

SYMPOSIUM*

CHILD PROTECTION AND INFANT MENTAL HEALTH: AN ESSENTIAL PARTNERSHIP

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I. INTRODUCTION

For many years I worked as a general and behavioral pediatrician in a busy, small town practice. The Attention Deficit Hyperactivity Disorder (“ADHD”) evaluations, as they were called, were my responsibility. Typically

* On November 8, 2012, the West Virginia Law Review hosted *Child Protection in the 21st Century*, a multi-disciplinary symposium focused on understanding how to better protect and care for children, specifically within the legal system. The keynote lecture was given by Claudia M. Gold, M.D., a pediatrician and the Director of the Early Childhood Social-Emotional Health Program at Newton-Wellesley Hospital, who discussed how the field of mental health can inform the field of child protection. The other speakers were Judge Gary L. Johnson, J.D.; Margie Hale, M.S.W., of West Virginia KIDS COUNT; Kendra Huard Fershee, J.D., Associate Professor of Law at West Virginia University College of Law; and Andrew G. Oosterbaan, J.D., Chief of the U.S. Department of Justice Child Exploitation and Obscenity Section.

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this involved a fifty-minute visit for a diagnostic evaluation. Diagnosis of ADHD is based on symptoms as defined by the *Diagnostic and Statistical Manual of Psychiatric Disorders*, published by the American Psychiatric Association.¹ Parents would often come armed with standardized questionnaires, usually the Connors Rating Scale.² There was usually an expectation that, because a child had many symptoms of inattention and/or hyperactivity and impulsivity, he would receive a diagnosis of ADHD and a prescription for medication. A child would then have a thirty minute follow up visit every three months. Prescription refills were picked up at the office once a month. If an appointment was missed, a child could go as long as six months without seeing a doctor.

Robby was one such child, a six-year-old boy who had been evaluated by a psychiatrist in a nearby town and diagnosed with ADHD. The psychiatrist referred Robby to me because his family lived closer to my office. I met with Robby and his father's girlfriend, who was his current caregiver. His half siblings by his father, an infant and toddler, added an element of chaos to the visit. I reviewed the records before I went in the room. Robby had been removed from his biological mother's care because of physical abuse in infancy. He had been in foster care for a brief time, during which he experienced sexual abuse by another foster child in the home. For the past few years he had been in the custody of his father, who had been recently imprisoned.

Neither the referring psychiatrist, his caregivers, his teachers, nor my colleagues saw any problem with my treatment being the only support for this child and family. When I tried to engage the family in more comprehensive therapy, I was met with not only profound resistance, but also a paucity of adequate mental health care services. This was due to lack of resources in the form of quality psychotherapists, as well as restrictions from insurance. Even though Robby was clearly a very troubled child, it was perfectly acceptable to his caregivers, the referring psychiatrist, his teachers, and my pediatrician colleagues, if a visit once every three months with a pediatrician who was not a mental health professional was his only form of treatment.

Like many of those who work in the field of child protection (including lawyers, judges and social workers), I encountered many overwhelming and seemingly hopeless situations similar to Robby's. Because the child had a certain score on a checklist of symptoms (derived from the *Diagnostic and Statistical Manual of Psychiatric Disorders*³), simply writing a prescription and then seeing him every three months to adjust his dose of medication was sufficient. I was motivated to find a way to give a voice to children who were

¹ See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-IV-TR (4th ed. 2000).

² See generally C. KEITH CONNERS, CONNERS THIRD EDITION MANUAL (2009).

³ AM. PSYCHIATRIC ASS'N, *supra* note 1.

not being heard, whose full experience was not being recognized. Instead, they were being silenced by medication.

