

***PARENTING FOR EMOTIONAL GROWTH:
A TEXTBOOK***

Henri Parens, M.D., Project Director,
Elizabeth Scattergood, M.A.
Andrina Duff, M.S.S.
William Singletary, M.D.

TEXTBOOK

UNIT 1

Copyright (1995): *Parenting (Education) for Emotional Growth: A Curriculum for
Students in Grades K Thru 12.* Registration Number: **TXu 680-613**

UNIT 1

INFANCY: (0 TO 12 MONTHS)

***PARENTING EDUCATION FOR EMOTIONAL GROWTH:
A TEXTBOOK***

UNIT 1

INFANCY (0 TO 12 MONTHS)

TABLE OF CONTENTS

1.1 PHYSICAL DEVELOPMENT THAT DETERMINES
WHAT A CHILD CAN DO

1.11 Human Development: Degree of Helplessness,
Activity Level,
Adaptive and Learning Functions,
Social Responses and Reflexes

1.12 Child Rearing: What Can the Parent Do That Is Securing
of Good Physical Development?

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.211 Human Development: Sleep and Wake States and Patterning

1.212 Child Rearing: How to Optimize Sleep-Wake Patterning

1.221 Human Development: Feeding Experience

1.222 Child Rearing: How to Optimize Feeding Experiences

1.231 Human Development: Crying

1.232 Child Rearing: How to Handle Crying

1.241 Human Development: Affects (Feeling Tone, How a Person Feels)

1.242 Child Rearing: What Can the Parent Do That Is Growth-Promoting
Regarding the Child's feelings

- 1.251 Human Development: Attachment Behavior
- 1.252 Child Rearing: What Can The Parent Do That is Growth-Promoting Regarding the Child's Attachment Behavior?
- 1.261 Human Development: Exploratory and Locomotor Activities -- The Beginnings of Autonomy
- 1.262 Child Rearing: How to Optimize The Beginning of Autonomy
- 1.271 Child Development: Developing Basic Trust as Compared to Basic Mistrust
- 1.272 Child Rearing: How to Optimize Developing Basic Trust as Compared to Basic Mistrust
- 1.281 Human Development: The Oral Stage of Emotional Development
- 1.282 Child Rearing: What Can the Parent Do to Optimize the Child's Oral Activity
- 1.291 Human Development: Aggression
- 1.292 Child Rearing: What Can the Parent Do that is Growth-Promoting Regarding the Child's Aggressive Activity
- 1.311 Human Development: Dependence
- 1.312 Child Rearing: What Can the Parent Do that is Growth-Promoting Regarding the Child's Dependence
- 1.321 Human Development: The Beginning of Intelligence
- 1.322 Child Rearing: Optimizing The Child's Developing Intelligence
- 1.331 Human Development: The Development of the Self and of Human Relationships
- 1.332 Child Rearing: What Can the Parent Do that is Growth-Promoting Regarding the Child's Development of Self and Human Relationships
- 1.333 Parenthood: Furthering the Development of Self and Human Relationships and Optimizing the Parent-Child Relationships

UNIT 1: INFANCY (0 to 12 MONTHS)

1.1 PHYSICAL DEVELOPMENT

1.11 HUMAN DEVELOPMENT: Degree of Helplessness, Activity Level, Adaptive and Learning Functions, Social Responses, and Reflexes.

Status of Birth:

It is said that of all mammals, the human infant is the least developed at birth and, as a result, is the most dependent on a caregiver for survival. The great challenge for the newborn is to adapt to functioning outside of the mother's uterus; to get all life support systems inside his or her own body to function adequately enough to insure survival and growth. The normal baby is well equipped to meet this challenge. At birth the normal infant is able to take care of some basic needs such as breathing, eating and digesting and excreting; if untroubled, he or she is able to regulate 2 to 4 hour sleep cycles, is receptive and responsive to tender loving care, and can signal when she or he is feeling distress or pain and needs help. Nonetheless, for the most part the infant is remarkably helpless and is absolutely dependent on the parenting (caregiving) environment for survival. In this functioning and early regulation of the basic social and physical mechanisms just mentioned, the infant reacts to experience by adapting in his or her own temperament-determined ways, each infant having his or her own specific inborn characteristic features. This composite of ways of experiencing and reacting, of functioning and regulating becomes the basic core from which development of more and more complex patterns of functioning and adaptation will arise.

Growth Schedules:

Each child has her or his own growth schedules, although for the most part all tend to follow a general time table. A great deal of growth occurs during the first year of life. This growth leads to enormous changes in the level of functioning, considering what an infant that is just born is capable of, as compared to that of a 10 or 12 month old. Several aspects of observable functioning enable us to recognize the very large degree of development that occurs during the first year of life: Let us consider the infant's degree of helplessness, the degree to which he or she can see, hear, move around (locomotion), make sounds of communication (vocalize), as well as the infant's social responses and the typical ways of reacting and adapting to everyday events.

The newborn is totally helpless with regard to providing himself or herself with food, and has very little if any ability to move at will from one place to another. The newborn's

movements tend in large part to be reactive to bodily sensations rather than by the infant's deciding to move his arms or legs. His or her ability to sort out visually and auditorily the environment in which he or she lives clearly operates but is quite primitive. The infant is able to distinguish patterns on a card or wall, seeming to scan with no apparent interest over fragmented lines but stopping his or her gaze briefly to look at a line design of a face. Week old infants will also stare at points of high light contrast such as at a window or at the caregiver's forehead (the area where the hair and forehead meet, as well as the caregiver's eyes). This, by the way, proves to be very important for the child's forming an attachment to his or her primary caregivers which we shall detail later (Section 1.215). Studies also suggest that newborns can already distinguish their mother's voice. In fact scientists have shown that an unborn 8 months old fetus will react with a startle response to a loud clap of hands a few inches from the pregnant woman's abdomen.

The newborn's ability to communicate with the environment is already evident especially when experiencing distress by both facial and vocal expressions (e.g., whimpering, crying). Thus the newborn is already equipped with important abilities that suggest a good deal of physical development of the brain, lungs, digestive system, etc. However, he or she is unable to grasp the breast or a bottle with his or her hands and put it in his or her own mouth, has limited ability to focus visually, is unable to sit up, and unable to move except on a very small scale.

By contrast the six month old has learned to distinguish persons, one from another, is able to recognize his/her mother, father, siblings, and strangers. The six month old is now able to distinguish the sound of mother and father, of siblings, as well as unfamiliar sounds. Many a six month old is able to crawl, some for quite some distances, and often has to be fetched by mother from areas where the infant should not be. The six month old also can sit up, and can use his or her hands and mouth in a coordinated manner which importantly enlarges the infant's ability to explore her or his own and other people's bodies, as well as the environment. So far as vocalization is concerned, the six month old will have already developed a set of signals by means of crying, cooing, babbling, smiling, which indicate certain specific moods and specific needs, and will have a repertoire of sound making indicating conditions of pain or stress which the average mother readily learns to recognize. With regard to the intake of food, there are various ways by which the six month old can now influence the bringing of food to his or her own mouth. Most six month olds when fed will reach for the spoon, reach for and touch the breast or grasp the bottle, and hold it quite capably.

A note is warranted on the maturation of the complicated physical processes that make the infant's digestive system work smoothly enough. A large source of problem -- because of the commonly found harmful effects it can have on the relationship between the infant and the mother or father -- is the difficulty we call "colic". Colic results at least in part from an infant's experiencing much pain in the course of food intake. Exactly what causes the difficulty is not clear. What is known, however, is that it commonly begins during the first few weeks of life and, most important, that it usually stops at about 3 months of age. We assume that it stops then because a further physical maturation has occurred in the digestive system which now makes food intake the comfortable and

gratifying experience it can and should be for all infants (and their caregivers). We do not yet know whether that maturation is in the digestive tract itself (that is, in the mouth, stomach and intestines) or in the brain, or both.

We should note that the primitive reflexes seen from birth on, although still present at six months, do not have the strength that they had when the infant was just born. For example, the Moro reflex -- which consists of a startle reaction usually with some sign of distress on the part of the infant, accompanied by bringing the arms around as if the infant is about to embrace and cling,--may well be gone by now and have given way to other clinging reactions in association with stress. The rooting reflex -- the turning of the mouth toward a stimulus that touches the cheek -- will also be quite weakened. The grasp reflex -- clutching with the hand of whatever touches its inside surface --, on the other hand, is still strongly present and will account for the infant's getting hold of the mother's hair and then not being able to release that hold, which often gives the mother the erroneous feeling that the infant is pulling her hair intentionally.

Temperament-based patterns of reactivity that emerged from the first weeks of life -- whether it is shyness or active contact seeking, low or high activity type, slow or quick reactor, etc. -- will most likely have become somewhat patterned and can be known and anticipated by most parents or other constant caregivers. A mother knows now how long her infant will be able to wait for feeding, the child's tolerance for delay, whether the infant will fall asleep easily, whether the baby is likely to be irritated on waking or how much he or she will become irritable before bedtime.

Perhaps most important of all these developments is that at six months the social responses on the part of the infant will have achieved a highly different level from that which existed in the first weeks of life. On average, at six months the attachment responses, including the social smiling response, the stranger response, the separation reactions and reunion reactions, are already clearly developed. These responses and reactions are important indicators of the child's forming relationships with those the infant now specifically values. This development makes for very important differences between the newborn and the six month old. One difference is that whereas the newborn is equipped to become one, the six month old is now becoming a social being who is forming very important and strong human attachments. All this is made possible by normal, expectable maturation of the brain. When, as occurs in a very small percentage of infants, the maturation of the brain that make the infant need to attach do not occur, that infant will not elicit the emotional contact it needs from the parents and/or will not respond to the parents' natural reactions of love and nurture. We do not yet know what causes this type of failure of brain development. We shall discuss in Section 1.215 why the brain development that makes attachment possible is so all-important.

If we contrast the one year old and the six month old in the aspects noted, we will again find a large advance in growth and development. We assume that brain maturation that serve the major physical senses (seeing, hearing, smelling, tasting), that serve intelligence, feelings and moods, and that development of the bones and muscles continue at an adequate rate. For instance, the development of vision in the one year old is quite mature; the infant is now able to focus readily on all items around and we assume sees all details as well as older children. The one year old recognizes sounds not only of

those with whom he is familiar such as the mother, father, and siblings, but also the sounds of various types of animals, various types of vehicles as well as other noise producing things and events. With regard to locomotion many a one year old is able to walk, is of course still unstable, but nevertheless is able to move upright, an extremely important development.

