, & Huntington, 1990; Bricker & Widerstrom, 1996). Several themes can be discerned from this rich and thought-provoking literature. First, there is little disagreement about the need for *infancy specializations* within the many disciplines that have a role in services for infants, toddlers, and their families. It is generally acknowledged that the training content necessary for work with infants, toddlers, and their families is unique. Fenichel and Eggbeer (1989) summarized themes that emerged from the work of stakeholders from a variety of disciplines participating in the TASK (Training Approaches for Skills and Knowledge) Project on training personnel for work with infants, toddlers, and their families. The TASK Project emphasized that "specialized knowledge and skills, as well as close collaboration between parents and service providers from a variety of disciplines, are required to support the development of children from birth to three and their families" (p. 2). While the majority of training is after undergraduate training, it is argued that preservice preparation is crucial for exposure to the core knowledge base that will begin practitioner training pathways to competence in work with infants, toddlers, and their

families. Research on training programs has indicated that the required skills are still not covered consistently in preservice curriculums offered to the majority of professionals (Bailey et al., 1990; Bricker & LaCroix, 1996; Bruder et al., 1991). Disciplines should be supported and encouraged to develop infancy specializations that include within-discipline best practice standards, curriculum content, and ethics guidelines for scope of practice.

In addition to the agreement about specialization, across disciplines there is agreement about what content to teach, that is, about what constitutes the specialized knowledge base for work with infants, toddlers, and their families. The TASK Project (Fenichel & Eggbeer, 1989) identified key concepts that “have emerged as powerful integrators of information” across disciplines and that form a basic framework for the infant-toddler knowledge base. The TASK Project recommended that these key concepts should be embedded in the training of all practitioners planning to work with very young children and their families:

1. Endowment, maturation, and individual differences in the first 3 years of life
2. The power of human relationships
3. Transactions between the infant and the environment
4. Developmental processes and their interrelationships
5. Risk, coping, adaptation, and mastery
6. Parenthood as a developmental process
7. The helping relationship

These key concepts do not define a specific set of theories or selected “information” about development such as milestones. Instead, the concepts are dynamic so that the infant-toddler knowledge base will continue to evolve in response to the ever-growing knowledge generated by research and clinical practice. In addition, the breadth and flexibility allows each discipline to emphasize areas of knowledge that could be considered more central to the discipline and are highlighted in that discipline’s best practice standards. Nonetheless, the key concepts help to establish the basis for a common language

that will promote effective communication among practitioners, across as well as within disciplines, and provide guidance for training curriculums. It is clear that there is much technical, science-based knowledge to learn about infants, their caregivers, the risks that impact their well-being, the factors that promote their resilience, and the types of services that may be most appropriate. Much of this learning involves acquiring both the infant-toddler knowledge base and additional discipline-specific knowledge about infants, toddlers, and their families, the technical expertise identified in Schön’s (1987) analysis.

PROBLEMS OF PROBLEM SETTING IN INFANT-FAMILY PRACTICE

The problem of problem setting in infant mental health requires recognition that infants and toddlers as a population present new, unique demands for practitioners and for human services. Schön (1987) has pointed out that practitioners have different ways of framing the problematic situations they encounter in practice. Knowledge bases are crucial as a starting point for the skills of noticing, naming, and framing the problematic situations. For example, in work with young children and their families, practitioners often ask, “Who are the babies and their families?” In other words, how is it possible to draw on the relevant technical knowledge bases in thinking about individual families? There are many ways to “divide up” the population of babies and their families into smaller subgroups that are presumed to be more homogeneous. These strategies of classification or categorization are closely linked to the knowledge base perspective and can help to organize the science-based knowledge necessary to inform practice and to guide training of practitioners. Examples of some common approaches to categorization are psychiatric status of parents; child disability category; quality of parent-infant relationships; and cultural and ethnic backgrounds. The many ways of characterizing babies and their families are useful in identifying relevant knowledge

bases to draw upon. There are ever-growing significant areas of increasingly specialized knowledge about specific subgroups, such as children with problems of sensory integration, infants in foster care, and ethnic and cultural groups, all areas of knowledge that practitioners may need to acquire depending on the specific populations they are working with. These classifications are examples of Schön's "technical knowledge." Scholarly information that makes up these knowledge bases is available in recently published handbooks on topics such as early intervention (Guralnick, 1997), systems of care (Pumariega & Winters, 2003), and infant mental health (Osofsky & Fitzgerald, 2000; Zeanah, 2000) and in specialized professional journals such as *Infant Mental Health Journal* and *Development and Psychopathology*.