My distress over this situation led me to discover the concept of childism, or prejudice against children, as a way to understand why we, as a society, tolerate such woefully inadequate treatment of children.⁴ It also led me to discover the world of research, clinical work and public policy that comes under the heading of a newly emerging field known as infant mental health.⁵

This Article will introduce the concept of childism and show how it is manifest in the field of child protection.⁶ Then this Article will introduce the paradigm of infant mental health as a new way to understand and help children like Robby and their families.⁷ These ideas were first presented at the 2012 West Virginia University Law School symposium, entitled *Child Protection in the 21st Century*.⁸

A. *Childism*

The concept of childism was defined by Elizabeth Young-Buehl in her book *Childism: Confronting Prejudice Against Children*.⁹ Young-Buehl, a brilliant psychoanalyst, biographer, and political theorist, died suddenly about a month before the book's release, depriving us not only of a great mind, but also the opportunity for public discussion of this important idea. Pre-release reviews spoke to the importance of the book, including this from pediatrician and child development researcher T. Berry Brazelton: "What a brilliant testimony as to why children's issues have taken so long to become of importance. Everyone who wants to change this, and I hope all professionals who are involved with families and children do, should read this work."¹⁰

Young-Buehl offers this definition of childism: "Drawing on a comparative study of prejudice forms, then, childism can be defined thus: a prejudice against children on the ground of a belief that they are property and

⁴ See generally ELISABETH YOUNG-BRUEHL, *CHILDISM: CONFRONTING PREJUDICE AGAINST CHILDREN* (2012).

⁵ See Joy D. Osofsky & Kandace Thomas, *What is Infant Mental Health?*, ZERO TO THREE J., Nov. 2012, at 9, available at <http://www.nxtbook.com/nxtbooks/zerotothree/201211/index.php?startid=9>.

⁶ See *infra* Part I.A–B.

⁷ See *infra* Part II.A–C.

⁸ Claudia M. Gold, Keynote Address at the West Virginia University Law Review Symposium: Child Protection and Infant Mental Health—An Essential Partnership (Nov. 8, 2012), available at <http://lawmediasite.wvu.edu/Mediasite/Play/424e60c29b50443db2e5d55f741c4e741d?catalog=16c0f0ba-f103-47a6-8c9d-cc899e844292>.

⁹ YOUNG-BRUEHL, *supra* note 4.

¹⁰ *Id.* (quotation is located on the back cover of the book).

can (or even should) be controlled, enslaved, or removed to serve adult needs.”¹¹

Childism occurs at the individual and the societal level.¹² As a societal phenomenon it manifests itself as a failure to prioritize the needs of children, as represented by the way ADHD is typically treated, as well as by the lack of resources devoted to the care of children.¹³ “[C]hildism is a legitimation of an adult’s or a society’s failure to prioritize or make paramount the needs of children over those of adults, the needs of the future adults over the needs of the present adults.”¹⁴

Central to understanding this concept is recognizing the nature of prejudice in general. Young-Bruehl describes how a prejudice is a projection of bad feelings that a person has inside on to the outside world.¹⁵ She writes, “In the modern field of Prejudice Studies, a broad consensus has developed among researchers that prejudiced people’s negative images or stereotypes are projections outward of hated or feared traits, aspects, functions, or fantasies of the prejudice person’s own psyche or history.”¹⁶

Young-Bruehl does not speak directly about the issue of medication and ADHD, but she does identify the rise in diagnosis of childhood bipolar disorder as a manifestation of childism.¹⁷ She writes of “a childism of the sort that is now fueling an epidemic of diagnoses of bipolar II disorder and the prescription of medications to children who are, in effect, being doped into acquiescence.”¹⁸

As exemplified by Robby’s story, the use of psychiatric medication is among the primary manifestations of childism that I encounter in my work as a pediatrician. But what does childism look like in the field of child protection?

B. Childism in Child Protection

After defining the term childism, Young-Bruehl turns to the field of child abuse and neglect to examine how this prejudice is played out in our society’s treatment of its most vulnerable members.¹⁹ Her insights grew out of her work as a psychoanalyst, when in therapy sessions five times a week for

¹¹ *Id.* at 37.

¹² *Id.* at 4–6.

¹³ *Id.* at 153–55.

¹⁴ *Id.* at 280.

¹⁵ *Id.* at 35–37.

¹⁶ *Id.* at 37.

¹⁷ *Id.* at 254.