With regard to vocalization, one year olds are able to recognize the meaning the many words, and the meaning of communications by their parents to them, even though they may not be able to say words with which they are now familiar. For example, in a group observed by us, when mother casually asked her 12 month old son Johnny to please get her a broom, we were all surprised to find within a few moments one year old Johnny coming to his mother, broom in hand. Johnny could not say the word "broom", yet could understand the word clearly. It is important to emphasize that the 12 month old, while not yet able to communicate verbally for the most part, is amply exercised already in communicating with those around her/him, the child communicating by means of feelings, facial expressions, gestures and nonverbal sounds.

In summary, the one-year-old's degree of helplessness has diminished. He or she is able to walk or to crawl with great facility, to grab a cookie from the table or another child's hand, and to hold things which he or she can bring to his or her mouth for the purpose of feeding the self. Many other activities of this kind, of course, are now available to the 12 month old because of the large development in coordination of the child's hand with the eye, as well as with the mouth, which serve to help the child explore the environment in which she or he lives as well as including the complexities of his or her own body, and those the child values.

Most primitive reflexes are essentially extinguished by 12 months of age except perhaps, again, for the grasp reflex that tends to hang on the longest. Most complex reactivity patterns continue, such as the tendency to smile on seeing a familiar person or having a greater or lesser intense stranger reaction on seeing someone the child does not know. By 12 months of age attachment and other social response have come under much greater control of the child's adaptive functions; they are no longer just built-in adaptive reactions. At one year of age the social responses of the child are further developed than they were at six months of age, the 12 month-old capably discriminating between people he or she knows and those the child does not know. A high level of preference exists for the mother, and secondly for the father depending on his degree of contact and emotional involvement with the baby. We also recognize that an infant, by 12 months of age, will have formed a quite meaningful relationship with siblings. For many a 12 month-old, a sibling can substitute for father or mother at least for a substantial period of time when the mother may be unavailable. Patterning of attachments and of all the adaptive activities we have talked about here are developed and set down in the brain. This gives these patterns of behaving some stability by the end of the first year. These will continue to develop under the influence of both inborn physical developmental programming directed by the infant's genes and by the experiences the child has.

In these pages, we have wanted to highlight the fact that the human newborn comes into the world ready to meet the challenges of surviving outside of the mother's uterus. Of course, a human infant -- like all living things -- is magnificent, more so than the

words of scientists, philosophers, or poets can describe. We only want to help future parents understand that the newborn's brain, internal bodily organs and his or her bones and muscles, are sufficiently matured and developed to function to sustain comfortable enough life when the newborn's needs are adequately met by the parents. When their needs for physical and emotional nurture and care are met well, infants will thrive.

Regrettably, a percentage of infants are born with their internal systems not able to function well even when very well cared for. One or more of their internal organs are immature at birth, or there may be some defect either in their organs' structure or in the way they function. A human infant is so complex, so many organs and systems develop, there are so many maturational changes that need to happen, that it is remarkable that so few immaturity and defects actually do occur.

Immaturity may catch up in time and the organ or system that was immature may then function normally. For instance, we think this is what happens with colicky babies. Defects too may or may not correct themselves overtime. These defects may be mild; some may be severe. Immaturity and defects of organs or systems that cause infants discomfort, pain or distress will make experience and adaptation more difficult for the infant, and therewith, for the parents. The common result is greater than average irritability, increased stress, frustrations and disappointment in both infant and caregiver and problematic parents-child relationships.

We also wanted to make clear in these pages that the first year of life is a period in which a great deal of physical development occurs, and that one can trace the large degree and detail of growth if one follows any particular aspect of functioning and compares its degree and level of development in the newborn, in the six month old, and the one year old.

Effects of the environment on development:

A number of factors affect the infant's growth during the first year, favorably and unfavorably. These include nutrition, the quality of health care and hygiene, the degree of rest and of activity and the opportunity for activity. We have learned this century especially, that the emotional atmosphere in which the child is reared plays an extremely important part in his or her physical development. Just as the formation and development of the infant in the mother's uterus was affected indirectly by the emotional status of the pregnant woman's family, and directly by the emotional state of the mother, even more now the physical development of the child is affected by both the physical and the emotional status of the caring and nurturing environment. We emphasize that the emotional atmosphere in which the child grows contributes not only to the child's own emotional development but equally the child's physical development. Pediatricians everywhere now know that a large number of infants who come into their offices because of their "Failure to Thrive", are infants whose growth has been stunted, not just by lack of food, but especially by insufficient emotional nurturing.

1.12 CHILD REARING: What Can The Parent Do That Is Securing of Good Physical Development?

The infant can do many things by herself/himself, such as breathe, swallow and digest, eliminate waste products, scan the environment, signal distress and the need for help. These abilities are built-in in the well developed healthy newborn. But even such a newborn, on the other hand, cannot do many things that are needed for healthy growth. He or she needs parental help with feeding, maintaining reasonable hygienic conditions (diaper changing, cleaning), etc.

These aspects of the child's needs are easy to see. The emotional psychological aspects of the child's needs, however, tend to not be seen as readily. Many parents, for instance, truly believe that holding their baby will make the infant more dependent, "spoil" the baby. The reverse is true. Many parents also do not seem to realize that it is growth-promoting to let the infant try to do things the infant has not done before, things that require effort, because this stimulates the development of new adaptive skills. One of these skills for instance needed by infants who react to feelings of hunger very rapidly, is increasing progressively, age-adequately the ability to tolerate frustration like waiting a reasonable amount of time to be fed. Other skills include moving and locomotion, exploring and learning about the world the child lives in. In these, intervening by the parent facilitates growth when the infant's efforts fail and would lead to too much frustration, leading to the infant's getting discouraged in trying to learn new skills, and in learning to cope. In this, it is important for parents to try to discern when the child is being too frustrated. This requires listening to and learning what the child's signs and signals of distress are. Too much strain and stress can interfere with continuing good physical growth and development.

We want to give you a very painful example of what happens to a large number of children who are neglected and/or abused during the first year of life with serious consequences to their physical as well as their emotional development. When we first saw Richie, he looked about 8 months old. He was depressed, with a distrustful look and sad eyes. He was subdued, barely moved, and his movement were sluggish. He was thin and quite irritable. Richie was then actually 14 1/2 months old. This was all the more striking because photographs of him when he was 5 months old showed an attractive, smiling child, well developed, healthy 5 month old. What had happened is that until the age of 6 1/2 months he lived quite comfortably with his 17 year old mother, her teenage boyfriend, and mother's aunt. At this time mother's boyfriend insisted that they move from the aunt's. Two weeks after this move into a place of their own, Richie's father left them. Now alone with her baby, Richie's 17 year old mother became very upset, and so did Richie. She began to find his being upset, fussy and crying unbearable, and she would at times put him in the hall to cry himself out. Things went from bad to worse and at 9 1/2 months Richie was eventually brought to the Emergency Room of our hospital with a fractured left arm and bruises. Although his troubled young mother denied the charges of abuse, Richie was taken from his mother by a Child Protective Agency and placed in the custody of her aunt, who had originally helped them. Because his recovery

was very slow and he was very irritable, we saw Richie now 14 1/2 months, with his great aunt. Records indicated that Richie's health and physical development began to deteriorate from the age of about 7 1/2 months. At 9 months he appeared withdrawn according to a reliable source. At 9 1/2 months is when his young mother brought him to the Emergency Room, very upset by his injuries and his distress.

Richie sadly illustrates how the physical (and emotional) development of a healthy baby (up to 6 1/2 months) by virtue of neglect and distress-instigated physical and emotional abuse by an overburdened and abandoned teenage mother can be seriously disturbed. Physical development that was normal and healthy up to 6 1/2 months, drastically deteriorated so that by the age of 14 1/2 months, he looked no older than 8 months. If the primary reason for the arrest of his development was only due to insufficient nutrition and hygiene, his development should have resumed from 9 1/2 months on, when he came into the care of his great-aunt, where ample food and physical and better emotional care were again available. The great-aunt's report was that his growth and his emotional state were not progressing and she needed help to know what to do.

In order to reverse this child's seriously disturbed condition, we worked with the great-aunt in her interactions with Richie and in his interactions with other children around him. We focused on helping Richie regain his great aunt's trust, to help him feel that his environment is now again nurturing and safe. As his emotional state improved, Richie needed help with controlling his rage and destructiveness. Such rage and destructiveness is usually one of the first reactions we find with young (and older) children who have been neglected or abused by their parents, when they are on the road to recovery. His progress was slow but it was clear that physical growth was picking up again. Although our focus here is on the possible consequences of hurtful environmental conditions on an infant's physical development, it is obvious that such conditions can also seriously damage an infant's emotional development.

Let us consider a few specific areas of adaptive functioning directly dependent on the state of the infant's physical development.

Activity Level:

Regarding the child's activity level and activity type, most infants tend to be moderately active from their earliest days. They sleep comfortably and for long enough periods. When hungry or otherwise distressed they react firmly and loudly enough to be heard in the next room. When awake and comfortable even from the 3rd and 4th week on they begin to look about, become busy to a greater or lesser degree. In such instances, the parent needs to do little to help the child attain a comfortable, growth-promoting level of activity.

Some infants though, may be so sluggish that in order to feed reasonably they need to be aroused gently by the nurturing parent. In infants whose sluggishness is quite heavy, the parent may have to waken the newborn after 5 to 6 hours and by gently rocking movements keep the infant alert enough to feed. Cases like that may reflect some problem in the brain whereby the regulation of normal expectable waking and feeding is

not functioning well, these infant's tend to come to the pediatrician's attention, as indeed they should.

Other infants may be easily aroused by very slight noises or movements, be too excitable or pressured by activity from within their bodies, so that in order to feed comfortably and sufficiently, they need parental help in calming down. By being gently, comfortingly calmed and slowed down a little they can begin to learn to calm and slow themselves down, to begin to learn to control their own tendency to over-excitation. The nurturing parent, by soothing, can initiate and maintain the process of calming, a process that from the earliest days can direct a potentially hyperactive infant toward becoming a reasonably calm one. Such infants become too easily excited or tense and need to be protected by the nurturing parent against excessive stimulation, such as excessive noises, lights, being handled by too many others for too long. The parent acting on the infant's behalf, in many instances, can provide the shielding needed to make the infant comfortable.

