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ABSTRACT

A search of requests for permission to photocopy articles from past issues of "Zero to Three" identified the seven articles of this collection, all published between 1985 and 1989. They deal with the care of typically developing infants and toddlers as well as with clinical practice with very young children with special health or developmental needs and their families. The seven articles are: (1) "Helping Young Children Channel Their Aggressive Energies" (Sally Provence); (2) "Parenting an Infant with a Birth Defect: The Regulation of Self-Esteem" (Dorian Mintzer, Heidelise Als, Edward Z. Tronick, and T. Berry Brazelton); (3) "The Immediate Impact of the Birth of a Low Birth Weight Infant on the Family" (Alan R. Fleischman); (4) "Infant-Parent Psychotherapy with an Autistic Toddler" (Barbara Kalmanson and Judith H. Pekarsky); (5) "Infants and Toddlers in Hospitals: Addressing Developmental Risks" (Joy Goldberger); (6) "Mediating Successful Parenting: Guidelines for Practitioners" (Serena Wieder); and (7) "The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers" (Louis Torelli). A topical index groups articles and reviews of publications that appeared in "Zero to Three" from September 1980 through June 1992 by topic. (SLD)

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- exercising leadership in developing and communicating a national vision of the importance of the first three years of life and of the importance of early intervention and prevention to healthy growth and development;
- developing a broader understanding of how services for infants and toddlers and their families are best provided; and
- promoting training in keeping with that understanding.

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Zero to Three Classics

Introduction

When we began planning to offer a collection of articles from past issues of *Zero to Three* as an incentive to new subscribers, we faced a daunting dilemma—how to choose among the dozens of articles that we have had the privilege of publishing since *Zero to Three* began, in September, 1980?

We decided, finally, to look in our files of requests for permission to photocopy articles from *Zero to Three*. These requests come most often from instructors in a wide range of undergraduate and graduate training programs; they also come from front-line practitioners and program planners who wish to distribute relevant articles at inservice training sessions or professional conferences. A selection of most frequently requested articles, we reasoned, would be likely to reflect the interests of our diverse readership.

The seven articles included in this collection were published between 1985 and 1989. They deal with the care of

typically developing infants and toddlers as well as with clinical practice with very young children with special health or developmental needs and their families. Authors include a child care consultant, a child life specialist, a neonatologist, two pediatricians, five psychologists, and a special educator.

Readers who find this selection of *Zero to Three classics* useful are invited to consult the topical index to volumes I through XII of *Zero to Three*, included at the back of this publication, and to use the enclosed form to order back issues of particular interest. In addition, the *Zero to Three Child Care Anthology* includes 16 articles, on all aspects of infant/toddler child care, that were published in *Zero to Three* from 1984-1992.

Emily Fenichel
Editor
August, 1992

Helping Young Children Channel Their Aggressive Energies

Sally Provence, M.D.

Ask any parent whether she wants her child to be an aggressive person and you are likely to get more than one answer. After all, aggression is associated with both approved and disapproved behavior in our minds and in our society—both with the energy and purpose that help us to actively master the challenges of life and with hurtful actions and destructive forces.

Most of us want our children to be able to take a stand for themselves when others treat them roughly. We hope that they will not start fights but if attacked will be able to cope with the attacker and not be overwhelmed. A child's learning to find a healthy balance between too much and too little aggressive behavior is probably the most difficult task of growing up.

According to developmental theory, aggressive impulses or drives are born in the human child and are a crucial aspect of the psychological life force and of survival. In the course of healthy development, these drives are normally expressed in various behaviors at different ages and, with assistance from parents and others, are gradually brought under the control of the individual—moderated, channeled and regulated but by no means stamped out. We expect that young children who are developing normally will display aggressive behavior—both physical and verbal—toward adults, other children, and objects in their environment. Brothers and sisters engage in combat. Young children in groups

inevitably behave aggressively toward one another just as they behave in friendly ways and join in interesting activities. When they want the same toy or the same adult, competition and strife are bound to occur. If a child is irritable or angry, he or she may lash out at another without apparent provocation.

During the first year, infants are not often thought of as behaving aggressively, and yet encounters in which an infant pushes, pulls, or exerts force against another are signs of the outwardly directed energy and assertiveness that reflect the healthy maturation of aggression. But the nine-month-old who pulls your hair does not know that it might hurt—it is done in the same exuberant, playful spirit that is seen in other activities. It is only in the second year, when the child develops a better awareness of his separateness as a person—of “me” and “you”—that he can begin to connect his actions with some kind of result and can begin to understand that he is angry at someone and behave with intentional force.

We do not usually talk about a child's being cruel or hostile toward others until some time during the second year. Even then, he does not know enough about cause and effect to understand the consequences of his action or how to regulate his behavior toward others. When your fifteen-month-old smashes a fragile object, he is caught up in the pleasure of assertiveness, not anticipating its result.

Parents sometimes tell me about their toddler who "knows better" than to hit or bite. They believe this is so because when he is scolded, he looks ashamed. What the toddler understands is not that he has hurt someone or destroyed something but that he has earned the disapproval of his parents. Conversely, when praised for being gentle with another, he knows and is pleased that he is approved of for that behavior at that moment. It will take time and many reminders before he can understand that not hitting or biting applies to many situations. Young children, particularly those under three-and-a-half or so, scarcely know their own strength. The differences between a kiss and a bite, between patting and hitting, between nudging and pushing someone down are not automatically understood and children need many reminders: e.g., "Let me show you how to pat the baby (or the family dog or Daddy's cheek)"; "Patting feels nice. Hitting can hurt"; or "Do it softly (or gently), like this."

As is true of the young child's development in other areas, there are steps and phases in the socialization of aggression, and it is worth your while to learn something about what kind of behavior to expect at various ages. If you understand what an infant or toddler or a four-year-old is capable of, you can adjust your own actions and teaching to realistic expectations and save yourself worry and frustration. You don't need the anxiety of imagining that your toddler who gets very angry and has very little control over his aggression when frustrated or upset is destined to become an angry, destructive, uncontrolled four- or ten- or twenty-year-old. On the other hand, if your four-year-old has frequent aggressive outbursts and seems not to be concerned about the effect of his aggression, or even seems to enjoy hurting others, you are correct in being worried and in seeking ways to help him toward healthier behavior.

How then do parents moderate and channel their child's aggression without stamping it out by being too severe? While

there is no exact recipe, here are twelve suggestions that may help you to provide your child with the guidance he needs.

1. Keep in mind that your child's feeling loved and affectionately cared for builds the foundation for his acceptance of the guidance you will provide as his development proceeds. This includes the regulation of aggressive behavior. Children who feel loved want to please their parents most of the time and will respond to their guidance. Putting reasonable restrictions on your child's behavior is part of loving him, just as are feeding, comforting, playing, and responding to his wishes.

2. Try to figure out what triggered your child's aggressive behavior. Ask yourself what might have happened that set him off—your behavior or that of another person, or something else in the situation; perhaps he is overtired or not feeling well physically. Being rushed, abruptly handled, being denied something he wants, even being unable to do something he has tried to do with a toy or physical activity often produces feelings of frustration and anger that result in aggressive behavior: the toy gets thrown, or the child cries and strikes out or stormily says, "Mommy, I hate you." This can also occur at times when there is no readily apparent cause for the outburst.

3. Make use of what you know about your child's temperament, rhythms, preferences, and sensitivities. For example, if you know that he is irritable or ill-humored for the first hour of the day or gets very out of sorts when tired or hungry, you won't pick that time to ask a great deal in the way of control. If you know that he is likely to behave aggressively when another child comes close, you will want to be nearby to help him control that behavior. If he easily becomes "wound up" with excitement and is more aggressive at such times, you will want to help him tone down the excitement so that he can continue to play. If you know that he gets upset, angry, and aggressive when teased, you will want to give him some

protection from teasing by others, especially by adults.

4. Tell your child what you want him to do or not do in a specific situation but try not to give a long lecture. Your child will be aware of your displeasure from your tone of voice as well as from what you say. It is important that you try to be clear about your disapproval. However, long lectures and dire predictions are usually counterproductive. Telling a three-year-old child that God won't love her if she hits her baby brother may frighten her, but it is unlikely to help her understand and develop her own controls. A better reason is that you don't want her to hit him because it hurts. That you don't like the *behavior* is your most effective message. It helps any young child who has earned the disapproval of a parent to be reminded that she is loved even when you don't like the *behavior*. And sometimes the young attacker needs as much comfort as the victim because of the negative feelings that are aroused by one's own aggressive behavior.

5. When your young child is playing with other children, keep an eye on the situation but try not to hover. What begins as playful scuffling or run and chase or sharing toys can quickly move into a battle between children, and they may need a referee. However, there are times when you can let young children work things out among themselves. When you believe that none of the children is in danger of being hurt, you may decide to see how they can settle their differences because if successful, they should be better able to manage the next situation more adequately. Age makes a difference, of course. Such solutions are often within the abilities of three- to five-year-olds, while the under-threes will need your help and protection more frequently.

6. When your child is being aggressive in ways you don't like, stop the behavior and give him something else to do. You may either suggest and help start a new activity or perhaps guide him to a place where he

can discharge aggressive feelings without doing harm to himself, to anyone else, to toys, or to the family pet. For example, a corner in which there is something to punch or bang or throw at can be utilized. You can say, for example, "If you feel like hitting, go and hit your pillow (or punching bag), but you can't hit the dog (or bang the table with a hammer)." Such an opportunity not only helps the child discharge some aggressive feelings but also helps him understand that there can be a time and place provided for such actions.

7. When time permits, demonstrate how to handle a situation in which there is conflict between children. For instance, if your child is old enough, you can teach him a few words to use in order to avoid or settle a conflict. A two-year-old can be helped to hold on to a toy and say "no" or "mine" instead of always pushing or crying when another child tries to take a toy. A four-year-old can be shown how to deflect a younger brother or sister who is about to move in on his treasures. Children need specific suggestions and demonstrations from adults in order to learn that there are effective ways to handle disagreements that are more acceptable than physical attack and retaliation.

8. If your child has language skills, help him explain what he is angry about. If you are able to guess and he cannot say, do it for him, e.g., "I guess you're mad because you can't go to play with Johnny. I know how you feel, but it's too late to go today" (or whatever the reason is). Among the things children begin to learn during the early years are some of the connections between feelings, thoughts, and behavior. This learning is accomplished gradually as the child hears what is said about himself and others, and as he is helped to understand that feelings and ideas lead to actions, some of which are approved and some not.

9. Ask yourself if you are sending "mixed messages" to your child about his aggressiveness. If you say "Don't hit" or "Be nice"

while you are not so secretly enjoying your child's aggressive behavior toward someone else, he will be confused, and such confusions tend to make it more difficult to develop self-control.

10. Keep in mind that parents are the most important models for behavior and the creators of the family atmosphere and guidance that children need in order to use aggression in a healthy way. If social exchanges in your family include much arguing or physical fighting in the presence or hearing of your children, you can count on their picking it up. You can expect that they will imitate that behavior in their interaction with others, becoming either excessively quarrelsome or physically aggressive or becoming excessively submissive out of fear.

11. Think about the very real disadvantages of physical punishment for your child. Children often arouse anger in adults when they provoke, tease, behave stubbornly, or attack others. If your practice is to hit or physically punish your child in some other way for such behavior, you need to think very carefully about what he learns from that. Even with the best of intentions, you

may be sending the wrong message. Rather than learning how to control his aggression as you want him to do, he may interpret your behavior to mean that physical force always wins out, and he may not develop other ways of settling disputes. There is the danger that he will become even more aggressive or may fail to develop the ability to cope with the ordinary pressures of social contact.

12. Your child's learning to love and live in reasonable harmony with others comes about only gradually and over many years. For you as parents there will always be ups and downs, periods when you despair of "civilizing" your child or when you will worry that he will be too timid for the rigors of the world. While living from day to day with the pleasures and frustrations of being a parent, it is also important to keep the long view in mind: there is a positive momentum to development. This forward thrust of your child's growth and development actually works in favor of his acquiring the ability to channel and productively use those aggressive energies that are a vital part of our makeup.