¹⁸ *Id.*

¹⁹ *Id.* at 98–139.

many years she got an in depth look at her patients' experience of abuse.²⁰ She came to recognize that the abusers acted from a belief that the child is at their service to satisfy their needs and desires.²¹

Drawing from her understanding of this belief as a manifestation of prejudice, she understands this as a developmental problem coming from within the abuser.²² Young-Breuhl writes that a prejudice "is a . . . developmental problem played out projectively in the world, among people. One of the key ways people have of keeping themselves on an even keel is projecting their conflicts on to others; they throw their baggage overboard in a storm. The result is a prejudice"²³

In other words, one cannot understand the behavior of the abuser, or begin to address the problem, without understanding the abuser him or herself.²⁴ She goes on to show how, historically, an effort to understand the abuser in this way has been missing from the field of child protection.²⁵

Young-Breuhl describes the "discovery" of child abuse by pediatrician Henry Kempe in the 1960s.²⁶ She points out that it is more accurately the "scientific discovery," because abuse has been described "in all societies for which there are records."²⁷ Kempe coined the term "battered child syndrome" based on his observation of children coming to the emergency room with unexplained injuries.²⁸ Young-Breuhl observes that it was, from the start, not a disease of the abuser but of the child.²⁹ She writes, "[t]he name thus from the start took attention away from abusers and their *motivations*; and it implied that children could be helped without their abusers being helped."³⁰ We will see in the following section the critical importance of understanding these motivations.³¹

The field of child protection grew out of this "discovery."³² "Kempe had launched one of the swiftest transitions from identification of a social problem to legislation in America's history The states all increased their

²⁰ *Id.* at 98–100.

²¹ *Id.* at 98.

²² *Id.* at 48.

²³ *Id.* at 48–49.

²⁴ *Id.* at 46–57.

²⁵ *Id.* at 100–11.

²⁶ *Id.* at 100–01.

²⁷ *Id.* at 100.

²⁸ *Id.* at 101.

²⁹ *Id.* at 107.

³⁰ *Id.* (emphasis added).

³¹ See *infra* Part II.

³² YOUNG-BRUEHL, *supra* note 4, at 100.

vigilance by establishing or strengthening Child Protective Services (CPS) departments.”³³

But from the start, the system was not founded with an understanding of child development.³⁴ It did not recognize abuse as a problem that resides in the parent-child *relationship*. Young-Bruehl writes: “[S]ince CPS was created as a rescue service—a child saving service—not a *family* service supporting child development generally and helping parents, greater efficiency in prosecuting parents was achieved but not greater understanding of them, educating of them, or working with them therapeutically to prevent child abuse.”³⁵

This approach was written into law with the passage of the Child Abuse Prevention and Treatment Act in 1974.³⁶ She identifies how, from the start, the law did not address the developmental and relational context of the problem.³⁷ If we understand abuse as a manifestation of prejudice against children and understand that prejudice is a projection outward of something that feels bad within the abuser, this approach is off the mark. Young-Bruehl writes that the problem the bill addressed “was whether and how to investigate and treat *parents* who are reported for or charged with abuse. The bill counted on sympathy for battered children, but it did not address their batterers, much less the social and *motivational contexts* in which batterers (or any other type of abusers) operate.”³⁸

Although “battered child syndrome” traditionally refers to physical abuse, Young-Bruehl describes how the same problem occurs with sexual abuse noting that “[v]olumes of studies of sexually abused children and volumes of studies of the behavior (rather than the *motivations*) of sexually abusing adults appeared, but only rarely were the relationships between children and adults seen as serving adult purposes and adult beliefs or prejudices.”³⁹

The foster care system grew out of this idea of finding fault with parents rather than being curious about the parents’ motivations and intentions.⁴⁰ She quotes from Kempe’s original 1962 article: “At present, *there*

³³ *Id.* at 123–24.

³⁴ *Id.*

³⁵ See Child Abuse Prevention and Treatment Act of 1974, Pub. L. No. 93-247, 88 Stat. 4 (codified as amended at 42 U.S.C. §§ 5101-07, 5116-16i (2011)); YOUNG-BRUEHL, *supra* note 4, at 131–32.

