

INFANCY

Introduction

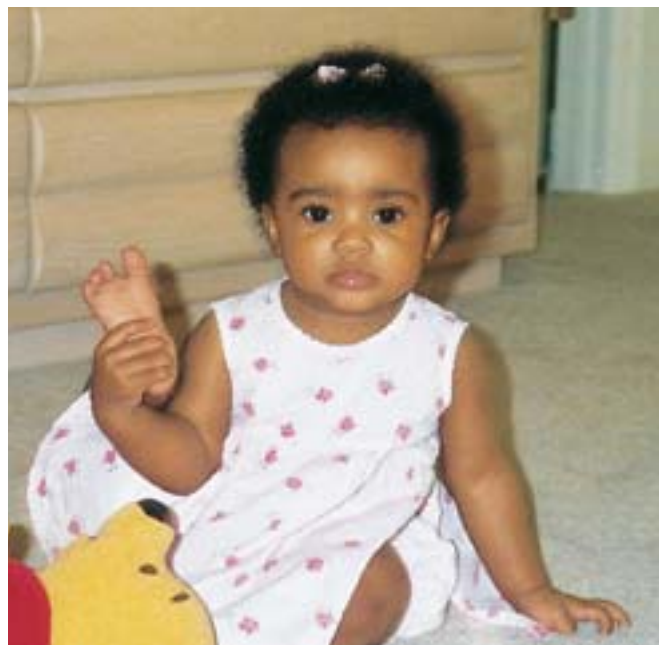
The infant's relationship to his parents, as well as the infant's early experiences, provides the foundation for future growth and development. An infant's mental health is affected by his physical health, temperament, and resiliency and by the love and support he receives from his parents and other caregivers. When an infant's basic needs are met, he becomes increasingly able to respond to and benefit from the stimulation around him. The quality of an infant's experience, as reflected by attachment, affection, health, temperament, resiliency, and the mental health of the infant's parents, forms the roots of future emotional well-being and self-esteem. In just a short time, the infant develops as an individual, begins the process of self-regulation, forms attachments to his family, and makes great strides in cognitive development.

The first year of life presents a wonderful opportunity for the primary care health professional to build a strong and trusting relationship with the infant and the family. A health professional who works closely with the infant and family can establish a foundation for supporting healthy family behaviors and interactions and promoting mental health. Anticipatory guidance targeted to the needs of the infant and family and a relationship of trust are the building blocks of a long-term collaboration that promotes infant and family mental health.

A working partnership between the primary care health professional and the family can help parents recognize and build on their infant's

strengths as well as deal effectively with high-stress situations the family may face. It can also help parents anticipate the changing developmental needs of their infant and grow in their parenting role.

During the infant's first year, the primary care health professional can gain awareness of parents' hopes for and perceptions of their infant. By listening carefully, the health professional can identify stressors from parents' pasts as well as current stressors that affect their parenting; understand the impact of the infant on the family's interactions and daily activities; help parents appreciate and capitalize on the strengths of the infant, family, and community; and identify concerns that need intervention. By adopting an empathetic, nonjudgmental posture, the primary care health professional can build a relationship that will promote mental health for years to come.



SELF

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to self in infancy:

Throughout Infancy

- How is Carlotta doing?
- What do you enjoy most about her?
- How would you describe her personality?
- How easy is she to console?
- Has she been fussy? What seems to calm her?
- Can you tell when Jamil wants to eat? Go to sleep?

- Is it easy or hard to find out what he wants?
- What new things is he doing?

9–12 Months

- How does it feel to have Jamil becoming more independent?
- What have his other caregivers noticed about him?

SELF: TEMPERAMENT

Each infant has a characteristic style, or temperament, of activity, mood, and reaction. These genetically derived characteristics evolve and develop over time, and they often underlie interactions and behavior. It is important, therefore, for primary care health professionals and families to understand the unique temperament of each infant.

The Emerging Self: Individual Differences We Call Temperament

During infancy, parents begin to recognize the unique temperament of their infant. Even though an infant cannot verbalize preferences, temperament can be assessed through observation. An infant's activity level, mood, adaptability, distractibility, initial reactions, intensity of reaction,

persistence and attention span, rhythmicity (regularity), and sensitivity are indicators of his temperament (Chess and Thomas, 1996). Being aware of their infant's unique temperament can help parents respond to him effectively.

Tips

- Help parents describe their infant's temperament with questions such as these: "What is Tanisha like? How calm/intense/active is she? How does she respond to changes in routine? How does she deal with a lot of stimulation?" If the infant's temperament is an area of particular concern, consider further assessment by using a temperament questionnaire such as the Revised Infant Temperament Questionnaire (Carey and McDevitt, 1978).
- Discuss the infant's overall mood and behavior. If the parents describe emotions or motivations

that are more appropriately attributed to an older child or an adult, explore further. For example, you might ask, “What makes you think Monica is knocking over the blocks to make you mad?”

- Ask parents, “Does your infant remind you of anyone in your family? If so, whom?” Parents often respond to their infant based on memories of their experiences with others. If the associations parents make appear to be negative, help parents see their infant as a unique individual.

The Uniqueness of the Infant

How long will the infant wait for a feeding before becoming upset? How does the infant respond to changes in household routines? Is the infant upset by bright lights or loud noises? Answers to these questions will gradually reveal the picture of the infant’s temperament. Infants who are very sensitive to their environment can quickly become overloaded, resulting in irritability, negative mood, and parental self-doubt.

Tips

- Praise parents for recognizing and responding to their infant’s temperament.
- Ask parents to note their infant’s reactions to objects he sees, to sound, and to touch (e.g., Does he startle easily or respond calmly?).
- Help parents learn how to protect the infant who is highly sensitive. Recommend that they keep the environment calm (e.g., keeping lights dim and noise levels

low) and limit the number of people who handle the infant.

- Help parents understand that an infant who seems irritable may simply be more sensitive to his environment. Suggest that they slow down his routines, giving him more time to adjust to transitions in activities. Discuss soothing techniques they can use to calm their infant.
- Encourage parents to share their understanding of their infant’s temperament with the infant’s other caregivers.
- Tell parents never to shake, hit, or slap their infant. Emphasize that shaking an infant can lead to blindness or other eye damage, brain damage, seizures, spinal cord damage, or death.



Area of Concern: Infants with Special Health Care Needs

Infants with special health care needs (e.g., premature infants, infants with cognitive disabilities or developmental delays) may not initially express their preferences and sensitivities as clearly as other infants. These infants may exhibit varying levels of responsiveness and less overall predictability. Help parents recognize their infant's subtle signals and find ways to soothe their infant, such as making the infant's fingers accessible for sucking, speaking softly, touching the infant repeatedly, and rocking. Help parents identify signs of stress (e.g., change in skin color or tone, hiccups) and signs of social availability (e.g., an engaging facial expression, extended arms and legs, claspings of the hands). Help parents understand that they will not always be able to console their infant. Help them develop a game plan for dealing with their frustration (e.g., seeking support and respite from family members and friends).