Parenting an Infant with a Birth Defect: The Regulation of Self-Esteem

**Dorian Mintzer, Ph.D., Heidelise Als, Ph.D.,
Edward Z. Tronick, Ph.D., and T. Berry Brazelton, M.D.**

While the experience of giving birth to an infant with a defect is similar to other painful experiences, such a substantial trauma confronts new parents with unique intrapsychic and reality based challenges as well. To observe the unfolding of parents' adaptation to the birth of a child with a defect; to gain a better understanding of how these parents handle their own feelings, especially their self-esteem, and develop pleasure in their infant; and to learn about the specific kinds of help needed by these families, we followed five families of infants born with defects over a period of two years, seeing them in home visits and laboratory sessions.

We learned that their reactions were influenced by a complex interplay of factors:

- the severity and correctability of the defect, how they were told about it, and the nature of the medical procedures required;
- previous expectations for the child and their view of themselves as parents;
- their prior means of coping with stress;
- the nature of the marital relationship and their own experiences in the parent-child relationship;
- the infant's temperament and capacity to interact and be organized;
- the uncertainty about the short- and long-range implications of the defect and its impact on the child and the family;

- and the role of environmental supports.

The parents experienced a series of assaults to their sense of self that affected self-esteem and interfered with the parenting process. We observed parents go through three stages of reactions and adaptations to the birth defects: (1) initial sense of shock and disappointment reflecting an intensely felt injury to their sense of self-worth; (2) a period of intrapsychic disequilibrium manifested in loss of self-esteem, painful feelings, inadequacy of defenses, and, at times, inappropriate handling of the infant; and (3) restoration of the intrapsychic equilibrium manifested in renewed parental self esteem, awareness of existing painful feelings but with adequate defenses, and more appropriate meeting of the infants' and of their own needs. During the period of disequilibrium, we found, the parents' capacity to parent is compromised if they view their infant as a negative part of their selves rather than as a separate person. The adaptive tasks for these parents are to identify positive aspects of the infant and to view the infant as a separate individual, rather than as a representation of their own inadequacies; to grieve the loss of their aspirations and ideals for a child and the wished-for relationship; and then, as they begin to reestablish self-esteem, to understand the special as well as the normal developmental needs of the infant and to find ways to experience pleasure in being

a parent given the reality of continuing pain.

Descriptions of the experiences of two of the five families illustrate the stages of reaction and adaptation.

The B Family

Bonnie was a pretty, cuddly infant—active and excitable, yet robust. When excited or upset she could calm herself with a pacifier or become calm in her father's arms. Born with congenital cataracts in each eye, Bonnie did not focus visually nor make eye contact with her parents, who had no way of knowing what kind of sight she would have.

The B's appeared to be nice, conventionally dressed people who looked a little older than their years. Mrs. B had worked until a week before Bonnie's birth, when she took a leave of absence, assuming she would not return to work during Bonnie's first few years. After seven years of marriage, conception had been wanted and planned. Mrs. B wanted a daughter and Mr. B preferred a son. Although Mrs. B had looked forward to natural childbirth, Bonnie was born by Caesarean section after a long, difficult labor.

The parents initially thought they had a healthy infant, but then learned on her second day that Bonnie had severe cataracts. They felt shocked, angry, helpless, and hopeless—"shot down." Magical thinking, confusion, disbelief, and self-blame were in evidence. Mrs. B, for example, immediately envisioned Bonnie as a blind baby but was afraid to ask the doctor questions lest verbalizing her fears would make them come true. Both parents blamed their own poor vision for Bonnie's condition and wondered if Mrs. B had done anything during the pregnancy to cause the problem.

The pediatrician told the B's that Bonnie would need some special attention. Mrs. B wanted to care for Bonnie right away, thinking that since her baby could not see, she would know people by their touch. This wish to provide mothering and to attach was thwarted because of a postpartum infection that separated her from Bonnie for seven

days. Her disequilibrium was reflected in her belief that Bonnie immediately developed a preference for Mr. B and would not like her. When she was finally allowed to touch Bonnie, she was afraid to hold her or feed her. She perceived herself as defective and was afraid that she would interact inappropriately with her infant. She regarded Bonnie's crying as an affirmation of her own inadequacy as a mother rather than as a reflection of Bonnie's sensitive state organization.

When the B's consulted two eye doctors and received conflicting recommendations about the timing and number of surgical procedures that Bonnie required, they turned with confusion to their pediatrician for help in the decision. Bonnie underwent a surgical procedure on her right eye when she was 2½ months old. Both parents became increasingly anxious as the operation date approached and decided to delay the surgery for a week so that she could be baptized beforehand. After the first surgery on her right eye, the parents were immediately told she would probably have vision in that eye. Two weeks later, however, the cornea clouded over; the parents learned that she would need additional surgery on the same eye. The second procedure, six weeks later, was followed by three weeks with an eye patch. The B's then learned that this eye had not developed properly prior to birth and that Bonnie had no vision in that eye.

The parents' hopes and fears kept vacillating. Although the surgeon expressed optimism about Bonnie's larger left eye, Mr. and Mrs. B felt betrayed by the surgeon and began to lose trust in him. They wondered if he was leading them on with "false hopes."

Their anxieties and fears persisted on and off until the surgery on her left eye. In short, during Bonnie's first eight months her parents did not know if they would have a visually impaired or a totally blind child.

Mrs. B was depressed throughout this period. She chose to resume her job. This step apparently helped her to regain a sense of competence and self-esteem; she needed

literally to separate from her infant in order to prove that she herself was not defective. Mrs. B was at first unable to acknowledge her painful and angry feelings and maintained a brittle, defensive structure of denial and avoidance. As her professional competence and ability to arrange for the baby's daily care in her absence helped her regain her self-esteem, she found some pleasurable ways to interact directly with her infant. For example, she played a game of touching and jostling with Bonnie which had both mother and child smiling and laughing; thus she achieved her wish for a smiling little girl. Arranging her work schedule to be flexibly available to take Bonnie to the doctor when needed further helped Mrs. B to feel like a good mother. Mrs. B was overly concerned about her own and her infant's appearance during the period of disequilibrium. She always dressed Bonnie in pretty, delicate outfits, taking pride when people commented on Bonnie's cuteness. Despite her visual disability, Bonnie progressed developmentally in other areas.

When Mrs. B was emotionally unavailable during Bonnie's early months, Mr. B assumed the primary caretaking role even though he was extremely depressed and had not planned to provide caretaking for Bonnie since he viewed early parenting as the "mother's role." Mrs. B at times doubted her own competence and at times felt competitive with Mr. B, convincing herself that Bonnie preferred Mr. B since he had provided the early feedings. While Mr. B welcomed and supported his wife's increasing attempts to become Bonnie's caretaker, he also subtly undermined her, asserting that he was more sensitive to Bonnie than she was. Yet as her own internal equilibrium was restored, Mrs. B's feelings of competence as a parent grew. The parenting roles gradually shifted; Mrs. B provided more of Bonnie's care, although the couple continued to share some parenting tasks.

When Bonnie was 8 months old, just prior to her third surgical procedure, and before they learned that Bonnie would have vision

in one eye, Mrs. B began to feel that Bonnie needed her and that she was capable of being Bonnie's mother even if Bonnie were a blind child. Mrs. B decided that regardless of the outcome of the surgery, she would take a leave of absence from work so that she and Bonnie could "get to know each other."

After the cataract on the left eye was removed, the parents were relieved to learn that Bonnie would have some vision in that eye. They wished for dramatic changes in her eyesight after the operation and were disappointed that this did not happen, but reminded themselves that Bonnie's use of vision would develop gradually. Mrs. B took three months off from work to spend time with her daughter during the transition from sightlessness to vision.

By a 2 two years Bonnie's motor, verbal, and social skills were well developed, and she clearly knew that she could influence events. She was well-modulated, organized, and calm. She connected words with wishes and could use sentences. She evidenced object constancy, had a good memory, and distinguished circumstances and events in her environment. When Bonnie is older she will undergo surgery to remove the cloudy covering on her right eye so it will look less abnormal.

The C Family

Charles was born 4 weeks prematurely, with 3 fingers on each hand fused, borderline small for gestational age, and suffering respiratory distress. He appeared to be a very temperamental, labile baby: his movements were jerky; he was wide-eyed, easily overstimulated, and disorganized, similar to many small-for-date full-term infants (Als et al., 1976). He needed continuous help with state modulation and organization. He had four operations to separate his fingers between 14 and 21 months.

Mrs. C, a slim, attractive woman who took pride in her appearance, had planned to work throughout her pregnancy, to take a two-month leave of absence after the baby's birth, and then to return to work. Both Mr. and

Mrs. C showed a mixture of easy verbalizations and some denial. While they could talk about previous losses, they could not make connections to current experiences.

Conception was planned and was wanted by Mrs. C, but Mr. C was ambivalent. Each preferred a daughter. Mrs. C had looked forward to natural childbirth and breast-feeding, but was hospitalized in her sixth month because of toxemia. For this reason, she not only missed the prebirth parents' sessions but did not have the entire pregnancy to prepare psychologically for the baby.

After Charles' birth, Mrs. C experienced a narcissistic disequilibrium characterized by feelings of guilt, worthlessness, helplessness, hopelessness, and self-blame. She was emotionally labile, either bursting into tears or laughing anxiously. Mr. C said he was more upset about Charles's prematurity than about the hand defect. Although he reported some sadness about the defect, he either denied or minimized concern by stressing that it could be surgically repaired. His sense of shame, however, was evidenced in his wish to put gloves on Charles's hands so his fused fingers would not be noticed.

The complications of pregnancy, the premature birth, and her infant's minor birth defect had made Mrs. C feel like a failure. Her low self-esteem and anxiety interfered with her early attachment to Charles; she decided not to breast-feed. She was gentle, empathetic, and patient with him, but her negative comments about herself revealed that she did not recognize her own competence. She was not confident that she knew what Charles wanted or how to help him and blamed herself for his behaviors and responses. For example, commenting that Charles had trouble with his bowel movements, she said, "It must be my problem, I keep wanting him to do more." She also said, "He smiles before he opens his eyes and sees what a mess I am," and, "When he's alert and smiles, it's as if he's apologizing."

Gradually Mrs. C found ways to interact with Charles and to enjoy him during the brief periods when he was awake and alert. Eventually she was able to help him to extend the awake and alert periods and to reciprocate in his play. Charles worked hard—and successfully—to engage his mother with smiling, tongue motions, a wide range of vocalizations, eye contact, and cycling of his feet and hands. Charles' ability to tolerate more direct touching and bouncing from his father and his broad smiles brought pleasure to Mr. C and fostered his attachment to his son.

Mrs. C took pride in her own and in her infant's appearance and did not regress to withdrawal or avoidance as much as Mrs. B. She was able to acknowledge and tolerate her sense of failure and disappointment and to ask for help. While this capacity may reflect her somewhat higher level of intactness, it may also have been influenced by her infant's comparatively minor defect, which did not interfere with pleasurable feeding or with face-to-face or eye-to-eye contact and which required no surgery during the first year. After the initial shock and upset, the disequilibrium of the first three months seemed related primarily to Charles's prematurity and subsequent neurological immaturity, which caused his highly sensitive state organization and temperament, and only secondarily to his birth defect.

During his fourth month, by which time Charles had compensated fairly well for his prematurity, the parents began to focus on his fused fingers. Their sense of injury and disappointment were retriggered at this time. Like the B's, the C's received conflicting recommendations regarding the timing and number of surgical procedures. They felt confused and worried about making the right decision. Mr. C said, "The birth defect was predetermined, it happened, we had to adjust. Now it's up to us to decide what kind of procedure Charles should undergo." Charles was hospitalized only during the first procedure to separate his fingers. His

parents took turns being with him in the hospital. At the parents' request the other surgical procedures were done on an outpatient basis. They felt the additional hospitalizations would be too disruptive for Charles and preferred to provide his care at home. After each surgical intervention Charles had his hands bandaged during the healing process.