³⁶ *Id.* at 131–32.

³⁷ *Id.*

³⁸ *Id.* at 132 (emphasis added).

³⁹ *Id.* at 186 (emphasis added).

⁴⁰ *Id.* at 133.

is no safe remedy in the situation except the separation of battered children from their insufficiently protective parents.”⁴¹

In the final chapter of her book, Dr. Young-Buehl proposes a new Child Development Act to replace the Child Abuse Prevention and Treatment Act of 1974.⁴² She writes:

We need to recognize that the narrow focus on protecting children, to the exclusion of providing for their developmental needs and making them participants in decisions affecting them, produced a huge distortion in this country. We were relying on concepts that ultimately could not even serve the purpose of protection, because children whose development is not being supported cannot be protected.⁴³

In summary, on an individual level, abuse represents a prejudice on the part of the abuser. A child protection system designed to prosecute parents rather than support families represents a form of prejudice against children on a societal level.

II. INFANT MENTAL HEALTH

The discipline of infant mental health, a field that grew in exact parallel to the growth of this field of child protection, offers an evidenced-based alternative model ideally suited for a paradigm shift to supporting development in the way Young-Buehl proposes.

This model for understanding and treating troubled children and families was born out of Selma Fraiberg’s seminal 1974 paper, *Ghosts in the Nursery*.⁴⁴ She describes the first infant mental health program.⁴⁵ A staff of experienced psychologists and social workers went into the homes of mothers who had been abused.⁴⁶ By forming a close connection in a supportive and understanding way while these mothers were interacting with their children in their own homes, the staff was able to significantly improve the parenting capacities of these traumatized mothers.⁴⁷

⁴¹ *Id.*

⁴² *See id.* at 266–97.

⁴³ *Id.* at 270.

⁴⁴ Selma Fraiberg et al., *Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships*, 14 J. AM. ACAD. CHILD PSYCHIATRY 387 (1975).

⁴⁵ *Id.* at 393–98.

⁴⁶ *Id.* at 394.

⁴⁷ *Id.* at 396–98.

The extensive literature⁴⁸ on what is referred to as “intergenerational transmission of trauma” shows that parents who have been abused are at high risk for abusing their own children.⁴⁹ The frame of infant mental health treatment is to provide support and understanding for parents while working with the parents and children together, with the aim of preventing this transmission.⁵⁰

The December 2012 issue of the *Zero to Three Journal*, entitled *Emerging Issues in Infant Mental Health*, defines the term “infant mental health” as “the developing capacity of the infant and young child (from birth to 5 years old) to experience, express, and regulate emotions; form close and secure relationships; and explore the environment and learn, all in the context of cultural expectations.”⁵¹ The field is described as multidisciplinary, covering research, clinical practice, and public policy.⁵² Its relational focus is central: “A major premise of infant mental health is that babies’ emotional, social, and cognitive development and competencies unfold in the context of their caregiving relationships; thus supporting *both the infant and the primary caregivers* is crucial to optimize the young child’s functioning.”⁵³

A. *Holding a Child in Mind*

Over forty years of child development research has demonstrated that, to support healthy emotional development, parents need to be able to attribute *motivations and intentions* to their child’s behavior.⁵⁴ This ability to attribute motivation and intentions to behavior is a uniquely human capacity.⁵⁵ In turn,

⁴⁸ See YOUNG-BRUEHL, *supra* note 4, at 180–85; LOST IN TRANSMISSION: STUDIES OF TRAUMA ACROSS GENERATIONS (M. Gerard Fromm ed., 2012) [hereinafter LOST IN TRANSMISSION].

⁴⁹ LOST IN TRANSMISSION, *supra* note 48, at xvi (explaining that the articles in the book dealing with intergenerational transmission of trauma “build upon the idea that what human beings cannot contain of their experience—what has been traumatically overwhelming, unbearable, unthinkable—falls out of social discourse, but very often on to and into the next generation as an affective sensitivity or a chaotic urgency”).