Some infants who are hyper-responsive, highly sensitive and/or hyperactive due to their inborn (brain function) disposition, may be very difficult to calm. Some just cannot be calmed by even the best of nurture and calming efforts. These infants experience much distress and cause much distress in their parents. One the major problems lies especially in that this condition can get the parent-child relationships off to a very troublesome start with possibly life long consequences.

By the time now 2 1/2 year old Suzy was 3 weeks old, her 31 year-old parents (mother a lawyer and father a teacher) were tired out and very upset. They felt they must be doing the wrong things because they just could not calm Suzy for more than a few minutes at a time. Mother said she must be a bad mother and father was becoming impatient with her (mother) because he felt she was just not doing the right things with the baby, even though when he tried, he often had no better success. Observing mother with Suzy several periods showed that in fact mother was holding and trying to calm, and interact with one month old Suzy very gently, indeed soothingly and warmly at first; but gradually she would become more and more troubled and even tearful and then angry with the baby. It was clear to us that Suzy was irritable, very difficult to calm, unable to relax, and seemed in distress especially when feeding. Even when she slept, she would move about a good deal, sometimes with jerky body movements. We told mother and father that Suzy was an infant born with some brain immaturity or mild dysfunctions -- which we cannot yet explain -- which made her very sensitive to all kinds of stimuli, made her easily irritably and seemingly in pain and made her unable to be calmed by even the very good efforts mother was making. Mother was immediately relieved and tearful. We assured her that her efforts to calm Suzy were really good and that we have no tricks in our bags to make Suzy better able to accept mother and father's more than adequately calming efforts. Father by now was apologizing to mother for having lost his cool and not having recognized that his baby had a brain immaturity/dysfunction problem. Although mother was greatly relieved that we could tell her that she was not a "bad mother", she was troubled that Suzy had this problem and she was mad (you could see it) at her husband for having influenced her feeling that she was doing everything wrong. We told the parents they would do well to help each other care for Suzy, that the

task is difficult. We told them that a large percentage of such babies eventually seem to become calmer, become better able to accept comforting and to calm themselves. We cannot predict how soon this would occur. We advised them to continue their good efforts even if they seem to not be effective at the moment. We also cautioned that when they find themselves getting very upset and then angry with Suzy to (1) remind themselves that Suzy can't help her way of reacting, that she is not trying to give them a hard time, certainly it is not that she is being an ungrateful or bad or evil baby; (2) that they can help each other, when possible, especially when whoever was caring for Suzy was getting upset; and (3) because mother was planning to return to work when Suzy was about 6 months old, they ought to try to make sure that whomever was going to care for Suzy was able to deal with a moderately difficult baby like Suzy in a loving and constructive, growth-promoting way.

One month after this first consultation, mother reported (and looked it) that she was feeling much better about herself, felt more consistently loving toward Suzy and found that she was not getting angry with her even though she felt that poor little Suzy was still having much trouble calming and being comfortable. Within 8 months, when she was 9 months, Suzy was already quite easier to comfort, could be very pleasant for hours at a time, and the parent-child relationship was successfully protected. Mother felt good about her efforts, was becoming confident in her ability to calm and love Suzy. Father was much less worried and engaging quite well with his daughter. Suzy was a bit thin and wiry and could too easily become irritable; but she was also quite nicely attached to both mother and father, had a lovely smile, was not having tantrums, and was developing quite well. We observed some very loving moments between Suzy and her parents.

Sensori-Motor Functions:

How can the parent promote healthy growth in the child's vision, hearing, vocalization, and locomotion (moving about at will)? Let's first say that vision, hearing and vocalization, and even locomotion, serve to develop an emotional dialogue, emotional inter-relating, between child and parent which is of supreme importance. Of course, the quality of that emotional dialogue is critical. Where the emotional dialogue is predominantly loving and respecting, it is one of the most important sources of security and well-being in the infant, child and later adult.

From the first days after birth, at first only briefly but for longer and longer periods, the infant explores his environment in two ways: (1) by scanning it, and (2) by focusing on one detail at a time. For instance, at two weeks of age, when the child is comfortable and awake, you can follow the scanning and then see the child's eyes stop moving and with effort stare at a face or at a high contrast scene, such as a light, or a window. This also occurs with hearing. The baby turns toward a sound. These are the beginnings of seeing and hearing, very important instruments that serve the child's adapting to her or his world. The parent can enhance the better development of these instruments (functions) by responding to them in the form of a dialogue, by providing sufficient but not too intense light and some colorful or black and white pleasant images (geometric designs or moving objects)--in contrast to somber, harsh or even frightening images. Most

important is that looking at the infant when he looks at mother, father, or sibling can help to firm up the image of a responsive mother, a responsive father, and sibling in the young infant's mind, a factor that enhances and optimizes such important developments as attachment, reciprocal human relations, basic trust, and good self-esteem. Similarly, responding verbally to the infant's hearing a sound to which he or she turns gives added value to listening and hearing.

It is growth-promoting to respond emotionally reasonably to the infant's vocalizations. Even the baby's earliest vocalizations have sounds that are pleasurable or have a stress quality which are powerful communications to which most healthy and mature people respond with a feeling of understanding what the baby is experiencing. These vocalizations, from their earliest utterances, if answered by comforting, affectionate or playful feelings and words, enhance the child-parent emotional dialogue. Responding reasonably and warmly to the infant's vocalizations strengthens that experience between them that will eventually become bonds of affection, of high emotional value, and respect between child and parent. It also leads to the child's learning to communicate in words, in thoughts, and with feelings, all of which facilitate the child's adapting to his or her world.

The parent's help in enhancing locomotion is probably among the best known ways a parent can help her or his infant develop new skills that will facilitate the child's efforts to adapt and grow. Most parents enjoy helping the child stand and later take his or her first steps. Responding to the cues that the infant wants to crawl, wants to stand, wants to walk is important. Usually, there is no need to push the child. When ready, the average child will be eager to crawl, stand and walk. The parent's best help may be in being able to wait for the child's cues, and to help when the child "asks" for it. In most children, from near the end of the first year of life, and in some children even from the first weeks on, the infant will want to do things by herself or himself without parent help. In fact, the infant may experience the parent's wish to help as an intrusion into her or his own efforts to master his or her own body and world. The parent who looks at the baby to discover what the baby can do will recognize that the child has a great internal pressure, which is felt as a need, to learn to control and master his or her own body and the external world into which he or she was born. Bear in mind that this is a new world for the infant. The better the child achieves this control and mastery in an age-adequate way, at a pace compatible with the child's age and abilities, the more the child will feel secure. So: it is "I wanna do it!" one moment; and "help me do it" the next.

It is, therefore, important that parents try to read their infant's cues; it is not always easy. But in return, the child is much more likely to learn to read the parents' cues too.

Social Responses:

In speaking of vision, hearing, and vocalization in the infant we have already talked of social responses. The infant's need for an emotionally positive (affectionate, valuing, respecting) parent-child relationship is great. Such a relationship begins to develop with the first social behavior and even before. The importance of an emotional relation to one or two parenting person(s) lies in the fact that a meaningful positive attachment,

emotional relationship, to a parenting person serves many vital developments. Among these are, as we shall detail in this Unit, the ability to get along with others, to develop a sense of self-reliance, inner security, self trust and respect, and to develop a code of morality consonant with the family (and society) in which the child lives.

In the first year, the child's emotional relationship to the parents is triggered by an especially strong inborn mechanism that serves to attach the child to the members of its own species (*Homo sapiens*). That mechanism for attachment to caregiving and emotionally interacting individuals shows itself in the infant's social smiling responses and its related stranger, separation, and reunion responses. At its beginning, the social smiling response appears like a complex reflex response; it is a powerful inborn activator of socialization in the child. However, a reciprocating nurturing response by the parents is required for the development of the all-important capacity in the child to form enduring and positive emotional relationships. Because these responses (behaviors) are so important to the infant's total emotional development, we will take these up separately under Behavioral Manifestations of Attachment in Sections 1.215 and 1.225.

Reflexes and Automatic Reactions:

The most readily observable reflexes are the Moro, the grasp, and the rooting reflexes. There are also more complex automatic reactions like clinging, crying, and smiling. Even here we ask, "What can the parent do in seeing that such reflexes or built-in reactivity is growth promoting?" For the most part, of course, nothing needs to be done. You may wonder, "Why bother knowing about reflexes or such early automatic reactions?" We think that each reflex is an automatic coping physical reaction to a stimulus. The more complex automatic reactions infants show are actually elicited by feelings the child experiences. Many scientists believe that reflexes and automatic behavioral reactions are, for the most part, inborn adaptive mechanisms. Sometimes, though, these can cause some distress in both child and parent. The parent can assist the infant's built-in reactions both when they are adaptive and when they miscarry. If the parent doesn't know that some reactions are automatic and reflexive, the parent may find the behavior worrisome or annoying. Here are two common examples.

When a normal seven month old infant sees a person that is new, or strange, to him or her, that infant may react with acute anxiety, latch onto mother, and cling to her for dear life. Some parents react to the tight clinging of their infants by trying to loosen the infant's hold; this, however, will tend to intensify the anxiety and with it the child's need to cling will intensify. The sooner the parent acts to calm and comfort the infant, the sooner will the need to cling lessen. Clinging is a normal, automatic response and effort to adapt to what the infant experiences as a stress situation. Anxiety or fear are what leads young children (and older ones) to need to cling. Lessening the anxiety by calming and comforting reduces the intensity of that need. Of course, when young children need to cling, they should be allowed to do so and do so for as long as the need is there. We emphasize that rejecting the need to cling does not make the need go away, it often intensifies it even if the infant complies with or accepts being forced to stop clinging. Many problems may arise from not having been allowed to cling (which means to be

held) to a degree reasonably equal to the need to do so. We will talk more of this later.

An example of a simple reflex that can cause some mild difficulty is the grasp reflex. If you gently scratch the palm of an infant, the infant's hand will react by grasping. Thus, a three month old may touch mother's hair which will activate in the infant's hand a grasp reflex. The mother then discovers that once the infant's hand grasps her hair, the infant seems to enjoy pulling at it. But what is really happening is that although the infant is equipped with the reflex to grasp, he is not equipped with the reflex to let go. In fact, the infant has a hard time acting against his or her own grasp reflex and cannot let go. He will not have that ability until that reflex wanes during the latter part of the first year. Some parents feel that the infant is nasty when this happens and become angry with her or him. Here the parent needs to help the infant let go by gently prying the infant's fist open along with a reasonable explanation that pulling hair hurts and the infant is not to do that. The infant has to learn to let go and during the first year needs the parents help at times to do so.