At age two, although his fingers looked abnormal, Charles had full use of his hands. He was a very active, alert, and engaging child who was functioning within normal developmental limits despite some delay in his speech. Because of his sensitive temperament, he needed a good deal of organizing and structure from his environment.

Parenting a child with a defect

The tasks of parenting a child with a defect are similar to those of parenting a normal child, requiring empathy, learning the infant's cues, organizing and expanding alert periods, and supporting the infant in the gradual development of a tolerance for frustration. While a normal infant is an active elicitor of parenting, the infant with an anomaly may be a weak parental ally in the adaptational process. The lack or distortion of the presence of normal elicitors of maternal responses, such as the lack of smiling, feeding problems, or the lack of eye-to-eye contact, creates a situation in which the initial mother-infant attachment is at risk.

Unfortunately, during the period of disequilibrium, the parents are not yet good allies to their infants. These parents, for example, experienced a real set of insults which included Caesarean section, premature birth, separation from the newborn and specific difficult caretaking needs. Their own lowered self-esteem also interacted with the severity and visibility of the defect to impair their good feelings about themselves and their child. The mothers who experienced the most severe sense of injury and the longest period of disequilibrium suffered many disappointments in their prebirth

expectations as to the sex of the infant, mode of delivery, and manner of desired feeding. These experiences lowered their self-esteem and might have put them at risk for parenting problems even if they had had a normal infant. Sadly, they gave birth to infants with continuously visible facial defects which made the initial communication between mothers and child difficult.

The marital relationship

Contrary to the notion that marriages break up with the birth of a child with a defect, we found that a form of balancing reciprocity for coping developed between the adult partners in four of the five families. The birth and parenting of an infant with a defect brought most of these couples closer together over time, although periods of marital disorganization occurred when they were at different stages of the adaptational process. The marital relationship of the Bs in particular underwent a great deal of stress. Both parents experienced their infant as a negative extension of themselves, they had stereotyped notions about parenting, and they lacked the ego strengths of flexibility and adaptability. Both Mr. and Mrs. B, however, believed that they eventually emerged from the disequilibrium functioning better as a couple than they had previously.

Restoration of parental self-esteem

The turning point in the restoration process of parental self-esteem came when the parents experienced their infants as separate persons rather than as negative extensions of the self and found aspects of the infant which they could identify as personal and individual. The parents' experiences with the infant gradually helped to focus their attention on such positive qualities as compelling eyes, cuddliness, and suck, and enabled them to enjoy their child and to enjoy being their child's parent.

As a positive parent-infant attachment developed during this process, the parents began to recognize their infant's cues and

were able to protect the infant, adjusting care and handling to their specific baby as do parents of babies without birth defects. Each infant in this study, similar to infants without defects, found ways to engage each parent successfully within the first months; these responses differed from how they interacted with strangers.

Ongoing sadness continued, but by the end of the study parents were sad for the child's realistic problems rather than feeling primarily self-pity.

Ongoing adaptation

Of course, adaptation was not a smooth process. Throughout the two-year study each family remained concerned about the outcome of surgical procedures, future consequences of the defects, and how the parents would be able to help their child understand and adjust to the defect. When the infants failed to progress according to normal developmental rates or to attain a milestone and when medical procedures were necessary, anxiety, depression, and self-blame were retriggered in the parents. Once the initial intrapsychic balance had been restored, these parents handled these anxieties with increasing adequacy and less regression; they were able to identify the patterns of their reactions and to reconstruct their previous handling of the crisis. This process allowed them to acknowledge openly their current pain and anxiety and simultaneously to recognize their developing coping strategies and energies.

Some clinical signs of restoration of equilibrium included:

- mutual parent-infant interaction, patterns as described above;
- integration of the infant into the family so that each member's needs were met—the mothers were able to relinquish the care of the infants to others, freeing time for the spouse or for themselves;
- an end to devaluing the parent and infant—the mothers started taking better care of themselves physically, participated in

activities such as travel or socializing without the children, took the infant to visit relatives, or invited grandparents or friends to come and meet the infant;

- activities to regulate self-esteem—the mothers would resume their job or start an activity to enhance prestige;
- development of a clear picture of the infant as a separate individual—all five sets of parents could describe their infants' strengths and difficulties with increasing specificity, identifying the defect directly and discussing its implications for their children.

Clinical implications

Although its purpose was not therapeutic intervention, we found that our developmental research approach in fact provided a model for clinical help to parents of infants with birth defects. This model focused on the parent-infant relationship and served to enhance parents' self-esteem and to foster their affection for and mutuality with their infants.

Overall, the research team developed a sequence of interventions. First, we focused on helping each parent gain specific knowledge about his child's behavioral organization and style. Second, parent-infant interactions were discussed, the team often pointing out how the infant needed and responded to the mother and had learned to differentiate between the parents. This helped to diminish parental competition since the parents saw how they complemented rather than duplicated each other, thus providing richer opportunities for the infant. Third, as the observational process continued, the team at times intervened in the parent-infant interactions or addressed specific issues of the parents, such as their sense of injury, need for grieving, options for themselves, or their marital relationship. At other times, child rearing issues such as limit setting, bedtime procedures, and responses to tantrums were discussed. When appropriate, we observed some periods of parent-infant disorganization without intervening, so that the parents

could find their own ways to develop mastery.

An awareness of the family system was necessary to determine the kind of intervention that would be helpful; that is, to assess whether parents might benefit from affective help, such as identifying and acknowledging feelings, having a cognitive framework within which to understand reactions and adaptations, and/or educative help about child development and parent-child interactions. In this sample parental adaptation included the parents' normal and reality-based sadness for the child and awareness of their own ambivalence. How the adaptational and parenting processes would have progressed for these families if the team had not been involved is impossible to answer. The research team clearly helped to prevent additional crises and helped to maximize parental attachment to the infants.

Our findings certainly suggest that the parents of firstborn infants with congenital anomalies need empathy and help specific both to their problems and to their own level of ego intactness. Because issues of parental adequacy and restoration of parental self-esteem continue over time, clinical support needs to be ongoing and include all aspects of the child and the family.

Parent-centered and parent-infant-centered intervention should occur as early in the newborn's life as possible so that patterns of distortion do not solidify but are transitions to new levels of functioning which yield a strong, positive affective relationship between parent and child.

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The Immediate Impact of the Birth of a Low Birth Weight Infant on the Family

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"He was on display in a brightly lighted glass case and it seemed indecent to look." The words are those of Peggy Stinson, the mother of a boy born 16 weeks early and weighing one pound, 12 ounces. These words reflect the power of the feelings evoked by the birth of a premature infant. The early end to the process of gestation not only results in the interruption of fetal growth and development, but also interrupts the psychological process through which the pregnant woman and her husband evolve with their fetus in preparation for beginning their relationship to their newborn.

In order to understand the impact of the birth of a premature infant on his family we must start with an appreciation of the psychology of pregnancy and birth.

In the first weeks and months of pregnancy, a woman may deny the full implications of being pregnant. Actual changes in her physical being are minimal and there may be no change at all in her lifestyle. But almost all women are aware that they are pregnant on a physical as well as an emotional level. The physical symptoms of nausea, gastrointestinal discomfort, changes in breast and silhouette may be exaggerated by some women who are in conflict about their pregnancies. In any case, this is a time of great need. A pregnant woman requires the reassurance of her partner, the support of her friends and relatives and medical support to emphasize normalcy of herself and her pregnancy. At this stage of preg-

nancy women do not focus so much on "having a child," but, are more concerned about "being pregnant."

As the pregnancy continues into the fourth and fifth months, the reality of the fetus and its relationship to the mother becomes primary. The physical changes in the woman's body, combined with the movement of the fetus in utero, are a constant reminder of the pregnancy. With the growth of her abdomen the pregnant woman begins to relate more directly to her fetus. She begins to imagine which sex the child might be, may give it a nickname, and begins to fantasize about the child's role in the family. Women frequently regress and feel more in touch with experiences from their own childhood during this time. They begin to anticipate the reality of being a mother and verbalize the desire either to be like their own mother or to be quite different. These middle months of pregnancy are often associated with a decrease in the incidence of nausea, gastrointestinal discomfort and fatigue, and free the mother to have a more positive attitude about the pregnancy and the impending delivery. A euphoric sense often occurs which may mask some of the common fears and concerns of the pregnant women. The entire family begins to give increasing attention to the fetus, and a process of maternal-paternal-fetal relationship develops.

If the pregnancy continues to term, anticipation and excitement increase and the reality of having a child and preparing for

it becomes paramount in the lives of the couple. A premature birth, then, abruptly interrupts this nine-month developmental process. It does not allow for appropriate closure on the developing relationship between mother, father and fetus which will be nurtured into the relationship to the normal-term newborn.

We should also be aware that all pregnancies are associated with some ambivalent feelings, and that in some instances, during the time of previability and up to even 20 to 24 weeks, mothers and fathers frequently think about, but rarely discuss, the idea of an abortion. Thus, a baby born between 24 and 30 weeks, extremely premature, may dramatically highlight the ambivalent feelings concerning the potential for abortion which was a legal and possible alternative just a few weeks prior to the actual delivery.

The feelings toward the end of a normal pregnancy are so intense that the actual birth of the baby may be for some mothers an anticlimax. Just as the anticipation of a gift is often greater than the reality, the birth of the child can be a letdown. Disappointment, fear, anger and depression are sometimes associated with the delivery of a full-term baby. This possibility is dramatically increased in the birth of an abnormal or low birthweight infant. All mothers and fathers face some fears of inadequacy in regard to caring for a new human being. They face concerns about financial matters and worry about the impact of this new person on the family, the potential intrusion on their intimacy and closeness, and other changes in the relationship between the parents and other members of the family.

The birth of a normal child helps reaffirm the parents' belief in their own normalcy and culminates in the excitement of confirming their ability to create a person in their own image. There is great relief that the baby is "normal," and a need for their observation to be confirmed.

When a child is born prematurely, little of this can occur. The parents are devastated.

As all newborn infants are in some sense felt by their parents to be extensions of themselves, the extremely small, fragile and vulnerable premature infant may readily evoke feelings of self-deprecation and lowered self-esteem. Fears occurring during the pregnancy that the baby would be abnormal are powerfully reactivated. The joy most often associated with an infant's birth is diminished and the parents feel a sense of fear, failure, guilt, anger and depression.

Parents have intense feelings immediately after the birth of a low birthweight infant. Most parents experience immediate grief reactions that are similar to those occurring at the death of a loved one. The parents may mourn the loss of the expected perfect child and begin to go through the process of anger, denial and depression. The mother particularly has an acute sense of failure. She, as the person in whom this infant was to have been carried to term, has failed in her task. Denial and guilt characterize the response and serve as defenses to ward off the more devastating feelings of anxiety and depression.

Having to deal with uncertain outcome is the single most anxiety-producing aspect facing the parents. The question all parents of low birthweight infants ask is: "Will he live or will he die; and which is the better alternative?" Understandable thoughts that the child might be better off dead are frequently felt to be unacceptable. Parents try to push them out of their minds but they continue to intrude. During this time of crisis parents may regress and themselves behave like emotionally labile children. They will certainly require a great deal of nurturing, comforting and sensitivity to their own personal needs.

The ambiguity of outcome, the fear of what the baby's living will mean and the equal fear of the baby's death frequently result in terrible feelings of helplessness and loss of control. In addition, parents have little sense that this baby really is theirs, so completely has its care been handed over to physicians, nurses, technicians and

machines. The medical jargon becomes second nature as the parents are co-opted into using terms like: blood gases, pO₂, apnea, IVH, NEC, bradycardia, etc., etc. They must adapt to these terms, adopt a new vocabulary and become part of the medical establishment in order to feel any part of the process of caring for their infant.