⁵⁰ See *supra* text accompanying notes 46–47.

⁵¹ Osofsky & Thomas, *supra* note 5, at 9.

⁵² See, e.g., *id.*; Carmen Rosa Noroña et al., *Broadening the Scope: Next Steps in Reflective Supervision Training*, ZERO TO THREE J., Nov. 2012, at 29, available at <http://www.nxtbook.com/nxtbooks/zerotothree/201211/index.php?startid=29>; Maria Seymour St. John et al., *Infant Mental Health Professional Development: Together in the Struggle for Social Justice*, ZERO TO THREE J., Nov. 2012, at 13, available at <http://www.nxtbook.com/nxtbooks/zerotothree/201211/index.php?startid=13>.

⁵³ Osofsky & Thomas, *supra* note 5, at 9.

⁵⁴ See Peter Fonagy, *The Mentalization-Focused Approach to Social Development*, in HANDBOOK OF MENTALIZATION-BASED TREATMENT 53, 66–82 (Jon G. Allen & Peter Fonagy eds., 2006).

⁵⁵ *Id.* at 55–56.

to support this capacity in parents, it is essential to attribute motivation and intentions to the parents' behavior.⁵⁶ This is the piece that Young-Bruehl identified as missing from the field of child protection.⁵⁷

This research has its origins in the work of John Bowlby, considered the father of attachment theory, who was among the first to identify the central role of secure early attachment relationships in healthy emotional development.⁵⁸ Greatly influenced by Darwin, he saw how these relationships were essential for the survival of our species.⁵⁹ Mary Ainsworth, a close colleague of Bowlby's and in a sense the mother of attachment research, developed a standardized assessment tool to study attachment relationships.⁶⁰ The subsequent extensive body of longitudinal research has demonstrated that safe and secure early relationships are central to development of overall mental health, the capacity for emotional regulation, cognitive resourcefulness, and social adaptation.⁶¹ The current explosion of research at the interface of developmental psychology, neuroscience, and genetics is showing how these relationships promote healthy brain development.⁶²

But what exactly is a secure relationship? Psychoanalyst Peter Fonagy of the University College London, along with his colleagues, drawing on the research of his predecessors, offers compelling evidence that the caregiver's capacity to reflect on the motivations and intentions of a child's behavior is essential for a secure attachment relationship.⁶³

⁵⁶ See *id.* at 74–77, 81; YOUNG-BRUEHL, *supra* note 4, at 12–17.

⁵⁷ See YOUNG-BRUEHL, *supra* note 4, at 12–17.

⁵⁸ See Fonagy, *supra* note 54, at 55; YOUNG-BRUEHL, *supra* note 4, at 127; Joan Stevenson-Hinde, *Attachment Theory and John Bowlby: Some Reflections*, 9 ATTACHMENT & HUM. DEV. 337, 341 (2007).

⁵⁹ See Inge Bretherton, *The Origins of Attachment Theory: John Bowlby and Mary Ainsworth*, 28 DEVELOPMENTAL PSYCHOL. 759, 759 (1992); Sebastian Kraemer et al., Editorial, *A Tribute to the Legacy of John Bowlby at the Centenary of His Birth*, 9 ATTACHMENT & HUM. DEV. 303, 303–05 (2007).

⁶⁰ See Bretherton, *supra* note 59, at 759 (explaining that Ainsworth both “contributed the concept of the attachment figure as a secure base from which an infant can explore the world” and “formulated the concept of maternal sensitivity to infant signals and its role in the development of infant-mother attachment patterns”).

⁶¹ See generally HANDBOOK OF MENTALIZATION-BASED TREATMENT, *supra* note 54.

⁶² CLAUDIA M. GOLD, KEEPING YOUR CHILD IN MIND: OVERCOMING DEFIANCE, TANTRUMS AND OTHER EVERYDAY BEHAVIOR PROBLEMS BY SEEING THE WORLD THROUGH YOUR CHILD'S EYES 16 (2011); see also Fonagy, *supra* note 54, at 55–66; Glen O. Gabbard et al., *A Neurobiological Perspective on Mentalizing and Internal Object Relations in Traumatized Patients with Borderline Personality Disorder*, in HANDBOOK OF MENTALIZATION-BASED TREATMENT, *supra* note 54, at 123–40.