Another way to organize the problem of problem setting in infant-family practice derives from naming and framing the type of work that is done. Heffron's (2000) proposed framework for understanding use of the term "infant mental health" is such an example and is intended to help program planners, practitioners, and others plan for staffing and services by offering clear distinctions among the categories of work with families; these 3 categories are promotion, relationship-based preventive intervention, and treatment. These concepts can be viewed as an operationalization of Schön's (1987) "problem setting" for infant mental health, especially the problematic situation of uncertainty about the presenting situation. The processes of determining the nature of the presenting problems and the appropriate type and intensity of support, intervention, or treatment are often termed "case formulation" in work with individual infants and their families. Case formulation is also the basis for determining practitioner competencies that are needed for the work with the particular infant and her family. Together, these processes of case formulation and determining related practitioner competencies are among the most challenging aspects of infant-family practice.

The broadest service concept, promotion of infant mental health or wellness, is aimed at the total population of practitioners, families, educators, and policymakers. Promotion includes all forms of public education and awareness-raising that stress the importance of supportive, responsive, and nurturing interactions between parents and children and between other important caregivers and young children in the early years. All practitioners who have the opportunity to form relationships with parents and caregivers of young children have the opportunity of informing and promoting practices that optimize positive infant development and mental wellness. Practitioners such as primary healthcare providers, child care providers, special educators, and others are likely to have many opportunities to promote infant mental health as they provide the care that is their specialty. The access these practitioners have to babies and their families creates opportunity to promote practices and share information that can enhance infant wellness. This service concept is closely tied to the first use of the term infant mental health and involves practitioner competence in recognizing qualities of an individual infant's experiences and caregiving context that are supporting or undermining the developing capacity of the child from birth to 3 to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. This practitioner competence is closely tied to continuing mastery of the evolving infant-toddler knowledge base.

Heffron clarifies relationship-based preventive intervention as a way of delivering a variety of services to infant, toddlers, and families, which include a focus on the importance of parent-child interaction, knowledge of parallel process or how the staff-family relationship influences the family-child relationship, and the deliberate use of the intervenor's self-awareness in working with infants and families where relationships are at risk. Heffron states that a key idea behind relationship-based preventive intervention

is to listen carefully to families to help them identify, clarify, and address issues that may be affecting the developing relationship with their infant. This service concept may be most closely associated with the third use of the term infant mental health identified earlier, an encompassing orientation to all work that involves interventions that support the infant, toddler, and family, involving populations at greater risk for problems than in promotion settings. This approach aims at increasing the family coping skills, underscoring and supporting positive family relationships, and building resilience in children by shifting the balance in risk and protective factors. Many professionals provide services that could include relationship-based preventive intervention, for example, infant educators, physical therapists, social workers, substance abuse counselors, and public health nurses. Heffron suggests that the concept of relationship-based preventive intervention poses the greatest danger of blurred role definitions, misperceptions, and misunderstanding about what intervenors are really attempting to accomplish. By implication, infant-family practice involving preventive intervention places substantial emphasis on "problem setting," thus requiring competence both in technical knowledge and in "naming and framing." Competences must include understanding of appropriate boundaries and capability for intervention techniques that are critical to effective relationship-based preventive intervention. It is essential for staff to remain aware that the parents in these service settings usually have not requested services because of their baby's or their family needs. In absence of readiness on the parent's part to be involved in "treatment" (see later), practitioners must explain from the beginning that they will be working with the family and baby together, that they work to support the family, and that family-infant relationships are linked to educational or other service goals that are associated with the service setting. Staff members also must remain alert to the possibility that they will encounter families who do need treatment,

and may present problems beyond the staff member's scope of competence.

The concept of treatment consists of specialized interventions in which clinicians with training in infant mental health provide a variety of services focused on strengthening the infant-parent relationship. Treatment has some similarity to preventive intervention because the importance of parent-child interaction, of knowledge of parallel process, and of the deliberate use of the intervenor's self-awareness are central aspects of working with infants and caregivers where relationships are already troubled or disordered. Treatment differs from preventive intervention in that it is most likely to involve families who have sought help for recognized problems or who have experienced uncomfortable feelings or have worries about their relationship with their child. Specialization for providing treatment often involves acquiring knowledge bases about specific subgroups, for example, high-risk groups such as alcohol-using pregnant women, drug-exposed premature infants, families experiencing domestic violence, mothers with histories of severe trauma, and depressed mothers. Often, the parents present with other mental health problems outside the scope of infant mental health treatment that require specialized treatment for the adult in addition to the work with the parent-infant dyad. This type of service bears the greatest similarity to the original use of the term infant mental health specialist, the discipline-specific reference to clinicians with mental health expertise who are also trained in infant-parent psychotherapy in order to provide treatment for at-risk or already troubled infants or toddlers with their caregivers. In addition to the infant-toddler knowledge base, discipline-specific knowledge about assessment and diagnosis of mental disorder, knowledge of relationship disorders, understanding of appropriate treatment techniques, and knowledge of dyadic approaches to treatment are some of the competencies necessary in problem setting with families most likely encountered in these service settings.

REFLECTIVE PRACTICE IN INFANT MENTAL HEALTH: THE CRUCIAL INTERPERSONAL CENTER

Schön (1987) has described reflective practice in terms of kinds of knowing, as reflection that goes beyond routine application of facts, rules, and procedures derived from a body of professional knowledge. What guidance can be identified for the processes of reflective practice in infant mental health?