The father plays a unique role in this process. Frequently, mother and baby are simultaneously hospitalized but in two far-distant sites. They may be far distant in the same building or in two different buildings, sometimes many miles apart. The father is often responsible for reporting the status of the infant to the mother. Because of their tendency to be protective of mothers who are often depressed and anxious, fathers frequently share only part of the information about the babies. However, this attempt to protect often isolates the mother and intensifies her feelings of lack of control and involvement, and increases anger, guilt and loss. The father is often focused on the monumental costs of the care and the future costs of rehabilitation, special schooling and changes in the home environment which this infant will occasion. The father's loss of self-esteem may also focus on his fantasies about playing baseball and football or taking his child to a sporting event: the birth of this sickly and puny child may smash such images. Whatever the reassurances about future potential, the father may focus on the weakness rather than the strengths of his infant.

No matter what the outcome of the low birthweight infant, parents must accomplish several psychological tasks during the hospitalization of the low birthweight infant if they are to bond and adapt in a meaningful way to their newborn. The period of shock and denial, sadness, grief, anger and anxiety must make way for a period of adaptation in which the family begins to relate in a meaningful way to the infant, even while he is sick; and, finally, the family must reorganize, coming to grips with the infant's special needs and prepare for the infant's

discharge to the home. These stages are not unlike the stages of resolution of the grief work during the mourning for a loved one who has died. The adaptation and reorganization phases allow the family to view the infant's potential and future more realistically and with a more positive attitude.

What of other family members? What about grandparents, aunts and other close relatives and the other children? Adult relatives frequently go through the same stages that the parents of the infant are going through. In their initial stage of anger, denial and disbelief, relatives may blame the parents for what has occurred. They criticize the mother's lack of ability to carry the infant to term, and often focus on either social activities or behaviors that the mother or father engaged in which they believe are responsible for the early birth. Grandparents frequently deny the seriousness of the illness and in an attempt to be reassuring, they, too, may bring inappropriate information back to the mother. What about the other siblings? Not having been prepared for the birth of a premature infant, siblings at first may react with considerable fear to the loss of their mother when she is hospitalized unexpectedly. This is followed by possible misunderstandings about why the baby can't come home and what the potential problems are concerning the baby's illness. Parents in their misguided desires to protect the siblings will often hide the fact that the infant is sick and try to keep their own personal grief from their children. This, of course, is a hopeless endeavor; their children immediately pick up the anxiety, tension, depression and sadness which the parents inadvertently manifest in their every moment together.

What then do we suggest the professionals in the neonatal intensive care environment can do to assist in minimizing the negative impact of the birth of a low birthweight infant on the family? How can they help the parents to progress through the necessary psychological stages of coping with their new infant? The first and most

important issue is the attitude of the professionals. Although the nurses, physicians and even social workers caring for hundreds of infants per year in a special care nursery take for granted much of the illness they see, it must be realized that for each and every parent any deviation from the norm is viewed as a serious and even catastrophic event. Although a premature infant may be doing well on a ventilator in the nursery and be viewed as a "healthy," rather "usual" case, the birth of a very low birthweight infant is clearly not a usual event for the family and must not be treated as such by the staff in the neonatal unit. Professionals must realize that although the patient is "routine" to them, the baby is unique to the parents. Jargon is frequently overused in discussing the baby and may unnecessarily distance the staff from their patients' families. It is important to clarify each aspect of the care and the prognosis in simple lay language and to be sure that the parents are allowed to question all of the terms that are used in explanation. Frequently, during the first visits of parents to the unit the monitoring equipment and all of the tubes and wires connected to the infant are misunderstood as not merely recording the activities and biochemical variables of the infant, but rather affecting the infant; thus, the monitoring leads attached to the chest or the temperature probe attached at the abdomen are viewed as routine within the nursery structure, but to the uninitiated parent they appear as major invasions of their infant, perhaps giving electric shocks, or worse. With time, reassurance and patience, the parents can be made to feel comfortable in the unit and helped to understand their baby's illness.

Much has been written about the importance of regional neonatal transport, moving a neonate from a community hospital to a far-distant neonatal center in order to enhance newborn outcome. It is vital to be aware of the psychosocial aspects of this intervention. The attitude of the team, the eagerness to discuss the infant with the

family while at the referring hospital, and the literal way in which they handle the infant are all critically important. A polaroid picture of the infant becomes the treasured link between mother and baby for many hours or days and is frequently caressed, kissed and talked to. The mother must see her infant prior to the infant leaving the hospital, even if the infant must be rolled to the mother's bedside in a recovery room or another part of the hospital; and, finally, the transport of the infant is not completed until a phone call is made to the mother in the hospital of origin to assure her that her infant's trip is over and her baby is in its new environment. This is done whether or not the father has come with the infant and plans to return immediately to the mother to give the same reassurance. This phone call, placed by the nurses or doctor caring for the infant in the center, has been one of the most powerful gestures of concern for mothers of any gestures made in the neonatal unit. Mothers' responses are overwhelmingly positive.

As the parents of the infant begin to visit the neonatal unit, it is important to realize that parents are facing totally new experiences with no background for understanding what would constitute appropriate behavior. The family must be educated sensitively about their "right to visit," their "right to ask questions," and their "right to call." Conferring these "rights" expresses a desire on the part of the neonatal unit staff for parents to have a meaningful role in the care of their newborn. These attitudes permit families to feel that they are still involved with their infant although they have lost control of the moment-to-moment care. The emergent nature of much of the care in neonatal units precludes long "informed consent" discussions about many treatments and procedures, but parents can and must be respected in their right and wish to know what is happening to their infant and to be involved in decision making as much as possible. Giving parents knowledge and understanding about what is

happening with their infant and some involvement in decision making empowers them and enables them to feel they have a meaningful part in the care of their newborn.

Despite the fact that the vast majority of low birthweight infants in the 1980s survive, some infants will die. A humane, caring and compassionate approach to death in the neonatal unit is an important part in helping the family deal with this tragic event. Prolonging an inevitable dying process is inhumane and unnecessary. Families should be involved in touching, holding and comforting their infant as the infant's life ends, just as they were during the baby's life. A quiet place in the nursery should be set aside for parents to spend those last moments playing the role of parent, holding and comforting their dying loved ones. Compassionate and caring physicians and nurses who spend as much time and energy in the process of their patient's dying as they did in their attempt to rescue their patient's life will play a meaningful role in the family's attempts to cope with this event. Comments like "it's for the best," "he's suffered a great deal," "it's good that it's over," are both inappropriate and unnecessary. Spending time with the family, sharing their grief, and understanding their sadness is more helpful

and more meaningful. It is also important to reassure the family that staff will be available to talk with them about this experience later. It is important to meet with parents within a few weeks to reflect on what has occurred and to help them adjust to their lives without the baby they had wanted.

Modern neonatology has given us optimistic mortality and morbidity data concerning low birthweight infants. Just a few years ago, a two-pound infant had a 10 percent chance of survival, and those who survived had major neurologic and cognitive deficits. Today, the overwhelming number of two pound infants survive and survive intact, with some developing minor, and fewer developing major, deficits. These data do not change the dramatic impact of the birth of these low birthweight babies on their families. The media have suggested that prematures will survive and most will do well, but when that premature infant is born, the family will need to deal with all of the feelings described. Professional caregivers for the newborn must be available for parents, to help them face this crisis and to deal with the deep emotion involved. The result will be a healthier family and a healthier baby.

Infant-Parent Psychotherapy with an Autistic Toddler

Barbara Kalmanson, Ph.D. and Judith H. Pekarsky, Ph.D.

The case presented here describes the treatment of Jonah, an autistic child who came to us as a toddler and whom we followed to the age of five. The work took place through the Infant Parent Program, and Infant Mental Health Program, begun in 1979 by Selma Fraiberg, and modeled after her innovative work at the University of Michigan. The Infant-Parent Program is part of the Department of Psychiatry at the University of California, San Francisco, and is based at San Francisco General Hospital.

The approach to the treatment of Jonah and his parents was an outgrowth of the method of infant-parent psychotherapy described by Fraiberg and her colleagues (Fraiberg, 1980; Pawl and Pekarsky, 1983; Lieberman, 1983). In line with this model, the primary goal of the work was to develop a mutually satisfying relationship between the parents and their child. This involved careful attention to the parents' feelings and a focus by both therapists and parents on the child's affective experience and needs.

Assessment

Jonah's family was referred to the Infant-Parent Program by his pediatrician when Jonah was 18 months old. He had been having staring spells for the last two months and often seemed extremely aloof, preoccupied, and difficult to contact. There were episodes of such inaccessibility that neither his mother's shaking him nor passing her hand in front of his eyes brought any response. In the previous two months Jonah

had stopped using all but three or four of the 15 words he had acquired.

In the course of our assessment, it became evident that both of Jonah's parents were in crisis. They were reacting to the difficulties in making a connection with Jonah and felt bewildered, rejected, and helpless. They were continuing to reach out to their son, but with a sense of increased foreboding about their ability to get a response.

As the assessment proceeded, Jonah's developmental history gradually emerged. Jonah was the Burkes' only child, the product of an uncomplicated pregnancy and delivery. From birth, Jonah was extremely irritable and unusually sensitive to light and sound. He had difficulty with state transitions. He cried for long periods and was very difficult to console.

Jonah's major developmental milestones were all within normal limits although no truly social smile had ever developed. Following breast feeding, he insisted on feeding himself and refused any lumpy or rough textured foods. Jonah also showed an intolerance for shifts and changes in his routine or environment.

At the time of the assessment, Jonah's affective and social functioning, his sensory integration, and his cognitive abilities were atypical. He was able to remain solitary and unrelated for long periods of time, never approaching his parents for reassurance, for comforting at times of distress, or to share moments of pleasure. Jonah never allowed mutual eye contact or cuddling, and

squirmed in distress in his mother's lap. His typical method of making contact was to direct the other person's hand like a tool in order to reach an object or facilitate its use. Jonah's slight and fleeting smiles were evoked by his own activities with toys, and the pleasure was experienced privately.

There was evidence throughout the assessment that Jonah had difficulties with sensory modulation and perceptual integration. He seemed easily overwhelmed by sensory input and gave evidence of unusual sensitivity to a variety of visual, auditory, olfactory, and tactile stimuli. When he experienced stimuli as too intense, he was driven to complete withdrawal and preoccupation with self-stimulatory activity.

Jonah's cognitive functioning was markedly uneven. He showed serious difficulties in language—with an unusual mixture of infantile vocalizations, squeals and squeaks, and two or three words not used communicatively. Jonah's comprehension of language appeared limited to the recognition of a few key words and invariant phrases paired with a consistent gesture or visual cue. In the area of symbolic functioning, he showed little evidence of early imitative abilities, object permanence was as yet incompletely established, and he had no representational play. In contrast, Jonah demonstrated precocious abilities in visual-motor performance.

The possibility that Jonah's disturbance resulted from a seizure disorder or hearing impairment was investigated and ruled out during the assessment.

When our assessment was completed, it was clear that Jonah met all the criteria for the diagnosis of infantile autism delineated in the American Psychiatric Association's Diagnostic and Statistical Manual III (1980). The onset of his difficulties occurred before 30 months: he showed a pervasive lack of responsiveness to others; he had gross deficits in language; and he was resistant to change. He also showed some of the "associated features" of this diagnosis: he was over-responsive to sensory stimuli, and he

demonstrated marked variability in his intellectual functioning with deficits in verbalization and symbolic thought and excellent performance on visual-spatial tasks. Jonah's intellectual strengths identified him as among the better functioning children with this diagnosis and suggested a good long-term prognosis. We therefore viewed him as in a good position to make use of our interventions.

First year of treatment

To meet the needs of all the family members, our usual model (Fraiberg, 1980) of infant parent psychotherapy was modified. Two therapists worked simultaneously in the family's home, meeting once a week for sessions usually lasting an hour and a half. This arrangement allowed one therapist to provide Jonah with the undivided attention he required to become engaged in the social world, while the other therapist was available to respond to Mr. and Mrs. Burke. The actual work with the child and his parents continually intersected and coalesced as Jonah and Mr. and Mrs. Burke attended to and interacted with one another, and the therapists.