⁶³ See Fonagy, *supra* note 54, at 68–71; GOLD, *supra* note 62, at 108–11.

This capacity is referred to in their work as mentalization.⁶⁴ There is now an extensive literature demonstrating the effectiveness of treatment aimed specifically at promoting mentalization.⁶⁵ This capacity is also referred to as reflective functioning,⁶⁶ and in work with parents and children, as “holding a child’s mind in mind.”⁶⁷ This research has shown that in work with parents, supporting their efforts to be curious about the meaning of their child’s behavior is key to promoting health development.⁶⁸ Promoting parental reflective functioning, in part by attributing *motivations and intentions* to parents’ behavior, is key to breaking the cycle of intergenerational transmission of trauma.⁶⁹

We see how this is in direct contrast to the approach of child protection⁷⁰ where, rather than being curious about the parents’ motivations and intentions, the system seeks to prove what the parents have done wrong.

In my book, *Keeping Your Child in Mind*,⁷¹ I review the literature described above⁷² and show what mentalization, or holding a child’s mind in mind (shortened for simplicity to “holding a child in mind”)⁷³ looks like in everyday interactions with children from the newborn period through adolescence.⁷⁴ I describe the research from the discipline of infant mental health in language intended for a general audience.⁷⁵

For example, the notion of mentalization becomes clear in a close look at parents’ use of the common term “defiant” to describe a child. I suspect that Dr. Young-Bruehl would have considered this term to be an expression of childism.⁷⁶ “Defiant” is a very negative word that represents a projection onto the child. Parents experience a child’s behavior as an assault on them, but that is not the meaning of the behavior to the child.

⁶⁴ Fonagy, *supra* note 54, at 54 (defining “mentalization” as “a form of mostly preconscious imaginative mental activity, namely, perceiving and interpreting human behavior in terms of intentional mental states,” including “needs, desires, feelings, beliefs, goals, purposes, and reasons”).

⁶⁵ See, e.g., HANDBOOK OF MENTALIZATION-BASED TREATMENT, *supra* note 54, at 183–267. See generally GOLD, *supra* note 62, at 14–16.

⁶⁶ GOLD, *supra* note 62, at 14–16.

⁶⁷ *Id.* at 7, 14.

⁶⁸ See *supra* text accompanying notes 54–56, 61–62.

⁶⁹ See, e.g., YOUNG-BRUEHL, *supra* note 4, at 134–35.

⁷⁰ See *supra* Part I.B.

⁷¹ GOLD, *supra* note 62.

⁷² See generally *id.* at 14–16.

⁷³ *Id.* at 7.

⁷⁴ See *id.*

⁷⁵ See *id.*

⁷⁶ See *supra* Part I.A.

A “mentalizing” approach, in contrast, would consist first of curiosity about the meaning of the behavior for the child.⁷⁷ In a normal healthy way, a child begins to assert his sense of self in the toddler years by saying “no.” When these normal assertions begin to escalate and disrupt the family life, it is often due to things feeling out of control in a young child’s life. This could be due to a range of experiences, including the birth of a sibling, marital conflict or an actively drinking alcoholic parent.

A second key component of mentalization is empathy.⁷⁸ It is not only cognitive understanding of the child’s developmental stage, but also empathy for his feelings. Defiant is an angry word, but “stressed” is an empathic and much more accurate word.

Equally important is limit-setting and containment.⁷⁹ As a simple everyday example, your toddler may want to have his blue sippy cup. If you left it at the playground, he might be very upset. This is a normal reaction, but if he then throws the cup across the kitchen in frustration, a clear limit, such as a firm “no” along with a brief time out is in order. And even if a child is stressed, such as in the face of a new sibling, he must know that his aggressive feelings are okay, but hitting is never okay, and will be met with firm limits on behavior.