Our aim in these sections has been to consider a few key physical, bodily organs and systems which must develop well enough because they are required for and make possible the infant's age-expectable experiencing and functioning during the first year of life. It should be clear to every parent-to-be that the mother-to-be's health is vitally important and determining during her pregnancy of how the infant-to-be's bodily organs are being formed and developed. How well developed and how normally functioning all bodily parts and systems are, importantly determines how the infant will react, respond and function when life after birth begins. Furthermore, parenting is certain to be more taxing for the parents when the infant's bodily functioning capabilities are not well developed.

We also aimed to alert the future parent-to-be to the fact that how they care for their newborns through the first year of life can have a profound influence on how these bodily organs and systems continue to develop and function. We have emphasized that a warm, loving, considerate and respecting human environment, along with the meeting of the infant's needs for food, shelter and good hygiene, is highly promoting of good physical development and health. Infants need a sufficiently warm, loving, attentive and respecting human environment to thrive physically as well as emotionally.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.211 HUMAN DEVELOPMENT: Sleep and Wake States and Patterning

There is a pattern of alternating sleep and wake states which gradually shifts from shorter to longer periods of wakefulness. The neonate may sleep as much as 3 to 4 hours and then be awake for from 20 to 40 minutes, each infant having his or her own time schedule. The neonate may thus sleep as much as 16 to 20 hours a day and have wake periods that total from 4 to 8 daily hours. These cycles of sleep and wake states modify in such a way that by the time the child is one year old the child may sleep for 10 hours during the night and perhaps sleep for one to two hours in the afternoon with a morning nap as well, but will now for the most part be awake for a total of anywhere from 8 to 10 or more hours per day. We assume that the sleeping state is essential for bodily adaptation and the stabilization of its functioning on its own (that is, outside the mother's uterus) rather than due to the need to recuperate from tiredness that results from wakefulness and activity. At the same time, the wake states are extremely important for the infant's progressive and necessary beginning acquaintance with the world into which he or she was born and beginning mastery of it. Observation will show that during the states of wakefulness the infant begins to explore and learn about his or her environment including its animate as well as its inanimate contents. Both good and sufficient states of sleep and of wakefulness are needed by the infant in order to adapt to his or her new world in a healthy manner.

We all assume that falling asleep is a most natural thing for infants to do and that it would be automatic. And for most infants it is. But for some babies it is not! Actually one has to be able to organize and synchronize one's bodily systems and what one is experiencing to fall asleep; one's brain and body have to coordinate and be at a sufficient level of restfulness for sleep to follow. Some infants are born with sensitivities to a variety of stimuli (from sources outside or inside the infant's body) that make it difficult for them to achieve that sufficient level of restfulness needed to fall asleep; or they may experience pain due to some bodily dysfunction (for instance, gastrointestinal irritation or cramping) which interferes with their ability to calm and rest; or they may have problems "holding" that state of sufficient restfulness to stay asleep for a reasonable duration of time. This, by the way, may lead to much discomfort and even distress for the child as well as the parents.

From what her parents described and what we saw, 3 weeks old Suzy was frequently irritable and difficult to calm. She seemed then unable to become restful enough to fall asleep. At times she seemed to have bursts of pain we believed to come from GI (stomach) dysfunction. Even in her sleep she did not just lie comfortably; she had occasional jerky movements and her face did not seem peaceful. As we said before, not only was Suzy in some distress, but so were her parents. What could they do?

1.212 CHILD REARING: How to Optimize Sleep-Wake Patterning

What can the parent do that is GROWTH-PROMOTING is our foremost concern. The ratio of sleep-time to time-awake goes from more sleep: less wakefulness to, gradually, less sleep: more wakefulness. Parents know that many infants under 4 to 6 months may have trouble calming and going to sleep or that they will waken during the night. By the time she was 3 weeks old, Suzy's parents knew that getting Suzy to calm, go into a restful state and fall asleep was interfered with, not by their poor caregiving as both mother and father thought, but by Suzy's own central nervous system immaturity or bodily dysfunction. With Suzy, going to sleep was a problem; but so was staying asleep for the hoped-for 3 to 4 hours. This was stressful for Suzy and it was so also for her parents; for her parents, especially because it made them feel they were not being good-enough, capable-enough parents. Unfortunately as happens too often, mothers get blamed and they take on the blame too readily. The infant's waking during the night also is experienced by all parents as a stress because parents have normal needs (from 6 to 9 hours of uninterrupted sleep) for good rest which the infant is disturbing.

Nevertheless, the "good-enough mother" or father (as Pediatrician-Psychoanalyst Donald Winnicott said) will have to come to the rescue of their infant, sleep-deprived and more or less stressed out. And the first question will be "What's wrong?" which is followed by "What can I do to put Suzy back to sleep." A number of factors may cause the infant's difficulty going to sleep and/or waking during the night. We can consider these factors in three major categories: 1) a sleep disturber coming from the child's own inner experiencing; 2) a sleep disturber coming from outside the child's self; and 3) a sleep disturber coming from tensions in the parent-child relationship.

1) From the child's own inner experiencing: A number of factors can be sorted out.

(a) Simple immaturity and slowed maturation of the infant's central nervous system may cause mild difficulty in self-regulation, calming and falling asleep or in maintaining a calm sleep state and may only gradually allow the sleep-wake cycle to become stable. Benign immaturity is a large reason for the less than four to six month old infant's difficulty in going to sleep or in maintaining sleep states sufficiently. Development, habituation and patterning of sleep-wake (and especially feeding) cycles into night and day cycles occur spontaneously but can be facilitated by the parent's reasonable planning for the infant's sleep and waking periods. Parents can gently encourage and discourage when the baby should go to sleep. In many small ways parents can do this and the infant learns to comply nicely. Affectionate, considerate, at times firm but loving ways of telling the baby what is expected always, in the long run, work better than yelling, ignoring, or hitting a less than one year old (or any age). Of course, the parent has to judge if the demand is one with which the infant can comply, such as to now go to sleep. On the other hand, the parent has to comply with the needs and demands that the infant

cannot control. These babies most commonly need more holding and soothing than a more matured nervous system baby. They do not yet have the ability to calm themselves. The give and take between parent and infant contributes to, is an expression of, and will forge the emotional dialogue developing between them. The give and take requires infants and parents to find ways of accommodating to each other's biological make-up, personalities and preferred and temperament-determined ways of functioning. It does not always have to be smooth or harmonious; it has to be sufficient or good-enough to satisfy adequately the needs of both infant and parent.

(b) More troublesome bodily disturbers, such as significant neurological (brain) underdevelopment for the infant's age, uneven development of brain functioning or brain processing disorders that make for excessive restlessness and irritability, sharp difficulty in self regulation and calming, in gastro-intestinal dysfunctions, allergies to food, to clothing and detergents, conditions such as asthma or skin disorders like eczema, can cause much irritability and restlessness as well as pain in the infant which then can seriously interfere with going into or disrupt sleep. These can cause serious hardships for both infant and parent. Pediatricians and general practitioners can be enormously helpful and should be consulted.

A less serious instance is that of Suzy and her 31 year old parents whom we saw when Suzy was 3 weeks old. Telling them that the difficulty Suzy experienced came not from poor nurture and comforting methods but from Suzy's bodily dysfunctions, her parents were greatly relieved. Both had really tried just about everything reasonable they could think of or they read about. Mother became worried that she was getting too angry with her 3 week-old baby. She felt she was a terrible mother, father too was having a hard time and turned his anger on his wife, blaming her for the baby's behavior.

This situation was very different from that of Richie and his depressed, deserted, and troubled 17 year-old mother. Richie had been a very well developed baby, healthy in all major ways and developing well until 6 1/2 months. His difficulty in sleeping did not come at first from within his own body.

When we worked with Suzy and her parents, we found that once her mother stopped believing she was a "bad mother" -- and her husband felt pretty miserable about blaming her --, she became more tolerant of Suzy's dysfunctions and irritability. Following our recommendations, she could now try to soothe and comfort her more easily, more patiently, and for longer without needing relief from her husband (when he was home). Father too was more patient and sympathetic to his baby, and offered to care for her much more readily than he had before. As a result, especially from about 3 months of age on Suzy seemed to become bit by bit easier to calm. Especially important is that she began to have longer periods of calmer sleep and wakefulness. The calmer sleep probably made bodily rest and development better and calmer wake states made her contacts with her mother and father more positive, loving and pleasurable, and gave her more time to visually and auditorily (hearing) explore the new world she was born into. By 9 months one could not tell from looking at her, that Suzy had been the very irritable newborn she indeed had been. There were no tricks and no magic in our recommendations. Recognizing the baby's inborn difficulty in soothing and calming, her

GI distress, patient soothing efforts by her parents, soothing by talking to her, sympathy for her discomfort and pain, hours of walking holding her lovingly, patience in feeding, trying to not feel upset when she would spit up some of her feedings, these were among our recommendations. As she got more than 3 months old, we suggested that once she was put down half asleep, or when she woke up too soon, that soothing to facilitate sleep (or facilitate the continuation of sleep) be done with the least wakening technique needed. That is, soothing by gently talking to the baby while gently patting her back or shoulder is less wakening than picking her up. Picking her up should be done only if patting didn't work and her crying would waken her more than her being picked up. If there was magic in what made things better for Suzy, it was in her parents' tender loving care (TLC), that powerful thing parents have.

(c) Transient distress which causes pain or illness (like a cold or a gastrointestinal ["stomach"] virus) will, of course, disturb sleep. Intense discomfort that comes with a fever may do the same. Let us also consider here acute states of anxiety as in the average six to 10 month old, at the time when the infant is establishing attachment to mother and father, and especially so when mother is away for a few days, be it on a business trip or for a hospitalization. Here too, we include frightening dreams that occur from about five to six months of life on. A variety of fears can cause such dreams, mostly having to do with fearing or feeling separation from mother (see Section 1.215). One can often observe an infant sleeping fitfully, restlessly; the normal five to six month old infant (and older) who is known to have been able up to now to sleep comfortably is now sleeping at times fitfully or waking due most likely to frightening dreams.

