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Ghosts in the Nursery Revisited

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ABSTRACT: In the last decades new research findings have illuminated many of the factors that affect the mental health development of the pre-verbal child. Attachment theory has emerged as a central concept which has great applicability to the clinical field of infant-mental health. The new knowledge base has been utilized by clinical research programs to develop new models of clinical intervention programs with infants-at-risk and their families. This article describes some of the theoretical and research findings which can be translated to, and enhance, traditional child welfare practice. The theoretical considerations are illustrated by case examples.

I. Introduction

In recent years, there has been substantial interdisciplinary research which has successfully illuminated a myriad of factors thought to affect the developmental well-being of infants and toddlers (Provence & Naylor, 1983). Slowly, an increasing consensus among researchers and thoughtful clinical practitioners is developing regarding those environmental, demographic, organic, health, and familial factors which can promote a child's developmental health.

Clinical researchers have used this new knowledge base for the development of new models of treatment to infants deemed to be "at-risk." There have been primary prevention research programs (Halpern, 1988), as well as enriched tertiary care research programs (Galenson et al., 1983). These research efforts have explored the importance and promise of early intervention in helping infants and toddlers remain on, or return to, a healthy developmental track.

The term "infant at-risk" has emerged from the theoretical and clin-

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ical research of the last decades. An infant is deemed to be "at risk" either because of his current developmental status, i.e., if there are clear signs of impairment in the health, cognitive, affective or social spheres of development, or clear indications of potential future impairment based on existent high risk factors evident in the family context or within the child.

Despite the extensiveness of the theoretical and applied research, and the findings that stress the importance of health and nurturance in the early years, there has been a significant lag between new research findings and effective translation of these findings to either broadly-based policy initiatives or significant changes in child welfare programs.

Most younger children at developmental risk who are receiving services are seen at agencies where social workers are the primary providers of care. It is critical, therefore, that social work professionals address the issue of how to implement best the insights gleaned from our expanding knowledge base. The institutions with primary front-line responsibility for care are traditional agencies such as: departments of social services, protective services, foster care placement, juvenile or probate court, community mental health and public health agencies, in addition to well baby clinics and inner-city hospitals. The children are often referred either because of special neo-natal complications, i.e., prematurity, low birthweight, or other medical conditions; or because they are already symptomatic with sleeping, feeding, affective, cognitive, or behavioral disorders (Greenspan, 1984). Further, the infants and toddlers referred to such settings are usually the children of vulnerable parents such as families in poverty; teenage, single or otherwise isolated parents, psychiatrically or medically at-risk mothers.

The complexities of these problems—often intergenerational in nature—create special treatment issues for the social worker involved. A critical need is the further development of assessment criteria that will enable the clinician to better evaluate not only the developmental well-being of an infant or toddler, but to understand the dynamic relationships between environmental and constitutional factors and the child's physical and mental health.

A further need for successful clinical intervention is the capacity to develop a working alliance with parents at a time of crisis. Recent clinical research has highlighted the importance of supporting the family, as the family is seen to be the primary mediating factor on the child's psychological health in the earliest years. In addition, a major theme of the recent years of research is the importance of the quality of the

attachment relationship in the parent-infant dyad to the developmental health status of the child.

The child welfare worker is frequently called upon to undertake an assessment which will have significant impact on the nature of the services provided to the referred child and family. This article will concentrate on the findings emerging from recent research programs that should enable social workers to strengthen the traditional assessment process. We will address both the nature of the criteria that should become part of the assessment, as well as the importance of the process of the assessment itself. The case examples emerge from one clinical research program, the Child Development Project (CDP) at The University of Michigan.* The general findings of the CDP are in line with other early intervention research programs (Greenspan, 1984; Provence & Naylor, 1983).

II. New Research Findings and the Assessment Process

A core contribution of recent research and clinical observation has been the development of baselines for the assessment of normality and pathology in infancy and childhood (Provence & Naylor, 1983; Galenson et al., 1983; Bailey, 1969; Fraiberg, 1980). Such baselines are, of course, the foundation on which a clinical assessment of an infant is based, enabling us to assess the developmental status of the child in the cognitive, affective and social spheres. Recent interdisciplinary studies have also deepened our understanding of the role of parenting and parenthood as developmental processes, and focused our attention on the quality of the dyadic relationship between caregiver and child (Galenson et al., 1983).