The last and most challenging piece of mentalization is to regulate your own feelings.⁸⁰ When a child is asserting himself, it may provoke feelings in an adult of other relationships, such as a spouse, boss, or even a parent not listening to them, or worse, being actively abusive. This memory may evoke a physical stress reaction that makes it difficult to think clearly. Getting these kinds of reactions under control is a critical aspect of holding a child in mind.

B. Mentalization Based Interventions

A number of evidence-based interventions aim to promote parental reflective functioning. Alicia Lieberman uses Child Parent Psychotherapy (“CPP”) with traumatized children at the University of California at San Francisco and works closely with the court system.⁸¹ Arietta Slade and colleagues at the Yale Child Study Center have developed the Minding the Baby program, a home visiting program with high-risk young mothers that is specifically designed to promote mentalization capacities.⁸² These programs,

⁷⁷ GOLD, *supra* note 62, at 7–9.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ See Dep’t of Psychiatry, *Biography of Alicia F. Lieberman*, U.C.S.F., <http://psych.ucsf.edu/faculty.aspx?id=322> (last visited Apr. 10, 2013).

⁸² See Lois S. Sadler et al., *Minding the Baby: A Mentalization-Based Parenting Program*, in HANDBOOK OF MENTALIZATION-BASED TREATMENT, *supra* note 54, at 276.

while proven effective, can be costly and time consuming. The challenge is to find a practical way to incorporate the concepts derived from infant mental health research into work with families that interface with the child protection system.

As a pediatrician, guided by the work described above, I see dramatic effects by simply viewing my task in everyday interactions with families as promoting parental reflective functioning. This case will serve as an example.

Twelve-year-old Sara was scheduled for a fifty minute “ADHD evaluation.” She came in to my office with her mother, Jane, who immediately began to berate her in an angry tone. “She never listens. She’s defiant. She’s terrible—all over the place. I know she has that ADHD thing and needs medication.” Sara sunk into her seat and withdrew into the hood of her jacket in the face of her mother’s attack.

I took a deep breath, thinking on my feet of a way to rescue the situation within the narrow time limit. I asked Jane to wait in the waiting room while I spoke briefly with Sara. I did not expect her to tell me what was wrong, but without her mother there, she responded to my interest by sitting up and answering my general questions about school. Then I had Jane come back in the room.

I positioned myself in a way that indicated I was ready to hear her whole story and expressed curiosity about when the difficulties started. For me, this involves a kind of slowing down and conscious effort to simply be present in the moment.

She responded by opening up. She first told of a traumatic fire a few years earlier that had forced the family (she had two younger children) to be homeless for a number of months. She had never told anyone because she was afraid the children would be taken away. Then, perhaps responding to my non-judgmental attitude, she went on. She told me of a traumatic fire when she was a child. Then she spoke of her own struggles with serious mental illness and her difficulty finding help for herself.

While Jane spoke, Sara relaxed and the hood came off. About twenty minutes into the story Jane turned to her daughter and said tearfully: “It’s probably been hard for you to see me like this.” And then to me, “I think she misses me.”

It was a small moment in a brief visit. But with the task of promoting mentalization in mind, I was able to give Sara the chance to feel her mother thinking about her and being curious about her experience. Given what we know about mentalization promoting healthy emotional development, I believe that this was of more value than writing a prescription for psychiatric medication.

My next step, once the source of the problem was identified, was to get help, a task that proved difficult because of both restrictions imposed by health insurance and a shortage of quality mental health care professionals who could work with Jane and Sara together. I now understand these problems to be a

societal manifestation of childism, in our lack of value placed on mental healthcare that supports children and families. This subject is, however, beyond the scope of this Article. I am hopeful that our current administration is making moves to alter this situation, particularly with the Affordable Care Act⁸³ and its focus on both mental health care and preventive care.⁸⁴

C. *Infant Mental Health Meets Child Protection*

So how can this model of infant mental health be integrated into the child protection system? It involves a paradigm shift from “proving what a parent has done wrong” to creating an environment that promotes mentalization. This paradigm shift is analogous to a shift within pediatrics from “managing behavior problems” to promoting reflective functioning.