2) A number of sleep disturbers come from outside the child as excessive noises, too much light, commotion, heat, cold, or a soaked diaper, etc. Of course, parents are enormously helpful in protecting the infant against such disturbers. Where such disturbers cannot be eliminated, such as excessive noises from the street, calming and comforting (TLC) can do much to help the infant accommodate and learn to not be awakened by such interferences. Infants do learn to protect themselves by shutting out disturbers of this kind, but may need help (commonly the best being TLC) in doing so.

3) Tensions in the parent-child relationship, especially in the mother-child relationship, may cause in the infant an inability to sleep comfortably. The baby's inner state of feeling resonates empathically with the nurturer's (be it mother's or father's) emotional state and, thereby, tension in the caregiver will usually cause tension within the baby. The counterpart of that, or its complement, occurs as well: the mother or father will resonate emotionally with tension within the baby. Such tensions are communicated in a number of ways: by bodily sensations such as muscle tension, stiffness in holding, roughness in body movements; by the tone of the caregiver's communications to the baby (impatient, distressed, angry, etc.) and by emotional channels best described by the expression that "feelings are contagious". As we shall detail in Sections 1.214 and 1.224, there is a direct line of communication of feelings that is open between infant and caregiver from the first moments of life on. Tension in the mother-child relationship

causes tension in the baby. It is then unavoidable that it causes restless sleeping and sleep disruption in young infants. It is thought to be a facilitator of colic in children who are predisposed to it. Of course, colic will not be caused only by a mother or father being tense. The infant who becomes colicky has this tending in his or her gastrointestinal system.

The best way to reduce tension in the baby is by decreasing the tension in the nurturing parent; this is the first step to be taken. Because it can start the parent-child relationship on the wrong footing and establish troubled, usually hostile patterns of relating with each other that may later be difficult to change, it is in the best interest of both child and parents that such tensions be dealt with early. In fact, where possible it is best to deal with them when they arise; if that is not done, then the sooner it is addressed, the better. We want to emphasize that it is never too late to try to reduce negative tensions in relationships and try to repair the harm it may have caused. One need not be ashamed of asking for help; it will save child and parent a lot of pain and grief for many years to come. The most probable and common cause for such tension in a young or first-time parent is part of a quite normal reaction to the tremendous responsibility of taking care of one's first child. Either a Parent Education group, or if the problem is difficult, individual professional help can be of enormous value.

What to Do

Let us look more closely at what to do. Generally, when a less than 6 month old infant cries, parents tend to get up, however tired they may feel (see below), and tend to the infant's distress and needs. The search for "What's wrong?" is automatic. And gradually the parents come to learn what kind of sleep disturber is troubling the baby, whether it is normal hunger pangs, or colic and other disturbers. It is important to go to the infant and do what one can to try to eliminate or at least reduce the less than six month-old infant's distress. And where the disturbers is one outside the expectable normal causes for sleep disruption, for instance if it is colic, or another factor that produces a harsh reaction in the infant like breathing difficulty, or a nasty looking rash, etc., consultation with the pediatrician is warranted. If the infant is under six or so months, unless one can clearly identify a pain-producing factor, it is most likely that the establishment of the patterning of sleep-wake cycles is probably at work. Under six or so months, the helplessness of the infant is so great that much of the comforting efforts have to come from the nurturing parents; for the most part, they cannot yet come from the child herself/himself. Sufficient comfort is prerequisite for the infant to sleep well enough; and comfortable enough sleep is required for the infant to establish good sleep-wake patterns. In fact, the infant's feeling comfortable enough much of the time is required for the infant to develop good basic patterns of adaptation to life outside the mother's womb.

From six to twelve months, the infant can be expected to have developed some ability to wait a bit, and to begin to respond to reasonable demands of cooperation made by the parents. One of the most common issues confronting a parent whose six to 12 month old is waking repeatedly during the night, or is having difficulty falling asleep, is: "Do I go

in again and comfort her or him? Or do I let him or her cry?" This may be among the first nastier problems parents may have with a healthy baby. Let's consider:

- (1) What's causing the problem?
- (2) What can stop the problem; and
- (3) How to go about it.

But before we do that, an important note. When the baby cries at night, he or she needs help (See Crying, below). But parents, given that they are human beings, need rest and usually from 6 to 8 hours of sleep. Being awakened during the night, during periods of "deep" sleep, causes us irritation, a feeling of malaise (a sick feeling) and sometimes even nausea. It is a physiological reaction, at least in part. Also, when we are awakened within several hours of going to bed, the unpleasure, if excessive, of being so awakened makes us angry--even those we love, even with our infants. So, the situation creates a dilemma. When baby cries at night, he needs help. Mother needs rest; so does father. Whose needs are the most critical at any given time? It is not always the baby's. Children have needs, and they have rights. So do mothers; and so do fathers. The baby needs the parent to respect her or his feelings and needs. Unfortunately, the baby has not yet had enough time to learn to respect the parents needs for rest and sleep. Parents much understand this. Respecting one's parents' needs is not inborn; it is learned; and it takes time. Parents, therefore, have to try to be reasonable. And parents can, from very early in the infant's life, work very slowly but definitely toward making the baby try to be reasonable too! With this in mind, let us return to the issue of the 8 or 10 month old, crying during the night.

Something is causing the baby to waken and cry during the night. Infants, like everyone else, do not cry without some cause. What is it? Which of the disrupters of sleep could it be? It is important to listen to the sound of the infant's communications; to let oneself feel it. What experience would make the parent make this sound if the parent were a baby. If you were feeling that way, what could be doing it to you? Although you may not be right, if you put yourself in the infant's shoes and imagine how you would feel if you sounded the way the baby sounds, the chances are quite good that you may be right on target. This is what we call empathy: to let one's feelings resonate with what another person feels. Feelings are contagious, and resonating in this way, will give the parent pretty good clues as to what is causing the infant's waking from sleep. If after consulting each other the parents cannot figure out which sleep disturber is at work, consult an experienced neighbor or other parent, or an appropriate professional person, if night waking occurs frequently and for some time.

Knowing what is causing the waking will help you know how to stop the problem, if it is in fact a problem. If the infant is crying, it is well to assume he is having some kind of pain. Can the parent stop the pain? The parent may not be able to sort out what painful factor is at work until the 8 to 10 month infant is looked at, and then if necessary only, picked up and held. For instance, seeing the infant twisting her or his body most commonly indicates inner body pain. Or if it becomes necessary to pick up the baby, feeling the tension of the infant upright against the parent in the well known burping position, the erupting of the air bubble and the infant's body then relaxing and molding

into the parent's body pretty well tell the parent that the infant had swallowed too much air while nursing. We use this illustration only for the purpose of emphasizing that observing the baby is essential; that it can give parent much truly needed information that will facilitate and guide to growth-promoting rearing. Listening empathically to the infant (trying to perceive what the infant is feeling) gives parents the first clue as to the nature of the sleep disturber. The second clue will most likely come from looking at the infant. The third will come from holding the baby. To hear, to see and to physically feel, all along letting oneself feel emotionally, that is empathically, is powerfully informing.

Considering "What can stop the pain?" and "How to go about it", brings us to a most important phenomenon. Sensitive parents will very soon find that unless the infant's inner state is too tense, too painful, they are able to comfort and calm their baby just by talking to and by holding the baby soothingly, tenderly, by being affectionate, loving, and considerate. TLC (tender loving care) is among the most powerful comforters in human interactions. Its ability to calm and soothe in the face of pain and inner tension borders on the magical. It is a magnificent tool in the hands of caregivers, and, of course, parents are the prime caregivers throughout the world. Consideration, concern, affection, and tenderness are easiest with those we love. They are drawn from most of us especially by our own infants.

The magic of TLC does have its limits. If an infant's inner state of tension is too great (due to pain or anxiety-panic) TLC will not be able to cut through such tension. Even there, however, the parent's trying to comfort the infant will improve significantly the child's feeling state. We adults know that it is more difficult to face pain and terror alone than when side by side with a caring and protecting individual. We must emphasize that even when the parent cannot eliminate the pain, the parent's presence and TLC, and the parent's efforts to alleviate pain, seem to be experienced emotionally, positively, by the infant. Although very young infants cannot speak or think in words, they do feel; they feel "at a gut level". (These "gut feelings" determine how we feel at all ages.) In parenting, it is best to assume that from birth on, infants can experience "gut feelings".

When parents wonder, "Should I go in and pick up or comfort the baby; or should we let the baby cry?", they are often torn in knowing what to do because they feel stuck between 2 questions: "Is my baby in pain which I ought to alleviate?" or, "Is that kid getting spoiled?" It is at times difficult to decide if the 8 month old is anxious (nervously afraid) or is being "ornery" or "spoiled" ("I want what I want when I want it!"). Feeling anxiety means: feeling something dreadful is about to happen. It causes sharp inner pain; it can, if sufficiently intensified or prolonged, lead to panic, which is extremely painful emotionally and can traumatize the child emotionally. It is not necessary to jump in quickly. Wait a bit (use your judgment) before going in and see if the baby calms and goes back to sleep. If the anxiety mounts, and you sense the infant will not be able to stop his or her distress and go back to sleep, go in. If the child is anxious, the parent's TLC will be extremely helpful even if the calming effect it has now is no guarantee that the child will not be anxious again later or tomorrow night. Because most sleep disturbing anxiety from six to twelve months of age is due to separation anxiety, that is, to feeling mother's absence, as having been abandoned by mother forever, hearing mother or father's voice, or, if going in was needed, seeing one of the parents will

make the anxiety pass. It is important to know, and we shall talk about this further in Sections 1.215 and 1.225, that 6 to 12 month olds whose fathers are only occasional caregivers will most likely call for their mothers when anxious.

Is the child being spoiled? Is the prince or princess screaming for his or her slaves (parents)? How can one tell whether one's child is feeling anxious or is being ornery? Again, parents ought to rely on their own gut feelings. Listen to the sound of the infant's fussing and crying. How does it feel to you? Consider what her or his face might look like right now. How does the same expression on your face feel to you? Does it feel like fear? Like Pain? Then it is probably anxiety (or pain). Does the sound and does the look you imagine on his or her face feel like indignation? Do you imagine the baby saying: "I want you to come in right now!" Does his or her expression look like pouting, or like just plain anger or rage? Then he or she is probably being ornery. It may not be easy to sort out, but try. If you cannot figure it out, go in, and see if you can by actually looking at him or her. If in doubt, comfort. If it causes you concern, call a parenting or infant development consultant (pediatrician, psychiatrist or psychologist).