The traditional approach to assessment thus can now be expanded and deepened. A need exists to assess not only the child's developmental status but to also observe and assess the parent-infant relationship and understand the family context. New insights regarding parental history, psychosocial status, and health, combined with infant/parent observations enable the clinician to develop a differential diagnosis that describes the problems with dynamic understanding which effectively informs treatment planning.

Indeed, we feel that an improved approach to the assessment process

*The Child Development Project was an interdisciplinary prevention clinical research program at The University of Michigan, directed by Professor Selma Fraiberg. This infant mental health program was funded by the Grant Foundation of New York, the National Institutes of Mental Health, and by a grant from The University of Michigan Medical School for General Research Support.

is perhaps the most effective strategy available for improving services to infants and their families within a delivery system characterized by severe resource constraints. There is, in other words, great leverage in using new research findings to strengthen this aspect of service delivery.

Of the many issues raised by recent research, three are particularly of great relevance: attachment issues, the parental nurturant history, and the neonatal health history of the infant and parents—particularly mother. We begin by considering attachment issues and the assessment process.

*(A) The Attachment Relationship as a Primary Assessment Issue**

Contemporary clinical approaches to interventions with high-risk families and infants are informed by psychoanalytic, ego psychology, and object relations theory. From such theoretical models, a shared assumption has emerged which posits that normative social, cognitive, and affective development during infancy occurs most effectively in the context of a consistent and responsive caregiving relationship. The quality of the attachment relationship is evident in observation of the parent-infant dyad and can be observed over time in the infant's changing relationship to mother. For example, the baby's special smile for mother, the baby's preference for mother, the quality of the baby's reunion with mother after separation, the use of mother for calming and as a safe base, are indications of a secure attachment relationship. Ambivalent and avoidant attachment relationships are characterized by evidence of conflict, or avoidance at times of stress or reunion after separation. Furthermore, the secure attachment relationship is one of the few variables which has been isolated as a reliable predictor of continued social and mental health development (Ainsworth et al., 1978; Sroufe, 1979; Sroufe & Fleeson, 1984; Sroufe & Waters, 1977; Stern, 1985).

Although no definitive profile has been established describing all those factors which, when taken together, could be perfectly predictive of a secure attachment relationship, it has become clear that the determinants of attachment quality lie within both the parent and the infant (Benedek, 1973; Waters et al., 1980; Chess, 1983). For example, on the parents' side, the capacity to be empathic, be responsive to verbal/non-verbal cues, to have good reality testing, to be nurturant and adaptive, and to be flexible to the needs of a developing infant, seem to foster high quality attachments. On the infant's side, a healthy neonate

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has a neurophysiological readiness to elicit parental nurturant responses, as well as the capacity to self-modulate or use the parents' help to modulate some basic internal states. Also the quality of the parent-infant attachment is affected by satisfying interactions between parent and child (Sameroff, 1979; Stem, 1985). The capacity of the parent-infant dyad to form and maintain a high enough quality of attachment is thought to be fundamental to ongoing growth and development. Therefore, assessing the quality of the attachment relationship and ensuring this quality of attachment are primary goals of many early intervention programs (Ricciuti & Dorman, 1983; Fraiberg, 1980).

Each phase of development presents infants and parents with different developmental tasks. For example, some major tasks for the parents and infant in the first three months of life center on the infant's needs to reach a homeostatic state. Complex factors within the baby and mother interact so that internal states may be modulated, experiences may be organized and basic needs may be met (Greenspan & Lourie, 1981). When internal states and needs are modulated sufficiently, the developing infant can form and maintain an investment in the external world and continue to explore the environment. These conditions are necessary for the formation of human bonds and the development of competency. A major function of the attachment relationship, as it develops over time, is to ensure such modulation, exploration and investment.

This investment in and exploration of the external world "looks" different in the developing infant at varied points in development, as does its notable absence. All ego functions, e.g., the capacity for object relationships, the ability to modulate affect, and the ability to test reality, are thought to form adaptively in the context of a consistent and secure caregiving relationship.

When a supportive environment does not exist, and the attachment relationship has been disrupted for a period of time, the infant may experience severe stress and develop maladaptive coping mechanisms. Correspondingly there may be impairments in the developing sense of self. For example, Fraiberg notes early maladaptive defense mechanisms of gaze aversion, withdrawal, or aggression against self, or hyperactivity in infants and toddlers responding in a flight or fight defense paradigm, to extraordinary stress. When attachment deficits occur, the developing child is likely to have neither the internal base (good ego functioning), nor the external base (a secure attachment), from which to achieve the sufficient growth, competency or mastery

over the environment needed for the continuance and sustenance of growth and development (Sroufe, 1977).