Temperament: “Goodness of Fit” Between Parents and Child

The “fit” between parents' sensitivity, responsiveness, mood, and expectations and their infant's temperament can provide insight into parent-infant interaction. Parents' expectations and personality traits may influence how they respond to their infant. How parents respond will affect their infant's self-esteem and adjustment. (See Tool for Health Professionals: Age-Specific Observations of the Parent–Child Interaction, *Mental Health Tool Kit*, p. 24. See Family, p. 28.) A poor fit requires continued monitoring. If the poor fit is persistent, referral for comprehensive evaluation by a mental health professional is warranted.

Tips

- Ask parents about the fit between their infant's temperament and their own personality traits, parenting styles, and expectations of him. If the infant's temperament is an area of particular concern, consider further assessment by using a temperament questionnaire such as the Revised Infant Temperament Questionnaire (Carey and McDevitt, 1978).
- Help parents find ways to deal with challenging areas of their infant's temperament (e.g., his response to change, intensity of responses, activity level, mood).
- Explore opportunities for shared fun, emphasizing that such activities can strengthen the connection between parents and their infant. Suggest activities such as singing to, reading to, and cuddling the infant.
- Discuss child maltreatment with parents and how to avoid it. (See bridge topic: Child Maltreatment, p. 213. See Tool for Families: Handling Anger and Countering Abuse in the Community, *Mental Health Tool Kit*, p. 141.)

Sibling Differences

Often children in the same family are quite different in temperament. Children with easygoing temperaments may be more resilient and/or less influenced by stress, whereas children with difficult temperaments may need more structure. Parents may need assistance in adapting their parenting styles and expectations to each child.



giving, feeding, and creating a soothing environment that allows for periods of rest and sleep as well as for periods of stimulation.

Feeding

Feeding time is a wonderful opportunity for parent-infant interaction. It is a special time for parents and their infant to feel close to each other and to establish a positive relationship. (See Table 3: Feeding in the First Year.)

Tips

- Encourage breastfeeding. Discuss the many benefits of breastfeeding for mother and infant and how mother and infant work together while breastfeeding, physiologically and behaviorally. Talk about how the mother can continue breastfeeding after returning to work. However, do not make the mother feel guilty if she is unable or chooses not to breastfeed. If the mother is having difficulty with breastfeeding, provide information on support groups (e.g., La Leche League) or refer her to a lactation consultant. (See Area of Concern: Feeding Difficulties, p. 23.)
- In the first 6 months, encourage parents to hold their infant during feedings to provide him with the physical contact he needs to feel secure. Exposure to a mother's or father's heartbeat and breathing may help regulate the infant's sucking, swallowing, and breathing rhythms. Ask parents whether they feel comfortable holding their infant for feedings. Help parents find comfortable ways to hold the infant. Tell parents never to prop the bottle during feedings.

Tips

- Ask parents how the infant is similar to or different from their older children.
- Help parents identify how their children differ in the degree of structure, supervision, and support they require.
- Encourage families to plan activities that accommodate the temperament differences among family members.

SELF: REGULATION

In utero the fetus is affected by maternal temperature variations, activity patterns, hormonal variations, and sleep and eating patterns. This maternal environment is primary in regulating the infant biologically and behaviorally before birth. After birth the infant begins to regulate her own basic biological and behavioral rhythms, still using environmental cues. Parents provide support for their infant's developing regulation through care-

Table 3. Feeding in the First Year

Birth–3 Months

Feeding times may be unpredictable.

Breastfed infants will eat more frequently, typically 8–12 times in 24 hours.

Bottle fed infants will eat as many as 6–8 times in 24 hours.

Feedings should coincide with the infant’s hunger cues, which include the following:

- Increased body activity
- Nonnutritive sucking
- Hands circling mouth or stomach area
- Waking and eventually crying

3–6 Months

Breastfed infants may continue to need several night feedings.

Bottle fed infants will begin sleeping through the night.

6–12 Months

As solid foods are added, encourage parents to introduce self-feeding with safe foods.

Instruct parents to introduce one new food at a time during the feeding time when the infant tends to be the most settled and to wait 1 week before offering each new food.

Source: Barnard, 1999.

- Encourage parents to capture their infant’s gaze while feeding him and to imitate his sounds and movements. As the infant grows and becomes more independent with feedings, encourage parents to continue to focus on the opportunities for interaction and companionship that occur while their infant is eating.
- Suggest that parents keep their infant’s feeding and sleep schedule somewhat regular to help the infant anticipate the day’s occurrences and promote a feeling of security. Routines are most important for infants who have difficulty dealing with change. Help parents understand, however, that unwavering, rigid feeding schedules should be avoided.

Although regular feedings help organize internal regulation, infants should be able to deal with variations in feeding schedules without major upset.

- Encourage parents to respect their infant’s ability to regulate hunger and not to force her to finish a feeding if she signals that she is full (e.g., she straightens her arms and makes no more sucking movements when off the nipple; she falls asleep in the parent’s arms).
- Help parents understand that feeding times help organize their infant’s sleep patterns.
- Recommend that parents try to maintain a regular feeding schedule when the infant has a minor

illness, such as an upper respiratory condition, to help keep the infant's biological rhythms intact. Reassure parents that an infant who is congested or ill may take longer to feed or be less hungry than usual.

- Encourage parents to determine an infant's reason for crying. Although the natural tendency is to feed a crying infant, the infant may be crying for other reasons. (See Tool for Families: How to Soothe a Crying Baby, *Mental Health Tool Kit*, p. 68.)



Area of Concern: Feeding Difficulties

Infants who do not make appropriate weight gains or have fewer than four to six feedings per day during the first 6 months should be assessed for physiological and behavioral difficulties.

Feeding difficulties, such as parents' discomfort with feeding and scheduling, may be a contributing factor. Parents and/or infants who do not find feeding time satisfying should be evaluated by observing a feeding, focusing on the parent-child interaction. Feeding difficulties may signify problems in parent-child relationships; therefore, feeding problems should be carefully monitored. If parents are not comfortable holding their infant, suggest alternative positions that may be more comfortable. Discuss feedings to determine whether they are too infrequent or whether the schedule is excessively rigid. Too few

feedings per day should be investigated further. (See bridge topic: Child Maltreatment, p. 213.) Local health department public health nurses and dietitians, La Leche League, WIC, and local hospital lactation consultants are possible resources for parents.