Mr. and Mrs. Burke

The treatment in this case included the most devoted and sensitive collaborators—Jonah's parents. They were in the prime position to help Jonah develop into a social and communicating being, since they were with their son continuously. The work with the Burkes was aimed at removing any internal barriers to rewarding interaction with Jonah. This involved exploring and offering continuous support around their complicated feelings about Jonah and themselves as parents particularly their sense of unimportance to him, their frustration and anger, and their feelings of responsibility and guilt. Along with the support provided, efforts were made to point out when there were signs in the sessions of Jonah's attachment to his parents, and evidence in his behavior that he was

registering and responding to their feelings. This allowed the Burkes to risk more attempts to contact their son.

Another major issue in our early work involved exploring the ways in which the Burkes' reactive feelings had influenced their relationship with Jonah. They reported that life was so difficult with him, they were nearly ready to give up. Through experience they had learned not to disturb Jonah, and they had become somewhat hesitant and tentative in trying to contact him. As they recognized this dynamic and its consequences, and as they began to glimpse some possibilities for interaction with their son, they became more able to reach out to Jonah and engage him.

Another aspect of the treatment involved investigating and revising the Burkes' many misconceptions about the meaning of Jonah's perplexing behavior. They came to understand that Jonah was not unwilling to relate to them, but was engaged in an internal struggle to manage stimulation. This understanding enabled the parents to empathize with their son and wholeheartedly engage in efforts to help him. The Burkes were eager participants in all of this work, and they rapidly became the skillful extenders of Jonah's treatment. This does not mean that they became therapists; rather they were able to sustain natural parental feelings and functions while providing their son with the special kinds of interaction and structure which he needed.

Jonah

During the first year of treatment our work with Jonah was primarily focused on encouraging reciprocal social relationships and developing mental representation and language. In order to make him available for relationships we also needed to learn how to manage the environment for him by modulating the sensory stimuli that caused him to withdraw.

Throughout the sessions with the family, I¹ attempted to follow Jonah's lead continuously and use every opportunity to gratify

¹The primary therapist for Jonah was Barbara Kalmanson. The primary therapist for Mr. and Mrs. Burke was Judith Pekarsky.

his wishes and draw his attention to the rewards of interaction. In my search for ways to engage Jonah and maintain his interest in social interaction, I experimented with various dimensions of environmental stimuli—including vocal inflection, and speed and intensity of voice, integrated with tactile stimulation and an optimal physical distance for maintaining eye contact.

I remained constantly available to Jonah throughout each session. Whenever I had the opportunity, I encouraged him to use me to open a latch, reach an object, or hand him a toy. I always handed him the object in our mutual line of vision so that he had to notice my face and hands simultaneously as I gratified him. He could not overlook the fact that this tool-like hand was part of the person who was responding to his wishes. Often, this entailed lying on the floor next to him, or scurrying about the apartment in tandem.

Over the course of many sessions, we evolved a repertoire for exploring the kitchen cupboards which made Jonah dependent on me for help. He needed me to lift him onto the counter top and to secure his mobility from one counter to the next. This exploration had other advantages as well. It put us precisely at eye-to-eye level, facilitating eye contact. Jonah's pleasure in his access to previously inaccessible territory allowed me to encourage small moves toward exploration without interfering with his familiar ritualized routines. I was also able to interpret to the Burkes that his interest in the kitchen represented an interest in them since they were avid cooks. Over many weeks, Jonah's exploration developed from a perseverative opening and closing of the cupboard doors and opening and closing of spice jars, to an interest in the smell of the spices, and eventually in tasting some unfamiliar foods in the cupboard. Because of his previous aversion to crunchy foods, his mother was quite surprised one day to see him nibbling at raw noodles. Gradually, Jonah began to try these new tastes during meals.

The curriculum in the cupboards gradually led us to naming objects, pouring beans and popcorn from one size container to another, water play in the sink (which included learning to undress and dress) and finally to the beginnings of representational play—pretend cooking with playdough. Pretend cooking became a favorite pastime for Jonah. His interest in cooking reinforced his parents' gradually developing awareness of their importance to him, and a recognition of his beginning identification with their involvement in cooking. Food preparation became the arena for family activity: the Burkes now included Jonah in all their baking, and even prepared home-made playdough.

Another of the reciprocal activities Jonah and I developed grew out of his parents' concern about some ritualistic behaviors that irritated and exhausted them. The most frustrating of these was an opening and closing of doors which rapidly disintegrated into frenzied banging. This seemed to be a rough experimental attempt to find out where things were when behind a barrier. Once we discovered this explanation for the behavior and discussed with Jonah's parents his attempts to develop object permanence, we were able to transform this ritual. We turned it into a social game that would satisfy Jonah's quest for object permanence, promote his use of people as helpmates in the learning process, and offer relief and an active role to his parents. We substituted a large box that Jonah could disappear into and reappear from.

Within a week, the box had become a focus of social activity between Jonah and Mr. Burke. Jonah's scurrying in and out of the box included opportunities for mutual gaze, vocal greetings, social smiles, and physical contact. On occasion, Mr. Burke's pleasure in this interaction and his wish for demonstrations of his importance to his son propelled him to follow his own desire for more intimate contact. Jonah's response was to arch his back, pull away, and turn his head from side to side, escaping his father's

attempts to embrace. With our support and guidance, Mr. Burke was able to understand that Jonah's avoidant behavior was not a rejection of his father but an effort to protect himself from overwhelming sensory stimulation. Such explanations helped Mr. Burke endure these rebuffs and carry on the game with the intensity of contact Jonah could manage. As a result, Jonah was able and willing to maintain the contact with his father. These shifts interrupted the well established cycle in which Jonah retreated when overstimulated and his parents gave up in despair.

As the reciprocal routines around the box became a comfortable part of daily play, the frenzied quality of Jonah's behavior disappeared: with his parents' warm approval, he had no need to fight their prohibitions with ritualistic insistence. From our point of view, the box set an ideal stage for social play. The game gave Jonah mastery over disappearing objects, and a contingently responsive interaction complete with verbalizations and eye contact. This experience always led us to look for the meaning in Jonah's sometimes apparently senseless behavior, and to attempt to transform his rituals into socially playful interactions that addressed the developmental task he was, however primitively, attempting to master.

After six months of treatment, Jonah had developed an interest in people. He attended to social interaction and showed pleasure in his parents' and the therapists' involvement with him, as long as we mediated the environmental stimuli, were attuned to his interests, and joined his activity.

At this point, we were able to focus more intensely on interpersonal communication. From the beginning, I had drawn his attention to speech by minimizing the number of words directed to him, slowing the pace of speech, and exaggerating inflection and facial expression. I provided an extremely simplified, slow-paced, repetitive monologue describing everything he was doing, as well as everything his parents and I were doing to interest him in relating.

DEVELOPMENTAL SIGNS OF AUTISM IN THE FIRST THREE YEARS OF LIFE

Autism is a pervasive developmental disorder with onset before 30 months. There is increasing agreement that the syndrome is actually present from birth. Typically, however, it is not identified until the child's failure to develop communicative language is apparent. Recent research on infant development and infant-parent interaction provides information that may allow earlier identification of the disorder.

Below are some developmental signs of autism which professionals might keep in mind. It is important to be aware that no single atypical behavior is indicative of autism. The disorder is defined by a pattern of behavior that includes difficulties with social relationships, communication, perceptual integration, and adaptability to changes in the environment.

Signs in Infancy

MOTOR	PERCEPTUAL	SOCIAL-EMOTIONAL	LANGUAGE	MENTAL REPRESENTATION
<p><i>Inactive</i></p> <ul style="list-style-type: none"> ● flaccid muscle tone ● rarely cries <p>or</p> <p><i>Irritable</i></p> <ul style="list-style-type: none"> ● inconsolable ● only soothed when in constant motion ● limp <p>or</p> <ul style="list-style-type: none"> ● rigid when held ● arches away from close physical contact <p><i>May have given up or lost an acquired skill</i></p>	<p><i>Unusually sensitive to sensory stimuli</i></p> <p>Auditory:</p> <ul style="list-style-type: none"> ● appears deaf to voice but jolts or panics at environmental sounds <p>Tactile:</p> <ul style="list-style-type: none"> ● refuses food with rough texture ● adverse reaction to wool fabrics—prefers smooth surfaces <p>Visual:</p> <ul style="list-style-type: none"> ● sensitive to light ● may panic at change in illumination ● preoccupied with observing own hand and finger movements 	<p><i>Unresponsive</i></p> <ul style="list-style-type: none"> ● no social smile ● avoidance of eye contact when held ● fleeting eye contact at a distance ● lack of anticipatory response to being picked up ● seems not to like being held ● seem content left alone ● fails visually to follow coming and going of primary caregiver ● doesn't play peek-a-boo or patty-cake or wave bye-bye ● fails to show normal 8-month stranger anxiety <p><i>Fails to form strong personal attachments</i></p>	<p><i>Delayed or absent coo and/or expressive vocalization</i></p> <p><i>Failure to imitate words, sounds</i></p> <p><i>Little communicative use of gesture</i></p> <p><i>Speech retarded or shows precocious advances followed by failure to use previously learned words</i></p>	<p><i>Decreased visual pursuit of objects or people</i></p> <p><i>Object permanence develops slowly or stops at stage 2 or 3 (secondary circular reactions)</i></p>

Signs in Second and Third Years

MOTOR	PERCEPTUAL	SOCIAL-EMOTIONAL	LANGUAGE	MENTAL REPRESENTATION
<p><i>Toe-walking</i></p> <p><i>Rocking</i></p> <p><i>Head-banging</i></p> <p><i>Whirling without dizziness</i></p> <p><i>Perseverative movements</i></p>	<p><i>Withdraws from environmental stimulation</i></p> <p><i>Engages in self-stimulation</i></p> <p><i>Preoccupied with spinning objects</i></p> <p><i>Suddenly ceases activity and stares into space, often with hyperextension of neck</i></p>	<p><i>Moves adult's hand like a tool</i></p> <p><i>Insists on sameness and ritualizes routines</i></p>	<p><i>Echolalia</i></p> <p><i>Delayed echolalia unrelated to social context</i></p> <p><i>Pronoun reversals</i></p> <p><i>Voice atonal, hollow, arrhythmic</i></p>	<p><i>No representational play</i></p> <p><i>Little appropriate use of toys</i></p> <p><i>Preoccupied with impersonal invariant information (e.g. television commercials)</i></p>

Following continuous observation and discussion during our sessions, the Burkes began adopting all of these approaches to interaction, adapting them to their own interpersonal style. Jonah began imitating sounds, single words, and phrases from bits of conversation as his eye contact improved and as he was encouraged to imitate words that verbalized his wishes.

Jonah's advances in the development of symbolic thought and verbal expression, and his investment in relationships led to a change in the treatment. The focus of the work with him shifted from developing the cognitive and affective components of human relatedness to understanding Jonah's affective experiences.

Second and third years of treatment

Treatment with this family continued for three and one-half years. After the first year, our work with Jonah centered on events in his family and the typical concerns of a preschooler. Jonah did show residual autistic characteristics in language, symbolic thought, and insistence on sameness. These were addressed through subtle interventions embedded in the playful interactions between Ms. Kalmanson and Jonah. The work with the parents during this period supported their empathy and practical efforts on Jonah's behalf. It also extended to their handling of emerging age-appropriate self-assertion and aggression. By the end of treatment, both parents appeared thoroughly pleased with their son and their relationships with him. They enjoyed him, were proud of his achievements and personality, and felt like generally effective and well-loved parents.