Thus, the understanding of the quality of the attachment relationship gives us important information about the developmental status of the child as well as insight to dynamic factors that are important for treatment planning. A case example of an eight-month-old child may be helpful here.*

Eight-month-old Nina was brought to the clinic because her mother thought she might be retarded. Indeed, observations of the baby and a formal Bailey assessment indicated that she was four months behind in cognitive motor development.

We soon learned that the baby had had serious health difficulties at birth. She was born with a cleft palate and with difficulties in digesting food. Her father had himself been born with a cleft palate and blamed himself for passing on this high-risk genetic factor to his daughter. The successful reconstructive surgery had required hospitalization and separation from the mother and father. Mother had a severe depression after the birth, and father in great psychic pain was unable to look at the baby when she came home.

The baby thus had minimal face to face interaction with either mother or father and had spent much time alone in the basement so her parents would not hear her cries. At eight months her verbal communications were primitive grunts or harsh cries. Our understanding of the poverty of the attachment relationship hinted that the baby's retarded developmental status was reactive to deprived social experiences.

The dynamic factors pointed to a treatment plan of parent-infant psychotherapy with a dual focus on the parents' feelings and the meaning of the baby to them, and to the developmental needs of the baby. The treatment helped the parents mourn their loss of an expected perfect child, and begin to develop a relationship with their daughter. Within four months the baby had caught up developmentally and there was beginning evidence of appropriate and warm reciprocity.

(B) Parental Nurturant Experience

Important insights have been derived from several clinical research studies, which clearly illustrate that the parents own nurturant history as a child may be important to the understanding of impaired parent-infant relationships. In the article "Ghosts in the Nursery," an important clinical and theoretical question was raised (Fraiberg et

*This is one of the research cases at the Child Development Project.

al., 1980). Why do some parents approach their new baby with hope, joy and optimism and others with sadness, helplessness and despair? It was found through retrospective histories of both vulnerable and healthy families, that some parents repeated their own history of suffering upon their children, while others who also had suffered sought new patterns of hope with their newborn babies. It was hypothesized that those parents who as children had experienced pain, rejection and terror, and had closed off these feelings by maladaptive defenses of denial and isolation, were unable to positively respond to their needy, dependent, newborn infants. Frequently the conflicts we observed between parent and their infant resembled the parents' description of their own early childhood (Emde, 1987; Fraiberg, 1987).

For example, a parent who would not hold her baby, had herself been severely abused and was fearful of losing control with her own infant; a parent who could not feed her baby, had a history of parental neglect due to her own mother's maternal depression—she now felt her baby's cries were unwarranted whereas the caseworker saw the baby and the mother as hungry for food and love respectively; a parent who could not calm her baby and frequently ran away from home, had herself been abandoned many times by her mentally ill mother and was traumatized by her baby's cries which reevoked her own infantile terror. Each of these parents expressed feelings of helplessness and conflict around issues of dependency, nurturance and trust. The parent-infant relationship was observed to be representative of earlier unresolved conflicts (Fraiberg, 1980).

It was noted that these parents, with histories of broken and impaired attachments, who had coped as children by developing maladaptive defense mechanisms, had poor histories of object relationships not only with parents, but often with peers, teachers, intimate partners, their babies, and "helping others." What was missing was a relationship built on trust, the capacity to modulate feelings, and especially experience in using words to alleviate pain and receive relief through sharing and insight.

It was found that interventions that supported these parents, by helping them with current needs (often including concrete needs for nurturance, safety, and housing) and addressing feelings related to past pain removed the baby in the present from the conflicts of the past and enabled parents to realistically see their baby in a positive light (Greenspan, 1984; Fraiberg et al., 1980). This was prevention on at least three levels; 1) The parents improved capacity for empathy and caregiving helped the infants and toddlers get back on the developmental track, and 2) prevented subsequent difficulties with younger

siblings and the babies in the next generation, and 3) helped the parents themselves in their own development.

These studies also highlight the difficulties in developing a working alliance with vulnerable families, and the need to understand issues of negative transference and early maladaptive defense mechanisms in response to childhood pain (Shapiro, 1983). This knowledge has implications for the initial phase of treatment, and we will soon explore this more thoroughly.