Sleep/Wake Behavior

In the first 3 months, infants sleep an average of 13–14 hours and have about five or six sleep periods in a 24-hour period. By 3 months, some infants can sleep for 8 hours at a time, while others, particularly breastfed infants, may wake up for several night feedings. The majority of an infant's sleep occurs at night. Infants begin to develop self-soothing techniques that allow them to fall asleep on their own. Discussion of concerns around an

infant’s sleep is often the primary care health professional’s first opportunity to demonstrate non-judgmental support of parents, which will encourage future openness and honesty. (See Table 4: Sleep in the First Year. See Tool for Families: Fostering Comfortable Sleep Patterns in Infancy, *Mental Health Tool Kit*, p. 70.)

Tips

- Explain to parents that infants may use self-soothing behaviors (e.g., sucking a finger or pacifier, body rocking, and using a comfort object

such as a soft toy or cloth) to help them fall asleep.

- Tell parents to place infants on their backs for sleeping to reduce the chance of sudden infant death syndrome (SIDS).
- Ask parents about sleeping arrangements. Ask whether parents are co-sleeping with their infant, and if so, discuss it. Offer guidance concerning safety. Discuss the physical circumstances in which the infant and parents co-sleep, and identify hazards, including loose bedding, overlying, the risk of falls, parental smoking in bed, and

Table 4. Sleep in the First Year

Birth–3 Months
<p>The sleep patterns of rapid eye movement (REM) and non-rapid eye movement (NREM) sleep, also called active and quiet sleep, can be demonstrated to the parent during the office visit.</p> <ul style="list-style-type: none"> • During REM (active) sleep, the infant has considerable body activity, visible eye movements under closed eyelids, irregular respiration, and sucking movements. • During NREM (quiet) sleep, the infant has almost no body activity, no eye movement, regular respiration, and no sucking movements. • Drowsy behavior is also easy to spot, because it appears similar in infants as in adults and is characterized by eyes opening and closing and random body movements, with occasional yawning. <p>There should be about five sleep periods per 24 hours and a total of 10–16 hours of sleep, with an average of 13–14. Out of the daily 13–14 hours of sleep, 8–10 hours should be at night.</p> <p>If the family has irregular schedules, the infant’s sleep patterns will be affected. Work toward a healthy solution for everyone.</p> <p>Remind parents that even adults need 8–9 hours of total sleep per day to keep healthy; help parents figure out how to get enough sleep.</p>
3–6 Months
<p>Infants sleep approximately 14 hours per 24-hour period, with more sleep at night and 2–3 naps per day.</p>
6–12 Months
<p>Infants sleep an average of 12–14 hours per day. They sleep more at night than during the day.</p>

Source: Barnard, 1999.

spaces where an infant might become entrapped and suffocate (infants should never sleep in a water bed). Explain that parental alcohol or drug use increases the risk of harm to the infant while co-sleeping.

- Explain to parents that it is generally inadvisable to wake their infant for feeding during non-rapid eye movement (NREM) (quiet) sleep. (See Table 4: Sleep in the First Year.) Waking the infant during NREM sleep may be almost impossible, and the infant will not feed well when awakened from this sleep state.
- Recommend that parents discuss with other caregivers their infant's patterns of activity and ways to maintain consistent routines.

Area of Concern: Sleep

Many new parents express concerns about their infant's sleep patterns. Parents may worry that their infant sleeps too little or too much, or may be frustrated by difficulties in getting the infant to fall asleep or stay asleep throughout the night.

Educating parents about the variations in sleep patterns during infancy can allay many initial concerns. For infants who present with persistent deregulation of sleep, assess the details of bedtime routines and help parents develop consistent routines as well as ways to encourage the infant to use self-soothing techniques (e.g., giving the infant a pacifier). Recommend resources such as *Solve Your Child's Sleep Problems* (Ferber, 1985), *Infants and Mothers: Differences in Development* (Brazelton, 1983), and *Guide to Your Child's Sleep: Birth Through Adolescence* (Cohen, 2000). If problems persist, consider referral to a developmental or sleep center.

Regulating Emotions

Around 6 months, as the brain develops the capacity to recognize and respond to specific emotional expressions of parents and others, infants begin to express emotions. The basic emotional states of the infant are contentment and distress. Parents who successfully help their infant out of distressed states communicate concern, affection, and effectiveness.

Tips

- Encourage parents to enjoy their infant's social responsiveness. Most infants are very emotionally responsive during early infancy, and their most predominant mood is contentment.
- Point out the emotional connections the infant is making, as evidenced by frequent eye contact, joyful cooing, and smiling.
- Encourage parents to respond to social overtures initiated by their infant. Explain that an infant's ability to sustain attention is supported by parental responsiveness, both physical and verbal.
- Suggest that parents play social games such as peek-a-boo with their infant. Explain that the infant will notice and be delighted when parents imitate her sounds and movements, which will result in vigorous and joyous interaction.
- Discuss the infant's crying in a developmental context. Crying is how the infant communicates distress. Parental responsiveness to identifying and eliminating the source of distress will help increase the infant's sense of security. (See Tool for Families: How to Soothe a Crying Baby, *Mental Health Tool Kit*, p. 68.)

- Reassure parents that infants with colic may be inconsolable for hours at a time, despite the parents' best efforts. Assist parents in thinking of ways to find others who can help care for the infant with colic so that the parents can rest.

Responding to Infant Distress: 0–9 Months

As infants grow, they become clearer about expressing their needs and, if they have been nurtured, also develop an increasing capacity to soothe themselves. In early infancy (0–9 months), infants communicate distress both through body language and vocally (e.g., crying).

Tips

- Discuss behavioral and vocal distress cues. Describe common behavioral cues (e.g., looking away, making diffuse body movements, frowning, pouting). The most common vocal cue is crying. Model recognition and responsiveness to vocal and behavioral distress cues so that parents will know what to do when their infant is in distress.
- Help parents recognize the difference between mild protest crying and distressed crying. Emphasize that if the infant is distressed, he needs to be comforted by a parent or other caregiver.
- Encourage parents to assist with their infant's regulation when the infant is fussy by maintaining close physical contact with the infant (e.g., carrying the infant in a body infant carrier). The parent's heart rate, respiration, and temperature can help regulate the infant's rhythms.
- Point out that it is beneficial and a healthy sign of development for infants to calm themselves by sucking their fingers and hands, rocking their bodies, or holding a comfort object (e.g., a blanket, a toy, an item of parent's clothing).
- Encourage parents to respond promptly to their infant's distress cues, which will show their infant that help is available and that he is worthy of attention. (See Tool for Families: How to Soothe a Crying Baby, *Mental Health Tool Kit*, p. 68.)
- Emphasize to parents that infants who are responded to consistently when upset are more easily soothed. Explain that their infant will eventually demonstrate less distress and will not be spoiled by receiving attention for his distress.
- Reassure parents that it is normal to feel frustrated, angry, and/or incompetent when they cannot soothe their infant. Discuss ways of managing such feelings.



Responding to Infant Distress: 9–12 Months

By 9 months, infants are more anxious about strangers and new situations and require increased soothing during times of transition.