One key aspect to this change is referred to in infant mental health as reflective supervision.⁸⁵ Those who work in the child protection system at any level would have an opportunity to share their experiences with supervisors and colleagues in a supportive environment. For example, in order for a social worker on the front lines to go into a home and listen to a parent in the way I have described, this kind of listening needs to be valued by supervisors, and there must be an opportunity to talk about particularly challenging experiences with colleagues.

By creating a culture where this kind of listening is valued, it supports the efforts of everyone, including judges, lawyers, and social workers, to listen in this way. It creates what pediatrician and psychoanalyst D. W. Winnicott referred to as a “holding environment.”⁸⁶ It is more than an environment of caring and support. It is an environment in which difficult feelings are understood, accepted, and contained.⁸⁷

A recent experience of mine offers an example. I was teaching a group of advanced social work students who were all working on the front lines of child protection. I was talking about the infant mental health research that I have presented above. One of the students appeared to be completely disengaged and uninterested.

Then, in the second half of my talk I shared information about how these concepts could be applied to specific developmental issues. When I started to talk about sleep, she began to perk up. I was explaining about sleep associations—how infants who have always fallen asleep with a person holding

⁸³ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

⁸⁴ *See id.*

⁸⁵ *See* GOLD, *supra* note 62, at 205.

⁸⁶ D. W. Winnicott, *The Theory of the Parent-Infant Relationship*, in *THE MATURATIONAL PROCESS AND THE FACILITATING ENVIRONMENT* 37, 43–47 (M. Masud R. Khan ed., 1965).

⁸⁷ *See id.*

or rocking or lying next to them do not know how to go from being awake to being asleep. In the toddler years and beyond, separation anxiety and battles for control also impact sleep, but often this issue of sleep associations is the primary underlying problem. Now this woman was alert and completely engaged. When I paused for questions, her hand shot up.

She explained that her job was to educate foster parents. Often children were returned, in a sense representing her failure, because of sleep problems. She had thought that it was all about attachment. She felt that if she could explain that this was a physical issue, that these young children did not know in their body how to go from being awake to being asleep, foster parents might be less likely to experience sleep problems as a rejection and more likely to have more patience and understanding. Perhaps then they would be more likely to keep the children. She said that she would incorporate this knowledge into her trainings.

I might have interpreted my student's lack of interest in a negative way. I might have felt annoyed or insulted. But this was not the meaning of her behavior. She was under great stress in her job, and perhaps frustrated by the fact that my presentation had not offered her any help. She was open to listen to what I was saying and was able to use the information to think about the situation from the perspective of the foster parents. She saw that they often viewed sleep problems as evidence of their failure to connect with the child, to provide a secure attachment. She now recognized this as a misinterpretation of the child's behavior. My student wondered if she were to educate the foster parents about the physiologic nature of sleep associations, they might be more patient and less frustrated. They might not only be more likely to help the child with his sleep problems, but also less likely to give up and return the child. This simple shift could potentially have significant implications for children in the foster care system.

In this situation I held my student in mind, reflecting on the meaning of her behavior rather than being critical or angry. She in turn reflected on the meaning of the behavior of the foster parents, and then had an insight about how the foster parents might better hold the children in mind.

My hope in writing my book *Keeping Your Child in Mind* was to effect a paradigm shift in health care and to make the promotion of reflective functioning a central task. I conclude with the following:

The image comes to mind of a set of Russian dolls. When the health care system allows the primary care clinician time to listen to the whole of parents' experience and to support their inherent wisdom and intuition, parents are enabled to be fully present with their child. In other words, the system holds the clinician, who holds the parents, who hold the children.⁸⁸

⁸⁸ GOLD, *supra* note 62, at 207.

The same image of Russian dolls can be applied to the paradigm shift in the child protection system: When the legal system allows the lawyers/CPS workers time to listen to the whole of parents' experience and to support their inherent wisdom and intuition, parents are able to be fully present with their child. In other words, the system holds the child protection professional, who holds the parents, who hold the children.