At the time of termination, around Jonah's fifth birthday, the only remnants of his former autistic state appeared in some concretization of abstract concepts and less flexibility in his expressive language than is usually available to a bright five year old. These did not prevent him from acceptance at a kindergarten in an excellent private school. Jonah's intellectual abilities were

above average, as measured by the Wechsler Preschool and Primary Scales of Intelligence (WPPSI). Socially, he was a very engaging, related little boy, with a fine sense of reciprocity in interactions. He had a full and sophisticated range of affective expression, and readily empathized with the experiences of those around him.

Several months before the treatment ended, Jonah summarized his own understanding of the metamorphosis that had taken place. Recalling a time when he was much younger and unable to make his wants known through language, Jonah wrapped himself up in a blanket and explained that he was in a cocoon. He then depicted his emergence from this state by rising out of the blanket, arms outstretched, with an elated expression on his face. He exclaimed, "Now I'm a butterfly!"

Discussion

The outcome of this case was especially successful. Although some autistic children develop equally sophisticated cognitive abilities, they generally continue to show affective and social peculiarities. It is highly unusual for an autistic child to develop and express a rich and varied emotional life, and to respond to others with empathy as Jonah did. This seemed to be a direct result of the treatment's focus on Jonah's affective experience and needs, and on his parents' ability to empathize with and respond to these.

A set of factors in the family enabled the treatment to proceed so successfully: Jonah's age at the beginning of treatment, his cognitive strengths, and the Burkes' ability to use and extend the treatment. The fact that contact began when Jonah was only 18 months old allowed the work to capitalize on the plasticity of the earliest years. Jonah's age also meant that his cognitive and affective delays and distortions had not yet grown to irremediable proportions. He still had relatively little catching up to do. Jonah's developmental strengths, apparent in earliest contacts, bespoke a constitutional

intactness which enabled him to make good use of intervention.

Finally, Jonah's parents were central to his recovery. Mr. and Mrs. Burke were able to develop and sustain an exceptionally sturdy therapeutic alliance on behalf of their son. They were willing to engage in painful self-exploration and were capable of setting their own needs aside in an effort to provide extraordinary care for Jonah. The Burkes were steadfast in their commitment, patient in the process of improvement, and creative in the extension of the treatment into their daily lives.

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Infants and Toddlers in Hospitals: Addressing Developmental Risks

Joy Goldberger, M.S.

Hospitalization represents one brief segment of some children's early experience; it is a repeated event for others, and becomes a way of life for a few. Of the infants and toddlers who are admitted to hospitals daily, some will have diagnoses that suggest full recovery while others will face chronic or progressive medical conditions. The process of providing essential treatment for these very young children may require simple IV therapy, one or many diagnostic procedures, one or many surgical procedures. During their contact with numerous, ever-changing hospital caregivers, many interactions will involve pain or discomfort, most interactions will be somewhat intrusive, and few will be responsive to the child's own cues. Feeding may be prohibited, severely restricted, or encouraged beyond the child's natural desire to eat. Physical restraint may be necessary for varying periods of time. Discomfort with little relief. Parents may or may not be available.

Surprisingly little attention has been paid to the experience of acutely and chronically ill infants in hospitals, other than those in neonatal intensive care, even though it is estimated that more than half of pediatric in-patient beds are filled by children under three years of age (American Academy of Pediatrics, 1986). This article describes the disruptive, chaotic and noncontingent qualities that hospitals share with other high-risk social environments; explores the developmental implications of these circum-

stances for infants, toddlers and their families; and suggests strategies for care to address the developmental needs of very young children who are hospitalized.

The hospital environment

In examining the social and developmental characteristics that typically accompany even high quality medical care, investigators have described the chaotic and non-supportive nature of the hospital environment (Goldberger, 1987, and in press; Grant 1983; Hagemann, 1981a, and 1981b; Jones, 1979; Smith, 1976; Thompson, 1985).

The physical environment is both monotonous and unpredictable. Sensory experience may be fragmented: tube feedings, for example, bypass the normal experience of sucking, swallowing, tasting and physical contact; the sounds of machinery or continuously playing televisions and radios cannot be connected visually to their sources by young infants (Jones, 1979). Life-sustaining care may involve both pain and unrelenting hunger as a result of restrictions on oral feeding. Infants and toddlers are restrained during medical procedures and to prevent pulling at or exploring medical tubing; they may also be confined in cribs, highchairs and playpens if caregivers are not available to supervise exploratory play.

A large proportion of social interactions in hospitals are non-contingent and intrusive. The large number of frequently changing caregivers may be particularly challenging to very young children. Conting-

ent, responsive care is made less likely by tracheostomies, respirators or the effects of handicapping conditions, which may make language for the young child impossible or difficult to interpret. Particularly for infants and toddlers with chronic conditions who become "favorites" during extended or repeated hospital stays, social interactions are typically highly stimulating, intrusive and sudden, much as are caregiving interventions. With the good intention of eliciting a smile or a cute trick, but often without empathy for the child's emotional or physical experience or developmental needs, numerous loving caregivers may interact briefly and in rapid sequence.

Despite the changes in hospital policy that followed seminal research on the developmental effects of separation and institutional care (Bowlby, 1960; Bowlby, Robertson, and Rosenbluth, 1952; Edelston, 1943; Provence, and Lipton, 1962; Robertson, 1958; Spitz, 1945) prolonged infant-parent separations still occur frequently and are of great concern. How long a separation is too long for a child to tolerate depends on numerous factors. Despite hospital policy that at least formally encourages parents to "live in," lengthy or repeated hospitalizations, parents' work responsibilities, the needs of other children, and lack of adequate transportation may make parents' absence necessary. The quality of interaction between parents and their young child may also suffer during hospitalization. Fear, guilt, grief, depression, exhaustion or inexperience and immaturity may exacerbate parents' emotional unavailability as well as inhibit their physical presence. Professionals eager to teach but not prepared to learn from families may fail to acknowledge parents' expertise and competence (Knapschaefer, 1987; Thomas, 1987). Furthermore, the focus on what is "wrong" with the child, both medically and developmentally, may result in inadequate attention to the child's strengths and areas of health. Professionals may contribute to what Green and Solnit (1964) described as the "vulnerable child syndrome," in which

some parents persist to a pathological degree in perceiving their child as sickly or vulnerable following an illness in infancy or toddlerhood, despite a full and satisfactory recovery.

Behavior of hospitalized infants and toddlers

Infants and toddlers who experience lengthy or repeated hospitalization often demonstrate certain behavioral qualities. These may include:

- social and exploratory passivity;
- an inhibited perception of their ability to move beyond immediate physical space (e.g., reaching for a toy requiring a slight stretch from a stable sitting position, or crawling once a quadruped position can be sustained);
- a narrow range of affective expression that may be limited to irritability or, just as likely, to the consistently jovial behavior that is reinforced by staff;
- distractibility;
- disinterest in fine motor tasks that require eye-hand coordination, and preference for a limited repertoire of gross motor schemata that allow the child to wave, bang, shake and mouth toys while visually scanning the environment;
- persistent mouthing of toys despite developmental maturity that would suggest the decrease or elimination of this form of exploration (particularly notable in infants and toddlers with tracheostomies, even if receiving oral nutrition, and in those who do not receive a significant portion of their nutrition orally); and
- notably minimal vocalizations and few attempts at intentional verbal communication.

The long-term developmental effects of hospitalization during infancy and toddlerhood have been explored by Douglas (1975), Dowling (1977), Quinton and Rutter (1976), Schaffer and Callender (1979), McDonald (1981) and Meijer (1985). The complex

interactions that occur between the hospitalized infant and the caregiving environment may best be illustrated by several case examples from a pediatric tertiary care center.

Shantal, now four months old, was born more than 10 weeks prematurely to a drug-abusing mother from whom she inherited both HIV antibodies and cytomegalovirus. She has a tracheostomy and bronchopulmonary dysplasia remaining from her extended requirement for a respirator. She may or may not develop symptoms of AIDS, but she is becoming medically stable.

Shantal's mother is increasingly ill, and no other family members visit the child. Despite the affection shown Shantal by her primary nurses, often no one is available to interact with her and optimize her experience during her brief naturally occurring awake and alert times. Since hospital policy requires her isolation from other patients, Shantal cannot even watch the pleasurable activity of the playroom. Finding a foster home is a challenge.

Frank developed necrotizing enterocolitis soon after birth, and has required significant and repeated abdominal surgery plus additional surgical procedures for placement of special intravenous catheters to enable the provision of total intravenous nutrition. In the six months of his life he has not had a single oral feeding. His parents visit each evening, but must work in the daytime to maintain their modest income and insurance coverage. As a result, Frank stays awake late at night but is sleepy during the day when nurses, physicians, therapists and nutritionists must evaluate his progress and provide their interventions. When they awaken Frank, these professionals may offer reasons: "He shouldn't be asleep at this time of day"; "He probably just fell asleep"; "He will probably wake up soon anyway"; "He won't mind"; and "It would be hard for me to come back to this unit later." Sometimes Frank is irritable. Some professionals consider him "lazy" or "spoiled."

Jasmine is now 14 months old and has been on our unit her entire life. Her prognosis is guarded, and she will likely be on our unit for many more months. She has never received oral nutrition. Each nurse, doctor, housekeeper, therapist, parent, and transport aid who has ever had contact with Jasmine is drawn to her smiles and "cute" responses. As each one passes her room, he or she calls out an affectionate greeting or stops for a quick hug or tickle. Jasmine smiles, calls back some enchanting response, and continues to play, never once looking at her hands and always scanning the hall for the next "friend." Each passerby loves her in his own way, and eagerly accepts Jasmine's generous social rewards. Jasmine gives people pleasure in their day. Some of these friends are known to give her secret licks of lollipops and other tastes, although her sensitive gut will not tolerate even slow, tiny drops of Pedialyte given through her gastrostomy tube. Her father, who has returned to his native country, would prefer her mother not to be involved with this sick female infant, who has many strikes against her according to their cultural and religious values. So family rarely visits Jasmine, and nurses love her as their own.

Sandi is particularly worrisome. She is a five-month-old, now hospitalized for the second of what will probably be many hospital admissions. She has significant orthopedic and neurological anomalies, and is failing to thrive despite much medical intervention. Sandi will have several persisting areas of handicap despite intellectual capacity that seems within normal limits.

Sandi's mother has a three-year-old to care for, but travels nearly an hour each way three or four times per week as often as her own mother can babysit to visit for several hours. Sandi's father is increasingly backing off and the marriage is increasingly rocky. Mom seems to be a real fighter, a devoted mother who will find a way for Sandi, and a way for herself, too, if need be.

When her mom has been with her Sandi has enough energy to look around the room and smile spontaneously at a very few familiar faces, and to reach for lightweight toys. Sometimes she even coos. But the therapist who visits in the morning, when mommy is never there, doesn't get to see this. She sees Sandi as irritable (which she is). Right now Sandi is not eating by mouth. She is ravenously hungry and somewhat hard to console. She gets her primary comfort from sucking vigorously on her pacifier. She tends to turn away from caregivers, and sometimes looks rather limp and dazed when she is held. So Sandi is not a favorite, and does not have, like her roommate Jasmine, a long line of people eager to nurture her.

Strategies for care

In this writer's experience the developmentally worrisome behaviors of hospitalized infants and toddlers are largely eliminated as significant problems when parents persist in providing daily, mutually gratifying interaction. Thus the foremost goal of psychosocial services to families should be encouraging parents' positive perception of their infants and involvement in their daily care. Unfortunately, as this is often not possible, professional staff must take special pains to address and to compensate for the effects of medical treatment.

One avenue of support for the development of hospitalized young children is through coordinated interdisciplinary care. "Interdisciplinary" is a hospital catchword of the 1980s. It often seems that the more consultants involved, the more people feel that the hospital is "doing something" for a child. However, interdisciplinary care can sometimes mean too many strangers to whom the infants must adapt or respond; too many strangers giving parents information or advice, or competing for the child's attention; days organized to fit caregivers' schedules rather than the infant's rhythms and patterns; and overwhelming, ever-changing numbers of caregivers, whose

agendas may be in competition with sick infants' needs for attachments, rhythm predictability, intrinsic motivation, and emerging independence.