Tips

- Help parents understand that infants become more discriminating about relationships as they develop. Infants, especially when tired, usually want their parents, whom they have learned to depend on for soothing and for making their world secure.
- Encourage parents to provide physical, visual, and verbal reassurance to their infant in new situations. Discuss how their staying close to the infant during the physical examination helps the infant feel secure despite the new situation. Encourage parents to spend a few minutes with the infant before leaving her with someone else in a new situation.
- Provide guidance to parents about expecting distress if the infant's routines are changed (e.g., as a result of moving, parents' returning to work, or changes in household routines or people living in the household).
- Explain that although some infants can move from a distressed state to a more relaxed state on their own, most need help from parents or other caregivers.



FAMILY

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to family in infancy:

Prenatal

- How has your pregnancy progressed? Was this a planned pregnancy?
- How do you feel about being pregnant?
- Have you had any physical or emotional problems during your pregnancy?
- Have you had any problems in previous pregnancies?
- How are preparations for your baby going?
- Who will help when you come home with your baby?
- Do you have other children? How do they feel about the fact that a new baby is coming?
- Many expectant parents have concerns about the baby or themselves. Do you have any concerns?
- Is this a good time for you to be pregnant?
How does your family feel about it?
- How do you think your baby will change your lives?
- How were things for you when you were growing up?
- Do you plan to raise your baby the way you were raised or somewhat differently? What would you change?
- Are you concerned about being able to afford food or supplies for your baby?

If the question can be asked confidentially:

- Does your partner ever threaten, harm, or hurt you?

Infancy

- What do you enjoy most about Bruce?
- Who helps you with Sara?
- Are you getting enough rest? Have you been feeling tired or blue?
- How are your other children doing? Are you able to spend time with each of them individually?
- Have there been any major changes, stresses, crises, or illnesses in your family since you had the baby?
- Have you been able to find time for some of the activities and people that were important to you before your baby's birth?
- Who takes care of Sara when you go out?
- Are you able to spend time with your partner?
- How are you balancing your roles of partner and parent?
- What do you do when problems really get to you? To whom do you turn at times like that?
- Is transportation a problem for you? Do you have enough money for food?

FAMILY: ATTACHMENT

The development of a secure attachment to parents is a significant milestone in the infant’s social and emotional development. Attachment develops over the first several months, becoming firmly established by 9 months. The establishment of a secure, loving relationship with parents is a major contributor to self-esteem and is later associated with positive peer relationships, the ability to be flexible in problem solving, and improved self-control.

Fostering Attachment Between Parents and the Infant

One of the goals of health supervision in infancy is fostering the growing attachment between parents and infants in a safe, nurturing setting.

Tips

- Help foster parents’ development of nurturing behaviors and understanding of infant cues while the infant is in the hospital by encouraging early parental contact and rooming in, helping parents read infant cues (see Table 5: Helping Parents Read Infants’ Cues), and ensuring that parents are comfortable with feeding.
- Inform parents that infants recognize voices and enjoy looking at faces.
- Help parents find ways to soothe their infant (e.g., wrapping the infant so that his fingers are accessible for sucking, speaking in a soft voice, repeatedly touching or rocking the infant). Advocate use of soft infant carriers to maximize physical contact with the infant.

Table 5. Helping Parents Read Infants’ Cues

Engaging cues: Infant turns toward parent, reaches up, opens eyes
Disengaging cues: Infant turns head away, begins to hiccup or drool, falls asleep (signals need for less stimulation)
Hungry cues: Infant fusses, places fists in mouth, makes sucking noises, turns to parent with flexed posture
Full cues: Infant falls asleep while feeding, sucks less vigorously, relaxes and extends arms and legs
<i>These observations are especially helpful with premature infants or infants with disabilities, who may be less clear in the cues they give.</i>

- Help parents as they go home with their infant by ascertaining whether basic food, shelter, and safety needs are met as well as encouraging them to enlist the help of family, friends, and health professionals as needed.
- Help mothers anticipate periods of feeling tired, “blue,” or emotionally reactive during the first week after delivery. If these feelings persist, refer mothers as indicated to a mental health professional. (See bridge topic: Parental Depression, Special Topic: Postpartum Mood Disorders, p. 308.)
- Encourage parents to rest when their infant is resting.
- Facilitate a smooth transition between obstetric care and infant health care. Discuss with parents when and how the health care team will follow up with the family (e.g., home visit by nurse,

return visit to obstetrician/midwife, visit with the infant’s primary care health professional). Ensure that notes from the obstetrician and hospital have been sent to the primary care health professional’s office to facilitate continuity of care.

Promoting Attachment

Sensitive and responsive caregiving are key factors that affect the development of attachment. By helping parents identify the infant’s cues, primary care health professionals can help parents understand and respond to their infant’s behavior, which can promote attachment. (See Tool for Health Professionals: Age-Specific Observations of the Parent-Child Interaction, *Mental Health Tool Kit*, p. 24.)

Tips

- Foster attachment between parents and their infant by recommending breastfeeding (or holding the infant when bottle feeding), making eye-to-eye contact with the infant, holding and touching the infant frequently, playing with the infant, and being consistent and predictable in responding to the infant.
- Help parents recognize their role in promoting secure attachment. Help them understand the messages they give their infant through their facial expressions and responses to the infant’s behavior. Try to understand parents’ feelings behind these messages, espe-

cially ones that relate to difficult memories or sad feelings.

- Point out the infant’s social milestones to parents to help them appreciate their infant’s growing attachment to them. (See Table 6: Social Milestones.)
- Discuss with parents ways to facilitate the achievement of social milestones. For instance, parents can show approval when their 5-month-old looks at a stranger and then back at them or can prepare their 9-month-old for separation rather than increase his anxiety by leaving without notice.
- Encourage the use of transitional (or comfort) objects (e.g., teddy bears, blankets). These objects can help the infant cope with being away from parents while still maintaining an attachment to them.



Table 6. Social Milestones

Newborn: Scans the parent's face, increasingly sustains eye contact
6 weeks: Begins to smile and coo responsively
4 months: Learns about others/begins to become aware of strangers
7 months: Exhibits growing awareness of strangers (stranger anxiety)
9 months: Remembers when parent is absent, experiences separation anxiety, turns to parent after exploring or when in distress

Attachment Is a Dynamic Process

Infants who develop a secure or insecure attachment to one or both parents are not necessarily destined to continue these forms of relating. By providing anticipatory guidance, primary care health professionals can promote the development of a secure parent-child relationship and institute nurturing responses when there are signs of an insecure attachment. (See Tool for Health Professionals: Age-Specific Observations of the Parent-Child Interaction, *Mental Health Tool Kit*, p. 24.)



Tips

- Help parents understand their infant's behavior and how their actions and reactions affect her behavior and attachment. The cycle of distress at parent-infant separation is an example of the dynamic nature of attachment. Infant distress at separation occurs as the infant becomes increasingly attached to parents (a healthy social milestone). Some parents, however, find this distress at separation very painful, and they convey their discomfort to their infant. Discussing with parents the developmental changes influencing their infant's behavior can help them develop new ways of responding.