A word about the fear of spoiling is in order. The great fear of spoiling the child is in fact itself the great spoiler of what can be a good, strong, loving parent-child relationship. Fear of spoiling a child often prevents a loving parent from comforting an anxious child, one genuinely in need of comforting. One can spoil a child by indiscriminately doing for or giving that child anything the child asks for. There are times to say "No" to a child as there are times to say "Yes". There are times, in other words, to benevolently frustrate and disappoint, at times when it will be growth-promoting to do so; and similarly there are times to generously gratify a child's demands. When a very young child is anxious, a parent's comforting is deeply salutary to the child's present state and to his/her overall emotional development. When a child, anxious or in some other form of distress, needs comfort, not to comfort enough or soon enough, intensifies the need to be comforted and generates anger as well as the fear of being abandoned; these then intensify even more the need for comforting.

What is enough comforting? This is not easy to answer. Each child varies in comfort-needs; one day so much may be enough, the next day it may not. Using one's own feelings, about what is enough will help guide the parent. Fear of spoiling is often based on misunderstanding the child's needs or what factors spoil and what factors help a child. We shall talk more about it when we talk about reasonable, growth-promoting limit setting (Sections 1.226 and 1.323).

One more thing to consider before acting on whether to go to your 8 month old who is having some difficulty falling asleep and you've already put him or her to bed. Although falling asleep should come easily to us, we all know only too well that this is not always how it goes. We cannot always soothe or calm ourselves to a rest state. But one can facilitate this self calming process, most usually by relaxation and self-quieting methods of our own invention. Young children can be encouraged to calm themselves, to devise their own self-quieting methods and to help themselves go to sleep. We assume that infants find ways to calm themselves that are not visible to the eye. For instance, it is likely that infants can "tune out" the outside world with its moderate noises, smells, even lights; they can resist incoming stimuli of moderate intensity. Of course the most visible

common method used by 8 month olds is the use of a "comforter". The most common of these is the night bottle, or a pacifier, or the child's own comforting thumb. Other well known ones are a baby's special "blanket" or teddy bear. It is important to understand that rather than making them be more infantile, as is commonly believed, comforters actually help a child be more self-reliant: "I can calm myself" is what the thumb in mouth is about. Two points then on this: (1) Help your 8 month and older children learn to facilitate his or her falling asleep by suggesting just that to him or her and not going to him or her too quickly. For infants under 5 months, several minutes' delaying going in is enough. For infants 5-6 to 12 months if it feels like high level anxiety, going in should occur in several minutes; if it feels like moderate anxiety give it 10 minutes; if it feels like orneriness give it at least 20 minutes. (2) Allow the use of comforters of the child's own choosing; children will be selective in this and may not accept the ones the parents might prefer. The infant should have the final vote on choosing..

Now, you have decided that your 8 month old is anxious, the less tired or less burdened of the parents should get up and tend to the distressed child. Go in and first talk soothingly; given that you assume anxiety, reassure, but do not ask questions (because questions stir the child to think, that is, it wakens the baby more). If you think the baby is in physical pain, then, do ask where it hurts. Do not yet pick up the baby. Talking soothingly can also be accompanied by gentle back patting, rubbing, or rocking. You want to help the baby put himself or herself to sleep. Do not, therefore, do things that will awaken the baby more, as picking the baby up does. If talking soothingly and patting do not calm the baby after 1 or 2 minutes, and you see the baby is not then likely to go back to sleep, pick the baby up and continue to soothe and comfort and do things that will induce the baby to put himself or herself to sleep. This is no time to start playing a game. The principle is: "Baby, dear, it's time for you to put yourself to sleep."

There are great advantages to parents taking turns at this task: there are few times in life when a child appreciates a parent more than when she or he is in a state of need or pain which the nurturing and loving parent alleviates. It is a universal reaction in humans, especially so in our young, to appreciate, to value, and to love a person who alleviates pain.

When, according to the reports we got, 7 to 9 months old Richie cried when his mother put him in his crib (at night and possibly also during the day), awfully distressed, depressed and in pain herself, she would put him outside her apartment, in the hall, to not hear his crying. We were not there and therefore cannot be certain of Richie's reasons for crying, whether due to separation anxiety, fear of angry noises (like when his young father and mother would fight), physical pain, insufficient food, orneriness, or who knows what. We can assume that Richie at first cried hard and long (or mother would not have put him in the all) and that he would fall asleep quite possibly in a state of hopelessness and exhaustion. This kind of experience caused both Richie and mother a great deal of hostility and resentment toward each other. It probably contributed to his 17 year old mother's despair and depression. Before 6 months of age Richie had been a real pleasure to those who cared for him. Now he had become a dreadful burden to his adolescent mother. We assume that each episode of Richie's crying himself to sleep led to his accumulating more hostility toward his mother and the feeling of hopelessness

became more and more stable. By the time we saw him at 14 months, the damage to Richie (and to his mother) was severe. Much work had to be done to get him back on a normal enough track of development.

If the parent has decided that the child is being ornery several approaches may be tried; some should not. To begin with, the parent ought to deal with his or her child in the form of a dialogue. Try to engage the child's cooperation. Tell the child what you expect of her or him in the form of cooperation. Yes, even at 8 months of age, parents should talk and say what they want and expect of their child. "It is now time for you to go to sleep. Calm yourself down and go to sleep." Being reasonable is desirable for both parent and child. Parents ought to make reasonable demands, and expect reasonable cooperation. Letting the frustrated more-than-six-month-old child cry for 15 or so minutes may be necessary. Parents ought to let themselves be aware of the anger their child can mobilize in them. Reasonable anger in a tired parent toward her or his child causes no harm. Act before you become too angry; talk, talk, talk; demand cooperation verbally. The parent may have to pick up the angry child to calm him or her sufficiently and to explain that the parent cares but now also expects the child to go to sleep and let others sleep. Talk, talk firmly, talk angrily. Threatening or striking an 8 month-old complicates matters unfavorably. A swat on the bottom may help the parent, if he or she reaches the point of "I've had it!" More than a swat is undesirable; it sets the stage for difficult human interaction, negativity (hostility, rage, and hate) in relationships. It also diminishes the child's potential respect for and empathy with the parent, and then others.

Problems with the child's sleeping may or may not be easy to solve, may take one or two, or three days. Or they may take considerably longer; they may require much work on the part of parents, much effort and patience. Parent's efforts to help their child grow well, when based on understanding and respecting the child's needs and experiences, always help even when they may not solve a problem. Parents ought to try to not feel shame about asking for help in trying to understand their children and in learning means of growth-promoting child rearing. There is more to being a good parent than loving and "doing what comes naturally".

Also, if the infant's restlessness is an empathic barometer of tension between the parents, or of other anxieties or problems the parents are experiencing, it is highly important for all family members that these core problems be addressed.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.221 HUMAN DEVELOPMENT: Feeding Experiences

Feeding an infant does much more than simply sustain life by providing the infant with food (carbohydrates, proteins, vitamins, minerals) needed for survival. The feeding experience is one of the major earliest events during and by which the sense of self and of human relationships begin to be organized and shaped. It is one of earliest experiences which influences how the infant becomes attached to the caregiving persons, comes to expect or not expect being gratified and emotionally nurtured. How the infant feels during feeding, is extremely important for the development of the total personality for the following reasons.

What occurs when a two-month-old infant is being fed? If the infant feeds from a propped bottle, he or she can be observed to look around, more or less exploring the surroundings until overtaken by sleep. The food is satisfying; the environment is interesting. But very important needs for emotional contact and interaction the infant feels are ignored, and opportunities are lost, which are basic to healthy emotional and physical development. On the other hand, if the infant is held by the nurturing person during feeding, in addition to the food being satisfying, the infant's gaze turns upon the feeding person's face, especially the eyes and the hairline of the forehead. Occasionally the baby will look elsewhere, but for the most part attention is focused on the face of the caregiver. Most important as well, an emotional interaction occurs. The baby feels the mother's holding, feels supported, warmed, and comforted by her. The infant also feels what the mother is feeling (her mood, her attitude toward the baby, and attention or preoccupation). And the mother feels not only her pleasure in holding and feeding her baby, she also feels what her baby feels. She feels warm and calm when the baby sucks well and eats well. She feels discomfort when the baby needs to burp. She feels pain and distress when her baby has trouble eating. Each feels what the other is feeling. An emotional dialogue develops, and with it, an ability to feel what the other feels.

What is the significance of all this? Child development specialists have learned that while being held and feeling together gratified, comforted and satiated, the infant and mother feel emotionally connected and tuned into each other. In this state, the infant is beginning to record in his or her memory the face and feelings of the human who is carrying out this nurturing, comforting, and gratifying experience. During the course of "feeling together with" feeding, consider the number of pictures that probably register in the infant's brain, pictures of the caregiver hovering over the self connected with being valued, emotionally engaged and connected while being fed and comforted. The infant whose bottle is propped does not have the opportunity to register these pictures of the human face and the feeder, and therefore does not have the opportunity to link being food gratified, being made to feel better, with feeling valued, emotionally connected to and resonating emotionally with a particular, unique human being. If the child does not have sufficient opportunities to link this sense of attempting to soothe inner feelings of hunger

and attain a feeling of well-being with another person, the infant may not insure his or her ability to get comfort from a relationship with another person. Because the needs for attachment (which we shall discuss in Section 1.215) are being frustrated, the bottle-propped infant will try to self-comfort through drinking more and more milk. That child frustrated in his or her basic emotional attachment needs may become more attached to the milk than to the human who provides the milk. The experience of feeding which is for the most part gratifying, when done in the arms of an emotionally tuned in loving parent, will greatly facilitate the formation of a positive emotional attachment between the infant and the nurturing person. The major benefit is that good emotional attachment to the caregiver contributes centrally to the development of basic trust, to a positive beginning sense of one's self, to the formation of good human relationships, and to the development of oneself as a person who can be trusted, counted on, and will, in turn then be able to nurture and to give to another. Good feeding experience contributes to inner security and does much toward healthy emotional development including also the development of a reasonable and healthy conscience.

Another developmental aspect of feeding during the first year of life is that it can be a vehicle for the expression of the infant's need and inner pressure to do things himself or herself. A six-month-old baby will take hold of a spoon that is directed toward his or her mouth and make an effort to steer it there himself or herself. A spinach-smear face may not be a beautiful sight to the casual onlooker. However, to the mother and infant involved it is a confirmation that one step toward autonomy has been achieved.