Genuinely interdisciplinary care should be noncompetitive with parents; should encourage parents' role as the ultimate coordinators of the team on behalf of their child; should reinforce parents' perception of their infant's areas of health as well as illness; and should also reinforce parents' perception of their own strengths. Nursing, child life and rehabilitation therapies should enhance the infant's emerging capacities for rhythmicity, attachment, pleasure, and self-motivated and successful activity, and balance predictable daily patterns with interesting novel events. Optimal interdisciplinary care should be carried out through consistent care patterns, performed by as few, rather than as many, different professionals as possible. Staff should be educated to engage in responsive, interactive social play rather than intrusive, interrupting play.

In addition, play can address emotional or developmental needs both preventively and remedially (Goldberger, 1988). Play can be used *preventively* to facilitate enjoyable parent-infant interaction, to aid parents in perceiving their infant's capabilities, to provide developmentally appropriate opportunities, and to structure time to order to both minimize stressful or fearful anticipation and provide normalizing experiences. Preventive play might include planning a child's care and medication to be grouped together to provide long, uninterrupted blocks of time for play and naptime. A three-month-old requiring arm restraints, for example, could then be supervised in a play setting without restraints and with ample opportunity for reaching and grasping; a child life specialist or nurse might facilitate hiding and finding games for a toddler prior to a parent's departure. Play can be provided *remedially* to aid in establishing predictable, enjoyable rhythmic patterns; to address problems created by the medical environment, such as passivity, incorporation of medical

equipment in body image, channelling anger and frustration; and to provide preparation and desensitization for medical and surgical experiences. A very few examples of remedial play might include directed throwing games to reduce tension in confined toddlers, doll play with medical tubing and familiar equipment specific to a child's medical experience, and use of mirrors and stroking to aid children in acquainting themselves with the parts of their body obscured by medical equipment (for example infants on respirators may not be able to see their feet, or even hands) in order to begin to reach for and explore them.

Let us now return to Shantal, Frank, Jasmine, and Sandi to see how we might be able to enhance their care.

Shantal. Our hospitals are filling with Shantals. We need to recall the insights of Spitz (1945), and of Provence and Lipton (1962), concerning the grim prognosis for infants and toddlers who receive adequate or excellent physical care in the absence of adequate emotional nurturing. Shantal needs consistent caregivers to enjoy her and to delight in her achievements. While she awaits a foster home, primary nursing and child life care can help Shantal to establish relationships and maximize her still brief periods of alert attention. Because stringent cost-containment policies have staff stretched to their limit, with too little time remaining for truly adequate attention to Shantal's social and emotional needs, a foster grandparent program could help greatly, although legal questions regarding confidentiality of patient diagnoses along with volunteers' rights to make an informed choice regarding contact with patients who test positively for AIDS antibodies complicate that solution. Policies encouraging more generous staff-to-patient ratios for children in isolation would be ideal.

Frank. A care plan that follows Frank's sleep and waking patterns would be likely to maximize his interest and performance, and to increase the mutual enjoyment and

gratification of child and staff in interaction. Several times daily, and ideally as often as his parents would like, the experience of feeding in an age-appropriate manner should be imitated as closely as possible. Even a few milliliters of Pedialyte could continue oral experience and sucking and swallowing, as could holding, cuddling and encouraging Frank to suck on a pacifier with a nipple whose shape is the same as the nipple that will be used for feeding. Again, precious staff time should ideally be used to provide such normalizing experiences in addition to essential medical care.

Jasmine. Pediatrician Arthur Parmelee (cited in Goldberger, 1987) requires that his staff interact with a hospitalized infant or toddler for at least 15 minutes; if staff can't spend that much time, they must come back when they can. Such a rule would be a creative solution to the innumerable, intrusive and overstimulating brief interactions imposed on "favorite" patients such as Jasmine. With her medical complications, Jasmine could have been identified soon after birth as at risk for extreme lack of oral experience, extreme learned passivity, daily challenges to her ability to learn to concentrate, and impoverished language opportunities. There is little we could do to prevent the consequences of repeated surgical procedures, which seem to occur just when she has become interested in or begun to master a new skill, and causing her to need to begin afresh after each surgery. We might concentrate on alternate ways of reaching beyond her immediate sphere and her motivation to be an active, problem-solving participant rather than a passive recipient of developmental stimulation. Toys with high rewards might facilitate this interest, but, again, responding contingently to her cues and behaviors would be an even more significant focus. Perhaps someone other than hospital staff might reach her parents more satisfactorily, such as a religious leader who might support their increased involvement. If not, better education and emotional support for staff might help staff channel

their anger and frustration at Jasmine's family's infrequent visits, and gain respect and understanding of their fears, inexperience, beliefs and cultural differences that are influencing their behavior.

Sandi. Even were she healthy, Sandi would probably be emotionally fragile. She is at her best when her mother is available: what can we do to maximize her mother's ability to be present? Hospital based day care for siblings? Counseling to address the family's increasing tension, which is often focused on whether or not Sandi should come home or be included in family holiday events? A parent-support network that encourages parents of children and similar handicapping conditions to encourage and learn from each other?

Sandi is beginning to enjoy social contact, particularly from a distance and if touching is not involved. At those times when Sandi is offered oral feedings, she will drink while she is being held by the few people who enjoy caring for her; she will refuse feedings, no matter how hungry she seems, when they are offered by someone who does not enjoy caring for her. It should become part of her primary nurses' and child life care plans to respect Sandi's comfort level as much as possible, and move toward her slowly. Recently she has begun to tolerate a caregiver sitting next to her without her looking away. Even though she may not look at a favored caregiver, she least may not appear pale and limp when her arms are stroked. Cute clothes may help staff feel attracted to this infant, who is minimally interested in people and who is not enjoyed by most of the hospital staff.

Not long ago, a caring therapist expressed concern that when she tried to interact with Sandi after therapy, the infant did not visually track either her or a toy nor did she turn to sound. (At that moment, in fact, Sandi was using her energy to search for her pacifier which she could not successfully maneuver to her mouth because of the IV in her arm.) It was a new idea to this very kind, very concerned therapist (and to the

student who wanted to try a black-and-white stimulation kit to improve Sandi's visual tracking) that Sandi might not be watching them because she was too tired, hungry, stressed, and probably hurting to reach beyond whatever small, but predictable, comforts she could provide herself. It was new for the therapist to think of motor skills as so closely linked with emotional response.

Now Sandi is capable of and interested in reaching and grasping toys. We must provide opportunities with adequate complexity, variety, satisfaction, and interest, along with caregiving so that she will learn to enjoy people, to be interested in the world, to concentrate, and to pursue her own goals even in the hospital environment.

Conclusion

In these days of rapidly advancing medical technology and decreasing availability of and priority to psychosocial services, it will be a challenge to match the quality of emotional care to the quality of technical care. In addition, parameters for optimally supportive care for infants and toddlers in hospitals need further definition and demonstration. Staffing and services should aim to reflect more attention to quality of life rather than short-sighted financial constraints, and those responsible for the delivery of care should strive to understand infants' priorities and make them their own.

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Mediating Successful Parenting: Guidelines for Practitioners

Serena Wieder, Ph.D.

Parents learn to be parents in many ways. Some read books, pamphlets or magazines available at every checkout counter. Others watch TV talk shows, talk to their friends or neighbors, call their mothers, or remember their own childhoods. Still others take courses and join other new parents. Hopefully, all learn from their infants as they care for them, enjoy them, and grow together.

At-risk parents are often unable to use these resources to learn. They may be distressed by overwhelming realities, overwhelming pasts, and previous failures and fears which continue to interfere with their functioning in general, and as parents in particular. Too often they do not have the chance to enjoy what other parents enjoy with their children: singing songs, dressing up, taking pictures, or playing.

Whatever the structure or goals of an intervention program, working with these parents and infants involves interacting and relating in many ways. Specific techniques are described below to mediate more successful parenting. They are derived from therapeutic and mediated learning experience models which can be integrated into common interactions and play during time spent together.

Give the concept of being a mother or father positive meaning and identity—build consciousness and awareness of being a parent. It is important not to assume that having a child means feeling like a parent.

Even if someone begins to feel like a parent, nurture this new identity with as much support as possible. This is done by admiring the parents, giving them credit for what they do, having fun together with the infant, and reassuring them the child is doing well. To do this, indirect comments are useful. For example, when seeing a baby who is dressed nicely or is attractive, one might say to the baby being held by the mother, "Mommy dressed you so beautifully today; she knows exactly what looks good on you!" Or, "You're so big, Mommy knows exactly what/how to feed you to make you grow!" Or, "Mommy knows how to dress you beautifully Suzy, you're a lucky girl!" Or, "What an athlete Daddy is making out of you." Such comments help a parent feel proud, focus on the process of what they have to do to feel competent, and lessen the risk of parental jealousy of the infant. One does not assume the parents appreciate or take pleasure in having their child admired when they are not directly credited or referred to.

Make the mother and father feel unique. To support the special attachment and investment parents need to make in their infants, reinforce the uniqueness of the parent to the child. This too can be done through a variety of comments to the parent, such as, "Mommy gets the best smiles from you; I know who is in love with you!" as the baby smiles at the parent. Similarly, when noting the baby looking at a new or strange face, say, "You sure know your mommy best of all because I can see you

staring at me and you don't know me at all!" In the course of following an infant, many opportunities arise which can highlight the parents' unique function. For example, when a baby fusses, the intervenor might say, "Mommy will know how to comfort you best of all," as you guide or support the parent's response to calm the infant. Here too is an opportunity to give the parents credit for anything they do, for the purpose of enhancing their special relationship with the child and supporting their self-esteem.

Focus on the infant's or parent's experience rather than right or wrong. It is possible to communicate to the parent that infants have feelings and experience things in different ways through straightforward comments or "talking through the baby." For example, one might say "Hold me tight; I like to be all wrapped up tightly too." Or, "Don't turn me so fast; it's scary and I'm afraid I'll fall." Noticing how the infant might be feeling is especially important for the parent who does not empathize readily, or does not think in terms of the infant's feelings, or may not be handling the baby very well and does not notice the effect she or he is having. Such comments support the parent's efforts without the practitioner's taking over or necessarily knowing what is going to work best. This approach encourages exploring different attempts to calm the baby by reading signals with the parent and relating to these signals as expressions of feelings.

Focus on issues relevant to the infant's specific stage of development. For example, when helping parents learn to read the baby's cues and signals as they begin to communicate in purposeful ways, highlight the meaning of these behaviors. For example, "You want to tell mommy something, don't you?" Or, "Figuring out what you want isn't easy at all; tell/show mommy what you want again." "Oh, look how he turns around to look at you just after he crawled away; he wants to make sure you're still there!" "Boy, you need your daddy's help, don't you,

it's hard!" Such comments accomplish multiple things. They focus on what is important for the parent to respond to at specific stages. They preempt misinterpretations of the meaning of behavior which can lead some parents to withdraw or reject or retaliate against their children if they disapprove. It is also easier for parents to learn an infant's language if they feel it is directed towards them. These comments support the attachment, identity and uniqueness of the parent.

Focus on the impact of current behavior on the future. With parents who do not relate current development to later achievement or success, or parents who have little sense or hope for the future because of being overwhelmed in the present, it is useful to create a sense of future success for the infant and the role parents can play. For example, when encouraging reading baby books, you might say, "When you grow up, you will be so smart because mommy is getting you ready already!" Or, when observing a child play with blocks, "I wonder if you will be an engineer or an architect, you build those blocks so well!" Or, "Daddy is so good with tools and you are following his footsteps already." Encouraging the ability to transcend the present is important so that parents identify infant learning with future success in school or work. But it is important to focus on the process of learning and not the product, i.e., discovering, exploring, trying new things, using toys or objects in novel ways, rather than being able to name letters, numbers and other concrete skills.