- Address factors that may be contributing to attachment difficulties. (See Area of Concern: Insecure Attachment.)
- Promote attachment between infants with special health care needs and parents.
 - For infants with sensory difficulties or medical illnesses, help parents recognize their infant’s threshold for stimulation and signs of distress. Suggest additional methods of interacting (e.g., movement, touch). Consider referral to other pediatric specialists (e.g., occupational therapist, developmental-behavioral pediatrician) if indicated to address sensory or regulatory sensitivities.
 - For parents with premature infants, offer home visitation for support. Help parents understand that their premature infant may not give clear cues about her needs and may often place greater demands on them.
 - For adoptive and foster parents, point out signs of attachment as they develop, help parents understand that their infant may need to mourn the loss of previous caregivers before attachment can fully develop, and discuss when and how parents plan to talk about adoption or foster care with their child when he gets older (Forsythe and Jellinek, 1998).
 - For multiple births, suggest respite care and support for parents. Help parents recognize the individual differences in their infants.

Area of Concern: Insecure Attachment

Attachment is a dynamic process that can be affected by infant and parental factors. Infants who may have special considerations around attachment include premature infants, multiples, infants with sensory difficulties or major medical illness, abused infants, and foster and adopted infants. Parents who may face challenges include those who have cognitive or emotional difficulties (e.g., depression, substance abuse), a history of maltreatment, or current family stress. Signs of insecure attachment include

- A withdrawn infant who ignores parents or does not seek comfort from them.
- An infant who is indiscriminately affectionate with any adult, showing little preference for her parents.
- An infant who has disturbance in appetite—either overeating or undereating.
- A parent who appears withdrawn, depressed, or intrusive with a child.
- Current family stress, conflict, and/or instability.

(See Tool for Health Professionals: Age-Specific Observations of the Parent–Child Interaction, *Mental Health Tool Kit*, p. 24.)

Assess for and address factors that may be contributing to attachment difficulties. Factors related to the infant include temperament difficulties, illness, or a history of trauma or neglect. (See Self: Temperament, p. 18. See the following bridge topics: Child Maltreatment, p. 213; Mood Disorders: Depressive and Bipolar Disorders, p. 271.) Factors related to parents include mood disorders, anxiety, substance use, inexperience, family transitions, stress, or a history of maltreatment. (See the following bridge topics: Parental Depression, p. 303; Domestic Violence, p. 227.) Refer parents as indicated to a mental health professional, parent support groups, and financial and respite services.

FAMILY: FAMILY FORMATION

Preparation

In the prenatal period, the expectant mother, father, siblings, and other family members (e.g., grandparents) have expectations and express many emotions ranging from excitement and hope to anger and disappointment. The primary care health professional can offer support and get to know the family during this exciting and vulnerable time.



Tips

- Encourage discussion in the prenatal and preadoptive period among family members about their expectations surrounding the new infant to facilitate the family's emotional preparation. (See Tool for Health Professionals: Fostering Family Adjustment Prenatally, *Mental Health Tool Kit*, p. 26.)
- Suggest that parents facilitate sibling adjustment by preparing their older children during the pregnancy, paying attention to them at the homecoming (e.g., bringing them a toy), planning special time with them, and paying attention to their behavior after the infant is home. (See Tool for Families: Helping Siblings Adjust to the New Baby, *Mental Health Tool Kit*, p. 71.)
- Ask parents how their older children are adjusting to the new infant. Discuss with parents any

concerns they have about having less time available for their older children. Help parents think of ways to spend time with them individually. For example, suggest that parents take turns caring for the infant in the evenings or on weekends so that each parent can spend time alone with the older children. Encourage parents to involve older children in developmentally appropriate ways in caring for the infant.

Collaboration Between Health Professionals and Families

Health professionals working with families can demonstrate to parents their availability and ability to be supportive at each visit. A “medical home” provides primary care health professionals with the opportunity to promote family adjustment and functioning and, if necessary, to intervene early.

Tips

- Work with parents in addressing their concerns. Ask parents about their concerns and allow them time during the visit to raise questions. This approach empowers parents and is likely to increase parental self-esteem and problem-solving capacity as well as their understanding of how they and the primary care health professional can work together.
- Facilitate parents' adjustment to the developing infant by offering anticipatory guidance concerning issues during the first year and encouraging discussion of these issues. (See Table 7: Common Parental Issues in the Infant's First Year, below.) Reassure parents that you are available to discuss other issues as well.

Table 7. Common Parental Issues in the Infant's First Year

3 weeks: Parents experience exhaustion and adjustments in their relationship with each other.
6 weeks: Parents experience increased confidence in their abilities.
4 months: Parents recognize infant's increasing awareness of outside world and infant's increasing need for cognitive stimulation. Parents return to previous external relationships.
9 months: Parents experience new concerns with separation, feeding, and sleep because of increased infant mobility.
1 year: Parents reflect on expectations of becoming a parent and their reality—the "anniversary phenomenon" (Brazelton, 1992).

Postpartum Period

It is important to address the emotional changes that may occur during pregnancy and the postpartum period. Many women (70–80 percent) experience the postpartum blues (American College of Obstetricians and Gynecologists, 1999), which usually occur in the first week after delivery and are physiologically normal. In contrast, some women may have significant and persistent depression that can impair parenting and affect the infant's development. (See bridge topic: Parental Depression, Special Topic: Postpartum Mood Disorders, p. 308. See Tool for Health Professionals: Edinburgh Postnatal Depression Scale [EPDS], *Mental Health Tool Kit*, p. 59.)

Tips

- Ask mothers whether they are feeling down, emotional, or irritable. Reassure them that many mothers feel this way during the first few weeks after delivery.
- Obtain a parental/family psychiatric and substance abuse history during pregnancy. Women who are at risk for such problems should be monitored closely during pregnancy and after delivery. Although postpartum blues are self-limited and respond well to increased social support, women with histories of major mood disorders are at significant risk for having a recurrence of their illness during the postpartum period. (See bridge topic: Parental Depression, p. 303.)
- Ensure that women who are abusing alcohol or other drugs or experiencing psychiatric symptoms during pregnancy obtain comprehensive medical and psychiatric evaluations, and refer them to appropriate treatment programs.

- Obtain a history of family losses (e.g., death of a child or recent death of another close family member, miscarriages) and other losses (e.g., loss of job) because these families are at risk for social and emotional difficulties. Methods such as the genogram can be helpful for charting family history (McGoldrick et al., 1999).

Early Identification of Families at Risk

Early identification of families at risk for social and emotional difficulties enables primary care health professionals to provide services that may have the potential to prevent serious problems from developing later.