(C) Neonatal Health Factors

Recent studies in neonatal medicine help explain further the dynamics affecting the quality of early parent-infant attachment. In this framework, it is posited that infants are born with a capacity and predilection for attachment to their caretakers. This attachment does not develop simply as a consequence of the mother's gratification of physical and emotional needs of the baby, although these gratifications enhance the attachment. The infant comes equipped from the first day of his life to participate in a relationship and to elicit parenting behaviors in his caregivers (Bowlby, 1969; Stern, 1985). Temperament, maternal and infant health, and neonatal circumstances are now considered important inputs to the promotion of bonding and attachment (Chess, 1983).

Infants who have a low birth weight or who are neurobiologically immature because of prematurity, are at high risk for several problems that have serious consequence for their emotional development, as well as their physical development. These babies are typically more disorganized as neonates, and have difficulty in settling into rhythmic patterns of eating, sleeping and alert wakefulness. They are more fussy and demanding, and yet less responsive to maternal comforting. There is considerable research evidence that speaks to the difficulties of nurturing a baby with neonatal complication (Galenson et al., 1983).

The mother's own health during pregnancy is seen as an important contributing factor to the health of the newborn baby, and is also related to socioeconomic class and level of education. If a woman has suffered from poor nutrition; if she has abused drugs, alcohol or tobacco; if she has been exposed to environmental toxins; if she has had an infection such as rubella or herpes; if she has had a chronic disease such as hypertension or diabetes; and if she is an adolescent or over 40-years-old—all or any of these factors put her at high risk for having a baby that is premature or having a baby who has a low birth weight for gestational age and thereby being at risk in many ways (Halpern, 1988).

Furthermore, as Theresa Benedek has written, the birth of a baby sets in motion a new phase of parental developmental growth that is effected by physiological and psychosexual developmental factors. Parenthood is a time of developmental reorganization and is usually a time where past conflicts in the parents own psychosexual history are revoked. If the baby is satisfied and satisfying, it is an opportunity for the mother (and father) to develop an added positive dimension to their sense of self. This is contingent on their self-esteem being buoyed by the successful nurturing of their baby which becomes evident through a satisfactory relationship and a healthy and happy baby. If things do not go well in this regard the parental self-esteem is decreased, increasing perhaps long standing feelings of inadequacy (Benedek, 1973). These new findings which we have reviewed are among the recently developed insights which are important to incorporate into the assessment process. We now turn directly to this task.

III. Using Research Insights to Expand the Assessment Process by Triaging Risk and Considering Realistic Treatment Needs

Intervention and treatment services to infants at-risk and their families generally take place in a variety of community-based agencies. Each particular treatment setting has its own mission, structure, resource availability and resource limitation. Some settings offer broadly-based based prevention services while others are centers of tertiary care to families with identified and urgent treatment needs. Many agencies can only give short-term services.

This paper will make the case that a broadly-based, indepth assessment is a most important component of short-term service. This assessment has a contribution to make to the family and to treatment planning apart from the availability of optimal service resources by contributing a realistic understanding of the family's context, the depths of the problems and a hierarchy of treatment needs based on judgement of risk to the infant. If services are not available that match these needs, the practitioner needs to advocate for and find alternative ways to support the family and protect the baby by clearly communicating to the family and referring agencies what the nature of the risk is, what help is needed, what is missing, and what may substitute so that the risks for the developing child may be mitigated.

The assessment process of at-risk infant and toddler cases has some unique characteristics. The social worker usually enters the case at a time of crises where time is of the essence because of the vulnerability

of infants and toddlers to their surroundings. In order to undertake a meaningful comprehensive assessment, the social worker needs to develop a working alliance with the parent, so as to gather an understanding of the child within the family context. Given the nurturant history of many of the parents, the development of a working alliance is often a difficult process. The base component of the assessment is gathered by a combination of clinical interviews, observations of the child alone and with the parent, medical records, and parental history. If possible, a formal developmental assessment is useful (Bailey, 1969). This assessment process, however, takes time and usually includes four to six visits to see the baby over time, including at least one home visit.

While there is as yet no definitive and unique assessment protocol that has emerged from the research, there are some common factors that are important components of any assessment.

1. The stability and safety of the baby's environment (available through clinical history and home observations and referral material).
2. The adequacy of the baby's medical, nutritional, and developmental status in terms of cognitive, social, and affective spheres—available from medical data and developmental tests, such as the Bailey Scale of Infant Development, and observations in naturalistic settings.
3. The quality of the parents' responsiveness to the baby's health and developmental needs (available through clinical interviews and naturalistic observations).
4. Quality of the parent-infant attachment relationship (observable in naturalistic observations or events such as feeding or playing).