Build parental self-esteem by selecting and admiring success. Whenever a child is doing something well, it is worthwhile pointing that out and building an image of the child as a successful learner and the parent as a successful parent who can be effective and help the child learn. General admiration or clapping such as, "That's great!" or "You're so good!" is not as useful as specifying what made the act successful or what difference it makes. For example, if a toddler is stacking rings, then he might

be admired for, "you figured out which one should come first and second and third; that's good thinking!" Even if the child cannot yet understand these words, commenting guides the parent to think in terms of thinking and problem solving rather than just the end product which may or may not be well done. Focusing on the process of how or why something succeeds encourages the parent to pay attention to what to do, rather than what they will get or other

concrete results. For example, admire the parent's success in getting the child to attend, "You really got him to listen when you got him to look at you before telling him what to do." When these behaviors are noticed in the course of natural interaction they convey the idea learning is going on all the time. They also put the parent in charge and reinforce effective behaviors rather than only focusing on problems and parents' inadequacies.

The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers

Louis Torelli, M.S.

The physical environment in a group care setting affects children, caregivers, and their interaction. A well-designed environment is, of course, safe for infants and toddlers, but it also supports their emotional well being, stimulates their senses and challenges their motor skills. A well designed group care environment promotes children's individual and social development. It is comfortable and aesthetically attractive to both children and their caregivers.

A developmental environment is designed specifically to promote learning that is both age appropriate and child-directed. The setting, layout and equipment all give infants many opportunities to challenge themselves through seeing, touching, feeling and moving. In surroundings that are safe to explore freely, infants learn to map their environment cognitively, to manipulate it, and to master it.

In group care classrooms without a developmental design, one generally observes young children spending a significant amount of time in either aimless wandering or teacher-directed activities. Because making friends is a social skill that depends on experience as well as age, a group care environment that is teacher-directed can deprive infants and toddlers of opportunities to enjoy positive interaction with their peers. Consider a toddler classroom

where the teacher takes out baskets of *Duplos*, brings them to the middle of the room, and sits on the floor surrounded by ten toddlers—all shoulder to shoulder. After only a minute or so, one child grabs another's *Duplos*. While the teacher encourages this pair to "be gentle," the same battle is beginning between two other children. Then a toddler who has been racing around the classroom suddenly runs to the middle of the room and kicks the tower of another child who has been deeply involved in play.

In contrast, a developmentally designed environment offers infants and toddlers choices of activities and opportunities to break away from the larger group. A multi-level design, for example, varies the floor height with appropriately scaled platforms, lofts, "nests" and canopies. These mini learning environments set up a landscape for safe exploration in which infants can handle a toy, look at a book, stack blocks, crawl up steps, or simply watch the adults and other children from a cozy semi-enclosed "private space."

For toddlers, a developmental design would also include an area for manipulative play with *Duplos*, shape sorters, pop beads, and the like. Such an area would be enclosed by shelves, low walls, or carpeted platforms. Because this would be one of several activity areas available, toddlers could choose themselves when they wanted to engage in this kind of experience and for how long.

Mini learning areas encourage privacy and small-group interaction rather than wandering and herding. In smaller groups, young children can be intensely involved with each other. In an environment that encourages focused play in small groups, relationships among children are less aggressive and more supportive.

After her classroom was redesigned according to developmental concepts, a toddler teacher summarized the differences for children and for herself:

"You can feel the difference when you walk in the room. It's so much more comfortable! Instead of moving around aimlessly, the kids are much more focused on activities. Now they can be active in the classroom without getting into each other's space. Instead of climbing on furniture, they have a place to climb.

Having all this storage makes me a much more organized teacher. In a way I really feel spoiled. But then I think, the kids deserve this, and I deserve this.

It makes me feel so happy."

Let us consider some specific elements of a well-designed group care environment for infants and toddlers.

Layout

Create mini-learning environments by placing multi-level activity areas around the periphery of the classroom. This leaves the middle of the room open for traffic lanes and "stage set" activities such as music and movement experiences. The open central section itself can be varied by using portable equipment such as carpeted risers and bolsters.

Motor challenge

Because motor activity is critical to the overall development of infants and toddlers, the physical environment must provide safe and appropriate motor challenges. A developmentally designed environment supports ease of movement, which then encourages active exploration.

Contrast an environment that encourages climbing, crawling, running and jumping with one that does not. The need to move still exists, but the environment does not

support this need. When the setting lacks appropriate equipment, the ten-month-old still moves, but she uses the high chair to pull up to standing and then is redirected because this is not safe. The eighteen-month-old attempts to use the toy and book shelf as a climbing apparatus, but he too is redirected. The two year-old who continually gets up on the table to jump off is redirected as well. The message to these children is: "Self-initiated exploration is not acceptable."

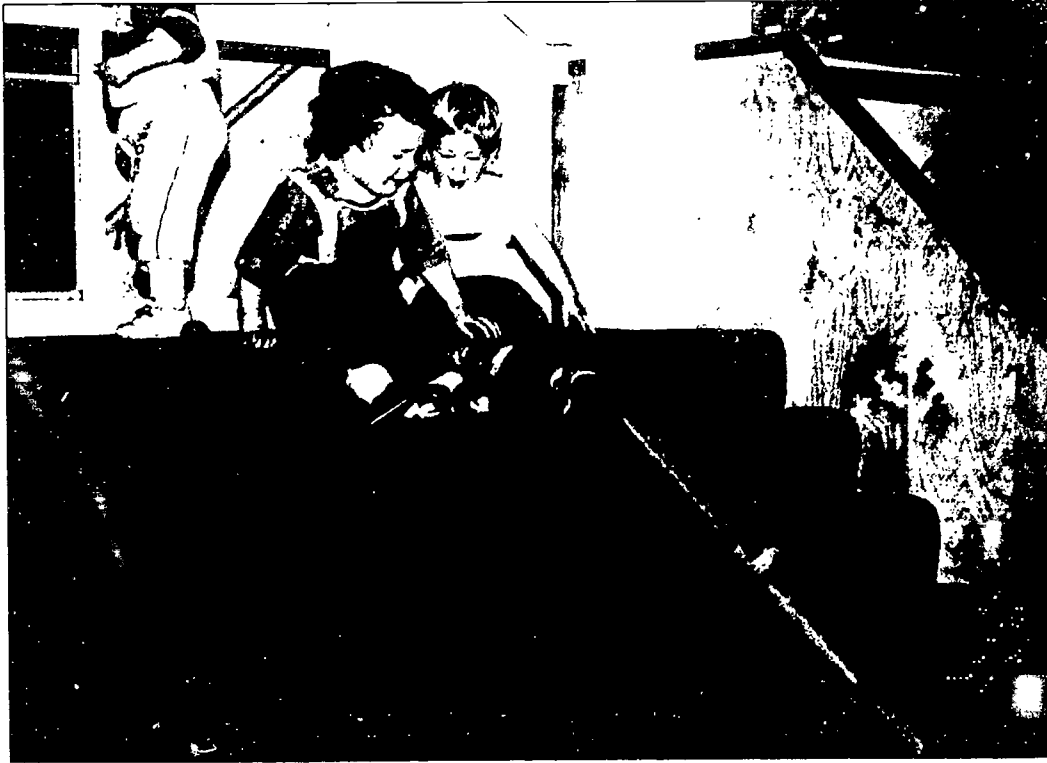
But an environment designed to meet infant and toddler needs supports and encourages active exploration. The children get the message that it is fine to explore and take risks here. Their motor exploration leads to motor competence, which then contributes to emotional well-being.

The role of equipment

Appropriate equipment is essential to meet the motor needs of infants and toddlers in group care. Equipment also affects peer relationships significantly. For example, equipment that may be ideal for individual development may be a burden in a group care environment. And since the field of group infant care is in its own infancy, choices of commercially available equipment are still limited.

Consider the infant ladder-slide found in many child care centers. Older infants and toddlers love to use it, but only one child at a time can play on it. In order for children to use this slide safely, the caregiver must police it, having children wait their turns and redirecting those who have difficulty doing so.

If the equipment were designed to allow more than one child to use it simultaneously, the situation would no longer be stressful for either children or caregiver. Toddlers could be more actively involved in motor exploration, and they would also have an opportunity for positive peer interaction. Instead of controlling and redirecting, the caregiver could be observing, learning more about the infants in her care.



Flexibility for mixed age groups

Mixed age groups present a particular challenge. The environment must support the motor interests of older infants and toddlers while providing safe, relaxed care for young infants.

Shelving, low walls, large pillows, mats, platforms and portable risers can all be used to separate different activities and thus respond flexibly to the diverse needs and interests of a mixed age group. When the whole group is in the room, the caregiver can enclose a corner with a few portable risers. Younger infants will be safe in this protected space with a caregiver, while the older infants and toddlers move freely around the classroom. When half the group is outdoors or several infants are napping, the caregiver can redesign the space to allow for more open play and movement.

Using storage for flexibility

Every activity area in the classroom—for eating, manipulative, art, books, blocks, etc.—should have its own storage space. To reserve as much space as possible for

children's use, locate storage space on the walls, at a height of 48 inches or more.

Infant/toddler caregivers inevitably spend much of their time changing diapers. Well-designed storage in diaper changing areas can leave the caregiver available to engage in responsive interaction with the child during diaper changing.

Mental health

A developmentally appropriate space is designed to be emotionally supportive for both children and adults. The setting encourages relaxation. It invites one to spend time.

Track lighting, carpeting, pillows, textured wall hangings, plants and animals can all contribute to a comfortable environment. Photographs of children and family members; wide, full-length plexiglass mirrors; and hammocks for rocking infants all offer emotional support. (Hammocks work better than rocking chairs because they allow the caregiver to rock more than one infant at a time if necessary. Rocking chairs can seriously hurt an infant who crawls behind one in motion; they also take up floor space,

while hammocks can be taken off their hooks and stored when not in use.)

Windows—especially those that open and look out to trees, grass, and passersby—contribute to a relaxed setting. Because older infants and toddlers love to watch others, child-level windows that look into another classroom can function as an additional learning center.

Privacy

Being alone provides time essential for reflection and growth. Although most adults recognize the need for privacy, we often expect infants and toddlers to function well in group care situations for upwards of ten hours a day, five days a week. Private spaces in the group care environment support the development of the young child's self-concept and personal identity. They assist all ages in understanding the "I" in relation to the "thou."

A private space could be a tunnel, a carpeted built-in cabinet with the doors removed, a cozy loft space, or a few risers enclosing a small corner of the room. Instead of experiencing the stress of being in a large group all day, the infant can withdraw to a private space to rest, observe, and recharge emotionally. With access to a private space, two toddlers who are just beginning to develop a relationship can go off together. Opportunities for privacy not only support the infants' developing sense of self; they also reduce aggression among children.

The people in the environment

While a developmentally designed environment adds significantly to the quality of group care for infants and toddlers, other

components of care are equally critical. While considerable attention has been paid to adult/child ratios, caregiver training and parent involvement, group size has still not been recognized uniformly as a key variable in quality care. A decade ago the National Day Care Study (Ruopp, 1979) found that too many children and adults grouped in one space affected relationships adversely. When more than seven infants or eleven two-year-olds were cared for in a group—even with one adult for three infants and one adult for four two-year-olds—observers saw more crying, hostility, and apathy and less cooperation, reflection and elaborate play than in smaller groups. In large groups, the infant experiences sensory overload and has a harder time forming a close relationship with a specific caregiver; forming a group identity is difficult.

Conclusion

A developmentally designed environment offers infants and toddlers opportunities to explore, make choices, and master their world. It offers caregivers a chance to be observers, facilitators and supporters of all aspects of development in the early years. A well-designed child care environment not only reassures families but invites them. When an environment is designed to be functional, attractive and developmentally supportive, everyone feels well cared for.

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Zero to Three: A Topical Index for Volumes I through XII

This index groups by topic the articles and reviews of publications that appeared in *Zero to Three* from September, 1980 through June, 1992. When an item is listed as "review of," this means that a brief summary of the publication appears in the issue of *Zero to Three* indicated.

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