Tips

- Assess family risk factors during the prenatal period and infancy in order to provide appropriate support. Risk factors include unwanted pregnancies; premature infants; infants with disabilities or with low birthweight; teenage and unmarried mothers or those who did not complete high school; social isolation; parents with a history of substance abuse; parents with a history of mental disorders; families with a history of domestic violence; parents whose own lives have been characterized by separation, abuse, or neglect; and families living below the federal poverty level. (See Tool for Health Professionals: Pediatric Intake Form, *Mental Health Tool Kit*, p. 4. See bridge topic: Domestic Violence, p. 227.)
- Provide additional support to parents who missed the opportunity for early communication and closeness with their infant (e.g., as a result of infant hospitalization after delivery), who may be

overwhelmed by their infant’s special health care needs or prematurity, or who have an older child with special health care needs, and to parents whose parenting styles and expectations differ significantly from their infant’s temperament.

- Look for and support strengths in parents who are teenagers. Even though teenage parenthood presents increased risk to infants, there are protective factors that can serve as a buffer. (See Table 8: Protective Factors for Families with Young Parents, below.) Suggest that teenage parents enroll in a parenting course.
- If parental concerns or infant characteristics indicate risk for early relationship problems, consider referring parents to a mental health professional with expertise in infant mental health.

Table 8. Protective Factors for Families with Young Parents

Support and involvement of father; employment of father
Assistance and support from, but not necessarily co-residence with, the maternal grandmother
Positive, realistic, and mature expectations of parenting on the mother’s part
Delay of subsequent childbearing following an early birth
Maternal educational achievement
Maternal self-esteem and feelings of well-being

Source: Adapted, with permission, from Wakschlag and Hans, 2000.

COMMUNITY

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to community in infancy:

Who will help when you come home with your baby?

Will you have the opportunity to spend time with other parents and their babies?

Do you plan to return to work? To school?

What plans have you made for child care?

Are you satisfied with your child care arrangements?

COMMUNITY: STIMULATION

Research on brain development suggests that early experiences in infancy shape the architecture and function of the brain. The early experiences that appear to best support complex brain development are repetitive activities that match the infant's interests and abilities and that occur within the context of a positive emotional relationship with parents and other caregivers (e.g., parents and other caregivers playing games such as peek-a-boo or pat-a-cake with the infant and talking to the infant during everyday activities). (See the link for BrainWonders, a Web site for health professionals, parents, and other caregivers that explores neuroscience and child development, on the ZERO TO THREE Web site at www.zerotothree.org/BrainWonders.)

Stimulating Cognitive Development

Interacting with her parents and others, exploring her environment, and playing help the infant gain the sense that she is capable of making things

happen. As infants play and interact with objects, they gradually develop a critical understanding of such cognitive processes as causality, object permanence, and imitation. (See Table 9: Cognitive Development, p. 38.)

Tips

- Explain how infants develop an understanding of the classification of objects (e.g., “These balls are for throwing; these crackers are for eating”), the spatial and temporal qualities of objects (e.g., “When I throw balls off my tray, they bounce; when I throw food off my tray, it splats”), and the emotional component of learning (e.g., infants quickly learn that throwing balls is OK but that parents disapprove of throwing food). It is through the interaction with objects and parents and others that an infant comes to understand the world.
- Help parents understand how infants develop the concept of causality. Through repetition, infants learn that one action causes another. (See Causality, p. 37.)

Causality

When parents coo in response to their infant's coos, when the mobile moves every time it is batted by the infant's hand, and when the parent responds to the infant's cry for food, the infant develops an understanding of the concept of causality.

Gradually, the infant's actions become more purposeful and goal directed (e.g., "I reach in order to grasp") and the infant begins to separate means from ends (e.g., "I pull the string to grasp the pull toy; I hit the button to make the balls spin around in the top").

Infants begin to see themselves as agents of change; they become purposeful learners who experiment to make interesting things happen.

- Help parents understand how their infant develops the concept of object permanence. (See Object Permanence, below.) As infants explore objects and the relationships between themselves and objects, they learn about the permanence of objects (i.e., that objects and people continue to exist even when they are out of sight).

Object Permanence

Initially, infants believe that objects that are out of sight no longer exist.

Through repetitive experiences with objects and people, infants develop the capacity to hold images of objects hidden under blankets or cups, usually at 6–9 months.

As infants' mobility increases, they search for parents and others who have moved away from them.

As infants develop the capacity to hold an image of their parents in their minds, they exhibit increased separation anxiety (e.g., crawling frantically after a parent who momentarily leaves the room).

- Help parents understand the concept of imitation. (See Imitation, below.) Imitation happens very early as the infant adjusts his movements to mirror the subtle movements of the parent (e.g., tilting his head as the mother adjusts her own head during a face-to-face encounter).

Imitation of language sounds and patterns of shared communication leads to infants' imitation of important early words such as "no" and "bye-bye" and to an understanding of how to have a conversation.

Imitation

Piaget described imitation as pure accommodation, changing one's own behavior and mental structures to copy the behavior of another.

Imitation of the actions of others provides infants with new ideas on how to explore the environment and to act on objects (e.g., the infant learns to roll a ball back to her father by imitating his rolling of the ball to her).

Initially, imitation immediately follows the action to be copied. However, as older infants develop the ability to hold action sequences in their minds, they display delayed imitation, storing such interesting spectacles as tantrums observed on the playground, and displaying them later in the day.

Imitating the actions of others leads older infants toward greater autonomy and independence, such as with self-feeding.

Table 9. Cognitive Development

Age	Permanence	Causality	Imitation
Newborn–3 months	Believes that objects that are out of sight no longer exist	Does not understand that one action causes another; however, by observing the connections between actions and outcomes (e.g., the infant flings his or her arm uncontrollably, hits a block, and makes the block move), these connections become more apparent	Sticks out tongue in response to parents or others sticking out tongue
4–6 months	Stops feeding to look around and locate source of sounds	Focuses attention on objects and attempts to make them do something (e.g., shakes a rattle or bangs a spoon to make noise)	Imitates parents' and others' sounds
7–8 months	Uses eyes to follow an object dropped from sight (e.g., watches food dropped from high-chair tray)	Repeats actions to make events happen after discovering the action by chance (e.g., batting a crib gym to activate a spin toy)	Imitates symbolic gestures (e.g., waves good-bye)
9–11 months	Searches for a partially hidden object (e.g., looks under his or her "blankie," peeks behind a chair)	Understands that one thing causes another and tries to imitate the sequence (e.g., unsuccessfully manipulates mechanism on wind-up toy and hands toy to a parent for activation)	Imitates others' actions on objects, (e.g., pushes button on busy box, dumps toys from box)
1 year	Searches for an object after seeing it hidden (e.g., looks for a block under a blanket)	Uses a string to pull a toy	Imitates social actions (e.g., "talks" on the phone)



Stimulation Through Communication

Early sound and language games and shared communication around daily routines support development of brain synapses and lay the foundation for expressive language development.