An informed assessment, however, helps assess the degree of developmental risk of the child and offers a strong base upon which to develop realistic treatment plans for the welfare of the infant and is well worth the initial investment of time. The assessment summary must, in brief, include the following:

1. A differential diagnosis of the child's development status.
2. An understanding of the dynamic factors that may be effecting the child's and/or parents' problems.
3. Recommendations about various treatment modalities and their availability in the community.

4. *An assessment of what form of help the parent can best utilize and the urgency of the need for treatment or alternative care.*

It is the last point which takes into consideration multiple factors informed by the attachment insights and research.

Perhaps the most important finding of the research studies is the realization that many of the parents of the infants at-risk who need help are the very ones who are the hardest to engage in a treatment relationship.

The therapist or caseworker must establish an alliance with the parents from the start. Yet, frequently the social worker is faced with a formidable problem. How does one begin to develop a working alliance with a parent who may be wary of the process, untrusting of others, worried about being "judged," and frightened of adverse findings and potential loss.

Most of the clinical research programs have come to realize that it is the staff person who must "reach out" meaningfully to the parent, particularly to those parents who have had poor nurturant histories. These parents often do not have an "inner sense" that clinical understanding can be helpful to resolve a problem or find reasonable assistance. It is up to the caseworker to find the "words" to allow the parent(s) to join in the assessment process. It is imperative that the social worker explain the purpose and process of the work, e.g., together we can come to understand what is the matter, what may be needed, and what the assessment involves, i.e., that it will include observations and talking and gathering information, and what the possible outcome may be. Even in protective services cases, the social worker can convey the concern for protection of the child and simultaneous *concern* for the parent's wish for a healthy child. In terms of the developing working alliance, outreach, truthfulness, use of simple language, empathy for the parent's plight, and clarity are very helpful factors.

Frequently parents of at-risk infants are called "hard to reach, unmotivated or resistant." It is helpful to understand that for parents with histories of broken or impaired attachments, there will be significant issues of negative transference which will impede the working alliance. In many cases, the parents have, for understandable reasons, developed antagonistic attitude toward "helping others." Frequently in research cases, the clinician has to work through this negative transference in order to establish a beginning degree of trust and common purpose. (Fraiberg et al., 1980).

Another issue that often needs clarification is the issue of "resis-

tance." Sometimes parents seem to be unmotivated, conflicted, or resistant to outreach efforts—how do we explain this when there is so much at stake regarding their own child? Many of the research case histories show that in long-term situations of deprivation the child develops a profound sense of hopelessness about change, and copes by the use of such defenses as denial and projection, in an attempt to avoid having to deal with the painful affects of anger, hopelessness, despair, and loss. This has important implications for the social workers who need to pace the work so as to support the mother's capacity to function. The resistance needs to be addressed with gentleness and empathy, while acknowledging that there may be much pain, but that by working together the mother/father may feel better themselves and feel better with their child.

The social workers themselves often have strong counter-transference feelings which cloud or interfere with the developing relationship between therapist and patient. It is not easy to open up one's eyes to pain in a dependent infant, without feelings of one's own pain, and/or to deal with one's own anger at the parents who are not protecting their infant.

Sometimes protective action *is* needed *even during* the assessment period. It is important for the caseworker to have guidelines which help inform him/her when to report concerns of actual abuse or high-risk neglect. In particular, good reality testing and capacity to cope with strong feelings are important needs of parents of at-risk infants. Parents need to know that clinicians undertaking the assessment have their and their baby's interest at heart, but they cannot accept acting-out of parents if it seriously endangers the baby. If clinicians actually see abuse but do not deal with it, they will be seen by the parent as colluding with and accepting this behavior. Most parents are relieved by the boundaries set, and the capacity to accept this "protectiveness" speaks to a better prognosis than the continuance of dangerous or irrational parental behavior.

While it is incumbent on the therapist to address these issues, an important diagnostic issue is how the parent can respond to the social worker's efforts to establish a therapeutic relationship and engage in a meaningful working alliance. This is important because it gives some prognosis of the mother's/father's ability to use a therapeutic relationship on behalf of the child. In some cases, as we shall see, the needs are so massive that alternate solutions need to be found in order to protect the baby in the short-term.