In describing what she and colleagues most wanted infant mental health trainees to learn, Pawl, St. John, and Pekarsky (1999) commented: "Many kinds of knowledge may be usefully accumulated and applied in infant-parent psychotherapy, but what we seek to cultivate primarily with trainees is a set of sensibilities integrated with a particular body of knowledge." Elaborating on these sensibilities, Pawl (2000) commented: "Several overarching ideas or beliefs form the central understanding of what we, as practitioners of various kinds, need to be aware of, thinking about, and trying to achieve when we work with infants, toddlers and their families." Pawl argues that these overarching ideas all transact with each other to create the "crucial interpersonal center" of the work we do, irrespective of our discipline, and include the following:

1. *Trust in parents*: In the face of a parent's anger or distress or the parent being upset, we need to hold some genuine trust in the parent, to believe that the parent has some investment in the well-being of his child. Pawl argues that this need is ours, not the parent's challenge, but our challenge to pull together the threads of hope and the evidence of possibility. She says, "without real trust, we convey despair . . . which all parents will apprehend . . .": (p. 5). The point here is that, as infant-family practitioners, we must be holders of the hope; that we must communicate a belief in possibilities. This is indeed an uplifting and sobering belief that can fly in the face of the

"realities" that a family situation may seem to present. Infant mental health specialists are mandated to find the best in a family and in a parent; trust is only the beginning.

2. *Mutual clarity*: In our work with a family, we need to reach an understanding of what we will actually be doing; we need to be clear in our own minds; we also need to work toward a mutual understanding with this particular family about the purpose of our being there with them. In essence, our work requires that we attend to establishing joint goals, shared objectives. In seeking shared objectives, we are compelled to find ways to understand a parent's views and wishes, however complex and seemingly inappropriate or out of reach;
3. *Hearing and representing all voices*: According to Pawl, we are "always dedicated to attempting to hear and represent all of the relevant voices." Often, this means we observe and represent the infant's voice; in fact, we are dedicated to representing any and all voices that are muted or muffled in the circumstances of a particular family.
4. *Hypotheses, not truth*: It is humbling to come to the understanding that we do not have truth, that our professional, technical knowledge is best considered hypothesis in its relevance to this particular family and baby. When we understand that those with whom we work have "all the information we need . . . then our attitude conveys this" and the parent (and the child) can sense themselves as sources, partners, rather than as assessed and judged recipients.
5. *Maintaining an appropriate role*: Most often referred to as adhering to boundaries, it is the flexibility that is important, according to Pawl, as long as the flexible boundaries serve to maintain and contain the appropriate nature of the relationship so that "unhelpful confusions, difficulties, and breaches are avoided."

Maintaining a clear sense of comfort with our roles is the essence of sustaining a sense of boundaries and flexibility in these boundaries “as they may need to shift.” More important, it is the sense of true mutual responsibility, the sense of working with a person rather than doing something to that person, that is the crucial attitude that protects everyone.

6. *Knowledge, beliefs, biases, and meanings*: Briefly, we each must learn to recognize our own beliefs and our knowledge. More to the point, we come to recognize that the other person’s sense of meaningfulness is equally as strongly embraced; our ability to be respectful of difference or sameness is terribly powerful; it leaves us able to be curious and to understand.
7. *Inclusive interaction*: Pawl defines *inclusive interaction* as “the capacity to continue to embrace and hold all of those with whom we are involved together at a particular time.” While it may be comforting to think of this as the challenge of attending to 2 or 3 people at the same time, Pawl makes it clear that this is also an issue of our own conflicts “that are not fully articulated or understood but are very basic, primitive, and rooted in our early experience.” This idea of relatedness is closely connected to the concept of “use of self” (see Heffron et al., 2005, this issue). Being aware of one’s feeling, reactions, and urges is a prerequisite for maintaining

understanding of interactions as they transact.

CONCLUSION

The concepts of reflective practice and of problem setting have much to offer to our conceptualization of infant mental health practice and to the development of training approaches. The complexities of infant mental health practice are further illuminated through distinguishing between knowledge bases and reflective practice. Schön (1983) suggests that the reflective practitioner does need to be technically competent, but that it is in the relationship with the client that he must be able to manifest his special knowledge. Pawl’s concept of the crucial interpersonal center gives further definition to Schön’s idea of reflective practice as it applies in infant mental health practice. These sensibilities describe a way of knowing that will facilitate problem setting, the noticing, naming, and framing of problematic situations that are the focus in the work of infant mental health. The greater challenge in infant mental health training is to prepare trainees to make sense out of the uncertain situations and uniqueness that are encountered in real-world work with individual families while remaining aware of and alert to differences of perspective or values. This recognition helps to guide our thinking about training in infant mental health and helps us to focus on the processes of educating the reflective infant-family practitioner.

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