Tips

- Observe how parents communicate with their infant; comment on parents' ability to communicate with her.
- Encourage parents to play sound games and talk with their infant even before the infant begins to verbalize. Some parents may feel that if the infant cannot speak, they do not need to speak to her. Emphasize that hearing language helps the infant organize sounds and learn to speak. Point out that infants can respond nonverbally.

- Discuss the importance of responding to an infant's early attempts to communicate (e.g., babbling). Parents' enthusiasm and responsiveness to their infant's early attempts to communicate will help the infant understand that her actions have an effect and will encourage her interest in communicating.
- Encourage parents to identify objects, narrate daily events, and label emotional states (e.g., "You are crying. Are you sad?") with infants, even those who are not yet

talking. For example, suggest that parents maintain a running commentary when changing their infant's diaper (e.g., "Let's take that wet diaper off and throw it away. Let's wash you up. Now we'll put powder on you. And here's a nice clean diaper. Now doesn't that feel better?")

- Encourage parents to interpret verbally their infant's intention (e.g., "I see you want me to pick you up"). Infants who communicate clear signals to parents develop a greater sense of efficacy. This, in turn, fosters increasing parental self-confidence, which is reflected back to the infant through appropriate interactions.
- Encourage parents to read simple books to older infants.

Area of Concern: Lack of Stimulation

Stimulation is key to infant development. Lack of stimulation can be associated with a number of factors, including extreme poverty, parents' lack of knowledge about the learning abilities of infants, parents' child-rearing and cultural beliefs, parental mental health difficulties, and infants' biological and neurological impairments. In addition, infants who have spent part of their lives in an institutional setting may experience developmental delays resulting from understimulation. Although each of these factors can be complicated, the message given to parents should be clear and uncomplicated: Infants are born with an intrinsic motivation to learn, to figure out how their world works. It is the parents' job to help their infants master their environment by taking the time to talk to them, play with them, love them, feed them, hold them, and keep them safe.

Untreated parental mental health concerns, particularly maternal depression, and environmental risk factors such as substance abuse and domestic violence, make it extremely difficult for parents to focus on an infant's need for stimulation and emotional support. For example, research on early brain development suggests that infants who are being raised by mothers who are depressed exhibit reduced left frontal brain electrical activity (Dawson et al., 1997). (See the following bridge topics: Parental Depression, p. 303; Domestic Violence, p. 227.)

The birth of an infant can offer a broad window of opportunity for primary care health professionals to provide information and support to families. Parents are often willing to make enormous life changes on behalf of their infants.

For infants whose apparent lack of interest in the world appears to be related to their biological or neurological development, it is critical to provide timely assessment and treatment through early intervention and community-based child develop-

ment programs. Primary care health professionals should refer infants and parents for early intervention services as soon as a developmental problem is suspected or identified.

Family support programs, home visits by health professionals, quality child care, and community-based programs such as Early Head Start can be important referral sources for primary care health professionals.

Stimulation Through Play

Play presents a natural window through which parents and other caregivers can provide repetitive, responsive experiences within the context of a positive emotional relationship to support cognitive and emotional development.

Tips

- Encourage parents to make their play responsive to their infant's needs and interests. Infants respond to experiences that are meaningful to them (e.g., being bounced on a parent's knee while they giggle and shriek for more, playing peek-a-boo, or enjoying a toy with a parent).
- Encourage parents to make play developmentally appropriate. (See Table 10: Stimulating Play.) Recommend that parents choose activities and toys that are developmentally appropriate. For example, after infants master dumping objects out of a container, they then revel in putting everything back in the container and starting the whole game over again.
- Encourage parents to let their infant initiate and lead play. Discuss with parents how to recognize the infant's cues indicating that he is ready to

Table 10. Stimulating Play

Age	Toy	Game	Song	Goal
Newborn	Mobile	Kissing/blowing on fingers and toes when changing diaper	Lullabies	Focusing attention and facilitating self-regulation
4 months	Crib gym, board books	Peek-a-boo (adult initiated)	Songs that involve movement, such as “Clap, Clap, Clap Your Hands”	Increasing awareness of actions of arms and legs
7 months	Dumping toys from a box, filling a box with toys, and stacking toys	Peek-a-boo (reciprocal) and pat-a-cake	Songs that involve interaction or hiding, such as “Where is Thumbkin?”	Beginning understanding of object permanence
9 months	Balls and other rolling toys	Rolling objects across floors	Songs that demonstrate causality, such as “Trot, Trot to Boston”	Beginning understanding of cause and effect (causality)
12 months	Push/pull toys	Playing chase while practicing emerging locomotion skills (e.g., “cruising,” walking)	Songs that use repetitive language, such as “Wheels on the Bus”	Developing motor skills and receptive language

play, and talk to them about how to play with their infant as he gets older.

- Encourage parents to support their infant’s drive toward exploration. Through their senses, infants interact with objects to determine what they can do (e.g., what can be rolled, chewed, or shaken).

Resource for Families

Greenspan SI, Hanna S, Wilford S. 1990. *Floor Time: Tuning in to Each Child*. New York, NY: Scholastic. Phone: (800) 325-6149. The kit contains a videocassette, a chart, a guide, and reproducible handouts.

Stimulation Through Mastery

The drive toward mastery that is evident in early childhood has its roots in early experiences as infants repeat actions over and over again to see the effect of their actions on their own bodies, on objects, and on parents and others. This initial sense of mastery, the sense of self as actor and doer, fuels the infant’s emotional as well as cognitive development.

Tips

- Help parents understand how their infant copes with and masters new experiences. For example, an infant may focus intently on the parent's face, while completely ignoring noise from the TV or a busy household. He may then avert his eyes from the parent's gaze, taking a break from the intensity of the parent-child interaction, before returning to gaze again intently at the parent.
- Help parents understand how their infant gradually starts to actively seek stimulation, first through the use of his own body, as seen with the acquisition of hand regard in early infancy, and then through the exploration of objects. This desire to explore guides the infant in the second half of the first year of life.
- Help parents see how repetition and stability help their infant master new situations. The infant may want to hear the same lullaby, play the same finger/toe games when being changed, and see the same mobile over the crib. However, the infant also needs these experiences to be interspersed with novel elements in order to thrive.
 - Infants love the “Wheels on the Bus” song because the refrain remains the same while the verses change slightly with each new element of the bus ride.
 - Infants enjoy discovering new toys that differ slightly in color, size, or texture from toys they usually play with.

Stimulating Environments

Infants are constantly processing input from their environment. Every setting infants spend time in has an impact on their development. Environments that are stimulating for infants are filled with objects to safely explore, allow freedom of movement, and provide a variety of sensory input (e.g., different colors, textures, and sounds). Spaces for infants should also include quiet areas where they can soothe themselves. (See Tool for Families: Stimulating Environments, *Mental Health Tool Kit*, p. 72.)