To summarize: total emotional development of the self is influenced by the quality of the feeding experience.

1.222 CHILD REARING: How to Optimize Feeding Experiences:

As noted above, it is highly important for the child's healthy development to be held in an emotionally close, engaged and loving way while being fed during the first months of life. It is also important that caregivers are tuned into the infant's emotional state and feeding needs, including to be tuned into the baby's cues about how often he or she should be fed. No one "schedule" is right for every infant. If feedings are spaced too close by the mother (or other caregiver) the infant may not feed well and may not have the opportunity infants need to learn competent ways to let others know that the infant needs help. If feedings are spaced too far apart, the child is exposed to unnecessary frustration and pain, with tension resulting in the mother-child relationship. Since mothers cannot always respond promptly, some waiting and frustration is inevitable. Infants vary in their inborn ability to wait, to tolerate delay in gratification of their needs. Each infant's characteristic way of waiting soon becomes known, and sensitive tuned-in responsiveness to the child's hunger signals will contribute to the development of trust in the caregiving person and in the relationship to that person (see Section 1.311).

Parents often ask whether it is better to feed the infant by means of a bottle or the breast. There are various viewpoints on that issue. No one way to do anything is the best

way to do it for everyone; there are more ways than one to do things well. From the vantage point of the child's emotional development what matters most is that the mother choose the method that makes her most comfortable and gratified with feeding her baby, whether it is by her breast or a bottle, that the parents' attitude toward their baby is emotionally engaged and loving and that the quality of the nurturing experience the child has is satisfying to both baby and caregiver (mother or father). If the parent is holding the infant in a loving, emotionally connected, and tuned-in comforting way, for the child's emotional well-being, it does not matter whether the breast or the bottle is used. In brief, what matters most is the emotional climate of the child's and the parent's experience during feeding.

Just a few comments on this question. Many mothers who breast-feed indicate that the experience is very gratifying to them, and as a result it brings the mother closer to the infant. Many mothers feel that a special emotional closeness is achieved through this specific physical contact and physiological interaction between the mother and the infant. However, not every woman who has tried to breast-feed has experienced this type of comfort. Many normal mothers feel psychologically uncomfortable about breast-feeding. If they feel this way, they need not fear they are depriving or harming the baby. For the child's emotional well-being giving the bottle with tender loving care will do just as well.

An occasional concern that we find is this: "Will the child become an excessive eater if I make the feeding experience so pleasurable for him?" Or, "Will the child want to be fed by me forever?" The answer to both questions is: "No." We all like to eat because it tastes and feels good. Some well cared for infants are pretty hefty eaters and can get pretty chubby; care should be taken that they not eat too much sugar (carbohydrates). And, of course, as adults we all eventually need to watch our weight. But, except for those rare cases of severe obesity of unknown origin, quite commonly, people become excessive eaters, when they are not sufficiently gratified in their basic emotional needs like the need to be held, to be valued, to be connected with and attached to those we love, that is when they are "hungry" for whatever it is they need and cannot get enough of. There are other factors that cause overeating such as for instance a child identifying with a mother or father who is overweight, or during adolescence for reasons we shall discuss in Unit 6. But, no, good early childhood feeding experiences of themselves do not produce excessive eaters. Gratifying your infant's emotional contact needs during the feeding process tends to make that infant stop when he or she's had enough food. Gratified infants end up needing to eat less, not more. Usually, it is the infant who is emotionally frustrated who wants to be fed more food.

With regard to the fear that the baby will want to be held by mother and fed by her forever, this is totally wrong. People tend to feel that if one is gratified by being held by mother or being fed by mother, that one is going to want to stay in that passive being-taken-care-of position forever. Infant observation shows that there is a very large push within the child, which we shall describe soon, to stand on one's own two feet, to become an individual, to be an active person, in addition to from time to time be satisfied passively. There is a tremendous inborn thrust to be the initiator of action and events and to want to do things oneself. We find that infants who are reasonably emotionally gratified do not want to remain in their mother's arms or on their mother's laps forever.

Usually, it is those who have not had enough of this gratification as infants, who later may have problems of clinging and excessive dependency.

One of the difficult challenges in rearing an infant is that parents need to try to sort out whether the expression of the need for attention by the infant is an expression of (1) the need for food (milk, cereal or juice, etc.), (2) the need to suck (which in many babies does not mean the baby needs food; the need to suck then is independent of the need for food), or (3) whether the need the child is attempting to get gratified is for emotional contact, for emotional nurture, to be held, to be paid attention to, talked to, cuddled, comforted. By listening for the message in the quality of the cry and trying to read the young child's gestures and facial expressions, a mother may be able to learn to tell the difference. We often find that a child's expression of need or distress is too often dealt with by many caregivers (mothers and fathers included), by routinely offering the bottle. Unfortunately, many children accept this as a substitute. But it is not a desirable substitute for emotional and affectionate physical contact, for comforting in mother's or father's arms, or for soothing, when pain or tiredness causes problems. The child is in need of TLC (tender, loving care), not milk or cereal. One of the main difficulties for development that the milk for every complaint approach can cause is that the infant may well learn by experience to use milk and cereal (food) as substitutes for TLC and human relationships and develop that pattern of coping with stress. They will, so to speak, "love" food and not so much the humans around them. Children with such experience may eventually use food to soothe themselves in times of stress, a common occurrence, which among other problems, leads to obesity, and meager human relationships. In more serious instances, some persons turn to other products as alcohol and drugs as substitutes for human sources of TLC, affection, and comfort.

All comforting experiences provided by mother or father (or a substitute caregiver) make a positive contribution to the child's developing trust in others and himself or herself. The feeding experience makes a large contribution to the quality and characteristics of the mother-child relationship; this is one of the major events where the mother-child (and where father is involved, the father-child) relationship begins to develop. So it is important to try to provide the infant with a gratifying feeding experience. But, in addition, there are other interactions between infant and mother (and father) and other ways in which parents can be nurturing and comforting to their children. If a parent has some difficulty with feeding an infant well, it does not necessarily mean that the parent's relationship to the child will be in jeopardy. Some parents who are not so comfortable with or successful at feeding (which may be due to the infant's having some feeding problem) can do other very helpful things quite well; such as the mother who can play warmly and comfortingly with her baby; or the mother who enjoys chattering and singing to her baby and does so well; or the mother who can help her child learn things well.

When Bernie was about 2 weeks old he began to have trouble during and after feedings. He had bottle fed well for the first 2 weeks and then mid feeding and for a while after, his fussing and crying with his twisting his body and bringing up his legs suggested he was having abdominal pain. Bernie by then would already respond with calming when he would signal to mother by clear but moderate sounds that he needed her

attention and she would respond from a distance that she was coming to take care of him. He would already calm before she got to him. Now though, she could not fully calm him when he had abdominal distress. Consulting Bernie's Pediatrician within a week, Bernie's milk allergy was found and he responded soon thereafter with non problematic feedings with one of the common milk substitutes. This was a brief eating problem. But we knew that from the way mother and Bernie already interacted so nicely, from the fact that she could usually calm him so successfully, that what they lost in the feeding experience could be made up by them in other ways. By the way, Bernie's mother also turned out to be very good at playing baby games with him later, like peek-a-boo and lifting him above her head -- which he just enjoyed thoroughly. We should note that Bernie's mother and father were by then already having some serious problems with each other. When Bernie was 6 months old, father left at mother's insistence. So, while mother and father both, mother especially, were very happy with Bernie, tension and stress between parents was mounting.

In other words, one can make up for certain weaknesses in one's ways of parenting (whether the problem is in the baby or mother or father) by developing other ways where one is more competent (if the difficulty is in mother or father), more comfortable, and more successful. Most important is for the parent to try to tune-in to the baby, try to understand the baby's feelings and communications and respond to these reasonably.

Feeding Difficulties:

There are different types of feeding difficulties. We can catalogue them as arising from organic problems in the infant or from stresses in the parent-child relationship, whether these initially emanate from the infant or the parent. It is not our intention to give much detail about organic difficulties in feeding but only to mention these in general so that the student will have an idea of what we have in mind. There are, for example, mechanical obstructions within the alimentary tract (the food passageway, from the mouth, to the esophagus, stomach, small intestines, large intestine including the colon and rectum), within the feeding system, which are generally the result of some unfinished development. In the course of the maturation and formation of the fetus, certain openings or tube formations within the alimentary tract have not been fully achieved, certain linkages were not made completely and obstruction to the passage of food can be caused by them. These are quickly picked up by parents as well as pediatricians and nurses and something can and, of course, must be done promptly to correct such defects. But it is important to note that such problems will make for a very difficult start for both infant and parents.

Another large category of organic difficulty is allergies as was the case with 2 week old Bernie. Allergies may be troublesome to sort out, whether an allergy is to milk or later during the first year to some other food, but these can usually be dealt with in due time. Milk allergies are common and pediatricians are alert to the possibility of an allergy-based feeding difficulty, and these do in fact commonly come to the pediatrician's attention. It is important that difficulties in feeding be picked up as soon as possible because they will interfere with the gratifying and comfortable feeding experience which

as we said before has a great impact not only on the child's well-being and attachment, but also has a large impact on the parent. Parents become very distressed when their infants do not feed comfortably, easily and well. Bernie's mother was initially very upset when Bernie could not be fully calmed by her. She was especially upset because she recognized that she was getting angry with her by then 3 week-old baby. By then she had already called the Pediatrician and steps were being taken to remedy his problem.

A word is warranted here: it is that feeding an infant is a highly valued function by most parents. Parents are gratified when their infants feed well. In fact, that goes further. Many mothers are deeply hurt when their children (or their husbands) do not like the food mother has prepared. This tells us that it is important to secure as good a feeding experience as possible not only in the interest of the infant but also for the feeding parent.

The most common organic difficulty associated with feeding is the accumulation of air within the infant's stomach which causes the infant distress. This everyday problem is well understood by parents and is generally dealt with easily and tenderly by the nurturer through the process of burping. Air in the stomach, as we all know, can be extremely painful, and it is reasonable that an infant will express discomfort when such an air bubble is large enough to cause pain.

Also to be added here, are transient organic difficulties such as those caused by an abdominal virus, or a respiratory virus that can interfere with the infant's feeding process. A plugged up nose will make it difficult for the infant to feed comfortably since the infant will have to stop feeding in order to breathe. One cannot breathe and swallow at the same time without the food also going into the breathing tubes which, of course, causes choking and much distress. Under these conditions the infant will express distress which will be readily observable in facial expressions, body contortions and vocalization of discomfort. Feeding will then have to be slowed down to allow the infant to alternately mouth-breathe as well as to swallow food.