Case Illustrations

Following are two case studies which were referred to the Child Development Project (CDP) by caseworkers in the Department of Social Services. The caseworkers were supervised by staff at the CDP. These cases illustrate how many of the new assessment issues discussed previously were addressed in the assessment process. Both assessments had a high outreach component, both families were impoverished, but the differential diagnosis indicated one of the babies (Delia) was quite healthy and close to the developmental norm, while the other baby (Sandra) was at great risk.

Delia

Delia was a four-month-old baby living with her unmarried mother and three-year-old sister. The family was impoverished and receiving AFDC aid. Delia's mother, Ms. M, was in her early twenties, obese, slow-moving, depressed, and disorganized. The child welfare worker saw the house as unkempt and uncared for, and was worried that Ms. M was unable to care for the baby, as she obviously was unable to care satisfactorily for the house or herself. A referral was made to the Child Development Project (CDP) for assessment and possible treatment.

Before the referral was mentioned to Ms. M, the child welfare worker and the CDP caseworker planned how the assessment would be presented to Ms. M. The assessment would be offered as a service that child welfare provided to parents who might need support or help with their children. They would offer concern to Ms. M regarding her feelings of loneliness. A child development specialist would visit and together with the mother assess what needs she might have in relation to her parenting. A first visit was arranged at the home, at mother's convenience.

In preparation for the first visit, the CDP caseworker reviewed what a normal four-month-old baby should look like. The caseworker had an idea of motor and hand development, and also the language, social, and emotional developmental of an infant that age.

What did the caseworker see: Amid a home, which was clearly impoverished and disorganized, was a young, heavy, and sad-looking mother whose eyes lit up whenever she looked at the charming active baby on her lap. Delia, the baby, obviously had had a great deal of social attention from her mother. Delia was expressive, responsive, and happy. She had excellent gaze exchange, and sought out mother's eyes as well as the caseworker's. She was more interested in people than in things. She smiled easily and vocalized responsively. When shown a new toy by the caseworker, she turned back to look at her mother and smiled, sharing the event with her. All these observations spoke of normal development.

The baby looked like she had been held a great deal. She was cuddly and relaxed as she nestled in her mother's arms. She had had experience sitting, evident in her motor and trunk development, as well as her hand and eye

coordination. She held her head up well and used her hands appropriately for her age, bringing them together, and reaching for the rattle the caseworker had brought. Delia's sister, too, seemed attentive and interested in the toys that were part of the assessment of the baby's sensory-motor development. There was a general feeling of harmony and responsiveness within the family.

While the family was very poor, the baby did not seem to be suffering from malnutrition, nor had there been any serious illnesses. The assessment took place over four visits. Over the weeks, one set of observations was worrisome. Delia was not visually tracking well for her age. During the Bailey Development Test, it was evident Delia could not follow a pencil in an arc, losing track of it at midline. Her sister, too, seemed to have visual problems. It was clear that both children needed eye examinations.

What was the stability and quality of the parenting environment? Ms. M clearly was attached to her children and was empathic and responsive. She showed good judgment, provided accurate descriptions of what the baby could do, knew what the baby liked, and was familiar with the baby's sleeping and eating patterns. She was a good observer and a careful reporter. The greatest concern of the child specialist was Ms. M's depression and loneliness. The specialist acknowledged how difficult it must be for Ms. M to respond to her baby's cries when it seemed she might feel like crying herself.

What did this home-based assessment reveal? Delia was a healthy, expressive, baby who showed signs of a very positive attachment to her mother. She had a visual problem which required medical attention. She was adequately cared for in most areas, except cleanliness. She was at some risk in that her overburdened mother was suffering from depression and without help might not be able to continue the good care she was presently providing.

The child welfare worker was able to use the assessment in case planning. The mother obviously needed further support for her own emotional needs, as well as guidance in housekeeping and some aspects of health care. The child welfare worker, however, could support mother for her good mothering and point to the progress her baby was making. Rather than revealing a situation of neglectful parenting, this evaluation opened the way to appropriate medical planning and supportive treatment plans.

Sandra

Let us now consider the case of Sandra. Sandra was a four-month-old baby girl referred for evaluation to the CDP by a public health nurse. The nurse's referral notes stated: "Sandra appears neglected. She is left to herself. She is always dirty. There are three other preschool age children at home and no father present. Mother seems unable to show warmth. She has refused help offered by the public health nurse and other agencies. Sandra was premature by one month. Her weight was 5 pounds, 3 and ½ ounces at birth. She has been rehospitalized three times for illness, and her development seems retarded."