Tips

- Ask parents about their home environment and other places their infant spends time.
- Discuss with parents the importance of providing safe and varied sensory experiences for their infant.



- Advise parents to observe areas where the infant plays from the infant’s perspective to identify potential safety hazards or objects that should be placed out of reach. Placing objects that parents do not want touched or damaged out of their infant’s reach will reduce parents’ frustration and create a safer environment for play and exploration.
- Respect family customs and beliefs that may be reflected in the home environment.

Child Care

When looking for quality child care, parents should consider the ratio of infants to caregivers; the number of children with whom their infant will interact every day; the existence of flexible routines based on developmentally appropriate expectations for infants; the quality of the sleeping, eating, changing, and play facilities; caregivers’ knowledge about child development; the level of stimulation their infant will experience; the policy regarding infection control (e.g., hand washing, procedures for caring for sick infants); and the overall philosophy of the program. Caregivers should be responsive, aware of the cues that each infant sends, knowledgeable about child development, patient, enthusiastic, and able to set limits. (See the following Tools for Families in the *Mental Health Tool Kit: Safe, Quality Child Care*, p. 74; *Stimulating Environments*, p. 72.)

Tips

- Discuss with parents their options for child care and any concerns they have. Child care decisions can be emotional for parents, and many parents

feel guilty about leaving their infant with other caregivers. Allowing parents the opportunity to discuss child care concerns can help them make more informed decisions about how best to meet their infant’s needs.

- Note any special child care concerns parents have regarding their infant’s temperament or age. Explore options, such as the nature and duration of care, that might help parents address their concerns.
- Discuss with parents that child care can be stimulating for infants, but that it also places a burden on infants to regulate their own behavior and excitement level in a group setting. Caregivers play an important role in helping infants adjust to such an environment by being sensitive to infant cues, by being patient and understanding if infants are not immediately able to adjust their behavior, and by providing alternative settings and sufficient staffing for individualized attention as needed.
- Advise parents to obtain feedback and updates on their infant’s development on a regular basis from the infant’s child care provider. Recommend that parents find ways to facilitate communication with the child care provider (e.g., talking with staff members and caregivers when picking up the child, volunteering at the site) and to make occasional unannounced visits at various times during the day to monitor the quality of their infant’s care.
- Offer child care information to parents (e.g., information on child care resources, vouchers, and subsidies).

OFFICE PRACTICES TO PROMOTE FAMILY PARTNERSHIP

- Set up your office so that it is warm, inviting, and nurturing, with comfortable chairs, appropriate toys, and enough space. Wash and sanitize toys frequently. Post positive parenting messages in the office waiting area.
- Train staff in relating sensitively and modeling nurturing behavior.
- Greet the family warmly; make positive comments about the infant's appearance.
- Highlight parents' strengths (e.g., avoid upstaging parents by consoling a crying infant if the parents are present, support parents in nurturing their infant).
- Comment on signs of attachment (e.g., "He certainly keeps checking with you to see if it is OK for me to examine him. He must really trust you!").
- Solicit input on the family from the entire staff so that it is apparent that each member of the staff has a role in making the family comfortable and in providing effective care.
- Provide and promote open communication and information exchange with parents. Allow time for parents to raise their questions and concerns.
- Develop systems for sharing psychosocial data between the obstetrician and the primary care health professional.
- Offer anticipatory guidance that leaves parents feeling valued and empowered (e.g., use the Touchpoints model, which provides developmental guideposts for emotional and behavioral development and parent-infant interaction. (Brazelton TB. 1992. *Touchpoints: Your Child's Emotional and Behavioral Development*. Reading, MA: Perseus Books.)
- Develop collaborative working partnerships with mental health professionals (e.g., integrate mental health services into your practice; schedule onsite consultations, workshops, or groups).
- Institute programs that promote reading and the closeness it encourages between parents and their infant (e.g., Reach Out and Read¹).
- Provide pamphlets and other reading materials or consider producing an office newsletter or establishing a Web site.

¹ Reach Out and Read is a national pediatric literacy promotion program, endorsed by the American Academy of Pediatrics, that encourages primary care health professionals to offer parents advice about reading to infants and children. Primary care health professionals are trained to provide developmentally appropriate guidance to parents about books and reading aloud and are encouraged to give a developmentally appropriate book to each child at each well-child visit. In addition, primary care health professionals are encouraged to have volunteers read aloud to children in the waiting room. Assistance in starting a Reach Out and Read program is available from Reach Out and Read, 29 Mystic Avenue, Somerville, MA 02145. Phone: (617) 629-8042; Web site: <http://www.reachoutandread.org>.

COMMUNITY PRACTICES TO PROMOTE MENTAL HEALTH IN INFANCY

- Develop relationships with community agencies and organizations that support families (e.g., family resource centers, play groups, faith-based communities).
- Provide a list of community groups and developmentally appropriate activities for your geographic area. Suggest that new parents find peers at places such as local parks, community pools, and libraries.
- Put up a bulletin board where community activities for families with infants can be posted.
- Provide a list of Internet resources that could be helpful for families with infants. Internet newsgroups, for example, are very useful to families, especially those living in small towns or rural areas.
- Parents of infants with developmental disabilities or special health care needs may need help finding new parent peers. Connect them with local support groups through such organizations as March of Dimes or Easter Seals, or set up a parent group in the office to discuss special parenting issues.
- Consider offering parent groups or community seminars on particular topics. They not only offer information but also help link parents to one another.
- Support comprehensive community programs that promote the healthy social and emotional development of infants and their families (e.g., Early Head Start, high-quality home visitation).



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Community

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INFANCY CHECKLIST

The following list highlights key topics to consider in promoting infant mental health. These topics may be discussed selectively during office visits, depending on the needs of the infant and family.

Self

- Temperament, including
 - Uniqueness of the infant’s temperament
 - “Goodness-of-fit” between infant temperament and parenting style and expectations

Self: Regulation

- Feeding, including
 - Breastfeeding
 - Solid foods
 - Self-feeding
 - Feeding difficulties
- Sleep, including
 - Sleep patterns
 - Bedtime routines
- Infant distress, including
 - Body language
 - Crying

Family

- Family formation, including
 - Preparation for the new infant
 - Preparing older children for the arrival of the infant
 - Support for parents in the first year
 - Postpartum mood disorders
 - Families at risk for social-emotional difficulties
- Attachment, including
 - Reading infant cues
 - Providing nurturing responses

Community

- Stimulation, including
 - Play
 - Cognitive development
 - Stimulating environments
- Child care, including
 - Selecting a child care provider
 - Concerns about child care

Bridges

- Opportunities for early identification and intervention, including
 - Anxiety disorders
 - Child maltreatment
 - Domestic violence
 - Insecure attachment
 - Mental retardation
 - Mood disorders
 - Parental depression
 - Pervasive developmental disorders
 - Postpartum mood disorders