This referral indicated a number of at-risk signals. Sandra was a premature, ill baby, and therefore difficult for any one to care for. Her mother, however, was having considerable difficulty providing basic nurturing care, cleanliness, and emotional responsiveness. In the referral, the baby was noted to be at

high-risk medically, as indicated by the three hospitalizations. Her development was in question.

A public health nurse encouraged the mother, Mrs. A, to phone the CDP clinic for an appointment to get help with Sandra. Although uneasy and suspicious, the mother did call and arrangements were made for a home visit where the infant specialist might explain to Mrs. A the services the clinic could offer.

All methodical planning for the visit was futile, however, because of the chaos and disarray the infant specialist encountered on the first home visit. Sandra lived with her three preschool siblings and her 25-year-old mother in a dwelling that showed signs of poverty and grave maternal inadequacy, perhaps mental illness. The rooms looked and smelled as though no one had ever cleaned them. The odor of feces was everywhere. There was no lock on the door, and the toddlers climbed on the staircase leading to the street. Mrs. A, haggard and unkempt, could only talk with anger about the two men who had fathered her children and left. Undirected rage and disorganization permeated the small apartment and surrounded the anxious toddlers. It was difficult for Mrs. A to concentrate on her children.

Where was Sandra? Sandra was almost invisible in this chaotic situation. The case report by the infant specialist reads: "On one of the straight-back chairs, there was a tiny infant lying on her back. Near the baby's cheek, but out of her grasp, is a bottle filled with milk. The baby is dressed only in a diaper on this cold day. An old shirt or rag is placed between the baby and the edge of the seat."

Since the mother knew the infant specialist was coming on that first visit, and also knew the public health nurse's concern regarding the infant neglect, diagnostically one must ask whether the mother was trying to convey how difficult and desperate her situation was. Perhaps she was telling the infant specialist that she was unable to provide adequate care to her needy baby by herself.

Over the next few weeks the grave status of this family became even more evident. Sandra's mother appeared increasingly depressed and distraught over her personal misfortunes. All her energy was directed to revenging those who had "betrayed her." The home situation became more chaotic as strangers drifted in and out of the house. There was little evidence of stability. Even the CDP infant specialist was treated like a shadowy visitor by the mother. He was allowed in, but Mrs. A could not focus on the concerns he had about the baby's health care needs. If Sandra were to cry, for example, the other children were ordered by her to get Sandra a bottle or to change her. Milk was often sour or unavailable.

What did Sandra look like over the four-week span? Because of the family stress, a Bailey Developmental Test could not be arranged. But, the observations of Sandra followed a consistent pattern. The case report states: "The baby clad only in a diaper in cold apartment. The baby positioned on chair or playpen so that she has no contact and cannot see others."

From this assessment report one sees impoverishment in the area of human attachments. "In the area of human attachments, there are no observations which show that Sandra recognizes her mother or discriminates her from other persons. There are no smiles for mother or vocalizations, no reaching for mother or anticipatory response to mother. This passive, unresponsive baby's

behavior is consistent with others who approach her, like the infant specialist." There was nothing in Sandra's repertoire that spoke of human relationships or social pleasure.

In the cognitive-motor sphere, Sandra was very far behind. She did not meet the developmental milestones expected of a six-month-old baby. She could not track or visually follow an object. She did not attempt to reach for an object. She did not have midline organization, that is, she did not bring her hands together. She had poor trunk and neck control, perhaps because of no holding. Vocalizations were muted and they were not socially reciprocal if they did occur.

Diagnostically one had to raise questions as to whether the developmental retardation was due to prematurity, illness, organic factors, or the clearly inadequate home environment. The limits of Sandra's potential improvement were unknown; but it was clear that the status quo was inadequate and the medical and developmental risks very high.

Very soon the assessment took a serious turn when Sandra developed a cough and the infant specialist took the mother and the baby to the hospital. Sandra was diagnosed as having pneumonia, and the hospitalization was seen as a turning point wherein an extended reassessment of the family situation had to be arranged.

The observations of the infant specialist in the home visit situation indicated a very grave situation. Mrs. A was unable to provide any stability, health care, or safety for Sandra or the other children. Sandra was developmentally impaired in the emotional and sensory-motor spheres of development, while the other children also had poor language development and seemed pathetically neglected. Mother was emotionally very fragile and depressed, and unable to bring good judgment and even the most meager sensitivity to her child care. She was caught in a vortex of many conflicting emotions. The quality of her object relationships was very poor, both with regard to her children and her own personal relationships. She could not develop a working alliance with the caseworker and was unable to participate as a "partner" in the assessment process. Diagnostically, an important question needed to be asked: Was this mother sufficiently psychologically healthy to use professional and supportive help at this time, so that the development of her children could be protected?

The immediate prognosis did not look good to the infant specialist. The specialist's recommendation to the public health nurse was that this family needed to be referred to Protective Services and Sandra either kept at the hospital or in foster placement until a more comprehensive assessment of mother's mental health could be obtained. Unfortunately no extended family was available to help. This recommendation was made with the goal of protecting the children, rather than punishing the mother. It would be important to assess whether, with an active outreach program and concrete support, such as day care for the children, medical and nutritional supervision, and long-term treatment for herself, Mrs. A could be helped to achieve a higher level of parental functioning. One positive sign did emerge, however. During the hospitalization of Sandra, it became evident that Mrs. A could respond to the baby's medical needs, at least in her understanding of those needs, and she was willing to accept the fact that Sandra might need special attention, at least by oth-

ers. This could be interpreted as a basis for treatment planning acceptable to mother.

While this case did not have as positive a prognosis as the case of Delia, the assessment process was helpful in articulating the various needs of the family and the urgency of these needs.

In these examples we have tried to illustrate how infant assessments and home visit observations may be helpful to child welfare workers in developing an assessment which can be used to develop treatment plans that are responsive to individual family needs. It was found in all the clinical research programs that, in order to assess the developmental well-being of each child, it was important to try to establish a working alliance with the parent(s). This working alliance was diagnostically relevant as the strength of the alliance indicated a great deal about the family's capacity to use help.

As has been found in many pilot programs, "infant work" is often stressful for the caseworker, as the infant at-risk is so vulnerable to environmental factors. This adds a sense of urgency to the caseworker's tasks and raises counter-transference feelings frequently toward less than adequately nurturant parents. The caseworkers themselves need collegial support and supervision. This work requires time, the integration of many factors, the opportunity to use expert supervision and ongoing training in this changing field.

IV. Conclusions

This paper has attempted to review new insights derived from various fields of study that have contributed to diagnostic and treatment processes particularly with reference to assessment issues in the delivery of services to infants at-risk and their families. There are special problems in translating these insights to hard pressed community service agencies, both in terms of modification of traditional casework practices and agency priorities and policy. The role of social work generally requires an integration of many factors and different streams of knowledge. In the case of services to infants at-risk and their families, a social worker needs to have knowledge about normality and pathology, knowledge about treatment services and the range of services missing and available in the community, capacity to work within an interdisciplinary or community-based team, clinical acumen, and empathy. The social worker as clinician, supervisor, or administrator can

utilize these insights not only by continued attention to new knowledge development but also in having the willingness to integrate and translate new approaches to traditional structures (Shapiro et al., 1978; Shapiro, 1985). Changes in practice are required such as the use of outreach and home visits, greater flexibility in role definition, use of interdisciplinary teams, and acknowledgment that extra time is needed to develop a successful working alliance with the parents. The assessment process itself is often dependent on an interdisciplinary team of child specialists with a caseworker being in an integrative role. A broad-based, indepth assessment which focuses on the child and the child-parent relationship sets a framework for both the parents and the practitioner. It is important to understand the depth of the clinical problem, so that one can understand whether crisis intervention, developmental guidance, short-term treatment or long-term intensive infant-parent psychotherapy, or support, is most appropriate.

Even in agencies giving primarily short-term services, the new knowledge base can be very effective in developing a realistic set of treatment plans. Alternatives to ideal treatment may need to be developed, given the resource constraints in many communities. Good day care, medical attention, homemakers, volunteers, therapeutic nurseries, provision of essential socio-economic supplies, can be used to supplement the treatment process.

In order to sustain themselves in this difficult work, the social worker also needs to be able to advocate for greater national and state support on behalf of children, particularly at the present time when so many families and children are at-risk (Edelman, 1987). The developing expertise of social workers in the field of child welfare practice and infant mental health, enables them to contribute on many levels: the furtherance of casework effectiveness, the development of new agency programs and policies, and the support of changes in state and federal policies which can support families and improve the chance of developmental well-being of infants and toddlers.

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