This takes us to the second large category of feeding difficulties, those arising from stresses in the parent-child relationship, whether these start initially from a problem the child or from the parent. A common and notable problem of this kind, is that which we all know as colic. Many professionals believe that colic is the result of an organic difficulty in the baby, perhaps due to allergy, perhaps it is a difficulty in the physiology (the functioning) of digesting, or perhaps it is a difficulty in organizing the various factors that make for a smooth feeding experience. However, many pediatricians, psychiatrists and nurses also believe that significant strain and tension within the mother-child relationship can also be a source of some form of colic. It is important to sort out the nature of that strain and stress as well as where it is coming from, whether from within a very irritable and tense baby or from an overly burdened and tense mother. If the parent is feeling tense, the baby will feel this by the transmission of her feelings to the baby (contagion of feelings) as well as in the tightness of her muscles and body stiffness as she holds him or her.

Colic of physical origin in the baby, commonly begins at about 3 weeks and ends at about 3 months. It is vitally important that parents understand that the baby is not trying to give them a hard time and that if a mother cannot calm a colicky baby, it does not mean that she is a bad mother. Commonly, a colicky baby of this type cannot be calmed

by even the most experienced mother or grandmother. When a baby's colic is due to stress and strain that comes from the mother, then another person, father or grandmother may be able to calm and successfully feed the baby. The baby with an inborn physically-based colic should be handled with as much appropriate calming and soothing effort the caregiver can devise. The ancient method of soothing a colicky baby by gently touching his or her genitals is not appropriate because it can lead to secondary sexual problems at a later time. It is important to remember with this type of colic that it will stop at about 3 months. What we will say about how Suzy's parents handled her irritability applies to the colicky baby as well (see below).

Where the infant's feeding problem comes from mother being terribly stressed out, as was the case with 7 month old Richie, help for the mother is essential. A caring father or grandmother can be very helpful. Sometimes professional help may be needed for the mother.

In addition to babies who have colic there are many babies who, because of some mild degree of immaturity of the brain may be very irritable. Or they may become irritable quickly because they just experience too much distress when they are stressed. These babies need to be calmed and comforted a lot more than others. Such an infant may become more upset when the mother picks the crying baby up in order to feed him or her. This baby may be so worked up and so tense that the feeding process may of itself become unpleasant and may not even get started.

Suzy was a quite difficult to calm baby. Feeding her was made difficult not by her having stomach upsets but rather by her irritability. She seemed to have some difficulty getting into a rhythm of sucking and at moments she sucked quite weakly and then would fuss, we thought perhaps because the milk didn't flow well enough then. When we worked with her and her parents, we believe that mother's believing us that she is doing reasonable things to calm Suzy, holding her well, trying to mold with the baby's body (which however did not stay in a molded posture due to some jerky movements), that her voice was soothing, mother became much less stressed and more patient, persisting in her efforts to calm her feeding baby. The parent's efforts to comfort and calm the baby by the way she holds and talks to the baby, by the way she offers either the breast or the bottle to the baby, will not always work well. But eventually, work it will. It eventually did with Suzy. Of course waiting too long in order to calm a baby before starting the feeding process will, of itself, may create more tension. It is at times like walking a tight rope and it can become a very difficult matter for the parent to know just how to pace herself or himself and the baby under these circumstances. But we can only encourage repeated efforts on the part of the parents, father, mother, both, to work together to try to decrease irritability or strain in the feeding of the baby.

We are not interested in blame! It is important to sort out if the difficulty is coming from the baby or from the mother. It can be enormously helpful to the baby and those who care for her. And we caution fathers against too quickly assuming that mother is to blame.

Healthy babies eat the amount they need without having to be pushed. Parents need not be overly concerned about the baby's not eating enough - except where an infant is not gaining weight reasonably and looks undernourished. Of course checking with the

baby's pediatrician is then warranted. It is important to know that pushing and forcing food can create all sorts of problems.

Many mistakes are made, unfortunately, when a parent is afraid to recognize tensions that come from our normal everyday lives. It is important to be able to acknowledge these so we can at least know where some of the problems may come from, work to reduce tensions, and then improve the feeding process. Again we want to emphasize that providing as good feeding experience as possible is thinking about the future of the child, it is optimizing the child's experiencing of himself or herself and of his or her human relationships.

Transient periods of physical illness will interfere with an infant's comfort and that of course can, for a little while, create some difficulties in the feeding experience. That, however, will not cause any lasting problems and need not worry parents. Young children have a great deal more adaptability and flexibility than people generally think.

Another issue to be addressed under feeding experiences and parenthood is whether the mother ought to be the only person engaged in the process of feeding the infant. There are advantages to the infant's being fed not only by the mother, but also by the father and, where they are old enough, also by siblings. Since a good feeding experience facilitates, accelerates, and stabilizes favorable bonding and the development of a positive attachment, if thereby, can help to establish a more favorable and meaningful relationship with the father and with the siblings as well as with mother.

It is especially important that father (and siblings) participate and play a part in gratifying and comforting the baby. We have seen numerous times that having a meaningful relationship with father and with siblings in the first year of life, as well as with a loving and good substitute caregiver, does not take away from the deep and all important attachment the infant makes to the mother. Rather, where the relationship with the mother is good, good relationships with the father and with the siblings further enhances the child's capability to form good human relationships and may enrich emotional and personality growth. The most important relationship in the first year of life is the relationship with the mother. Nonetheless, fathers and infants have much to gain from the father's being involved in feeding and comforting experiences, in addition to the usual expectation which comes later of father's protection against external dangers. Many times, unknowingly, a father is kept out of the tight mother-child relationship, a tightness that comes from biological and psychological unity that has existed between the infant and the mother from the time of conception. The father needs to be given enough space and opportunity to be engaged in the child-parent relationship; this, in fact, should be encouraged by both mother and father.

Equally we have seen infants turn to siblings when the mother or father has not been available in a way that is at times surprisingly meaningful and positive, to the advantage of both the siblings and the less-than-one-year old.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.231 HUMAN DEVELOPMENT: Crying

Most of us visualize a young infant as either asleep, or eyes open, quietly looking about, or more commonly feeding, or crying, pictures which are certainly correct. Crying, in the infant, is an inborn reaction to unpleasure (or displeasure), be it pain, distress or fear, of sufficient intensity and persistence. But crying is also a significant way (a built-in mechanism) for communicating needs the infant has to the environment about her or him. We do not mean that the infant knows from the beginning that when he or she cries mother will come. Soon, however, the child does learn that crying brings the mother, and will gradually learn that crying can be a method of communicating certain conditions of need.

As we just said, crying is a normal response to a condition of pain² There always is a cause for the crying. In infants, in most crying, the common denominator is an experience of heightened unpleasure: it may be due to hunger, irritation of the skin from a wet diaper, abdominal discomfort caused by an air bubble or a virus, marked tiredness, or the need to be held which has too long been frustrated. The resultant accumulating unpleasure triggers the mechanism of crying which under average-expectable conditions is experienced by the nurturing caregiver as a call for help.

The various causes of mounting unpleasure lead, interestingly enough, to different forms of crying. While at first crying may seem to be just one form of communication which has one quality and one character, quite soon the crying becomes different for different initiators of crying and the average mother and father is able to begin to identify what the underlying source of distress or pain may be. Crying varies in volume and also in quality. We are all acquainted with the fact that we cry in pain, we cry in sadness, in anger, in rage, and at times, we even cry for joy. Each of these forms of crying is a different communication although for the most part crying is an expression of feeling that is on the negative side of the spectrum of experiencing.

As we detailed in the section on sleep-wake states, crying often creates difficulty for the discerning and concerned parent. It is not always easy to sort out whether the child is crying because of an intensifying unpleasure experience which requires the parent's comforting and TLC, or whether the unpleasure comes from an excessive degree of self indulgence and the sense of self importance, or narcissism, which the normal infant needs the parents' help in taming.

1.232 CHILD REARING: How to Handle Crying

² It may be that even in crying for joy, crying may occur because an underlying pain-producing yearning is suddenly, finally or unexpectedly gratified.

We emphasize that there always is a reason for an infant's crying. First, it is a normal reaction to some kind of pain and, second, it acts as a means of communicating to the caregiver that help is needed. Sometimes in the course of trying to respond to their child's crying, parents are at a loss to know how to deal with it or stop it, and they trick themselves by believing that babies sometimes cry to exercise their lungs. Babies do not cry to exercise their lungs.

As we said in the previous section, there are different causes for crying, and different forms of crying, so that crying varies greatly in quality and in volume. As parents gain experience with their own individual child, they can learn to tell by the sound what is causing their infant's crying.

Whatever the cause of the crying, it is in the best interest of the infant and the parent for the parent to approach the child in a comforting mode and try to confirm or sort out and then to remove the cause of the crying. The amount and the kind of comforting required may vary widely according to the child and the situation. The kind of comforting that is appropriate in association with the setting of limits is different from the kind of comforting that is required for the pain of teething. For example, if a ten month old baby wants to crawl upstairs, or responds angrily to being put down for a nap, the parental response needs to be reasonable but firm, with the expression of understanding the frustration the child is feeling. On the other hand, when the baby is in pain, the nap time might even be delayed to allow for the soothing effect of cuddling or rocking; this usually makes the infant feel understood and comforted, even if the pain cannot be totally alleviated. If the parent can put himself or herself in the place of the infant, it is likely that the reason for the crying will be understood, and the appropriate approach to the problem can be found. We shall return to that issue shortly.

As noted earlier, crying is an experience of feeling, a communication of distress. We emphasize that from early in life, infants are quite capable of feeling. For this reason, let us look at some of these feelings and how parents can deal with them in a growth-promoting way. What we shall say in the section that follows applies also to handling an infant's crying.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.241 HUMAN DEVELOPMENT: Affects (Feeling Tone, How a Person Feels)

For reasons that are not clear, it has long been assumed that young children do not feel. Human beings, especially parents, have often acted in the presence of young children with the belief that the child will not understand what is going on and will have no feelings about it. People who work with children know this is not true. Professionals and many parents as well know that, in fact, children in the earliest months and years of life can be smiling, cheerful, convey a feeling of pleasure as well as show feelings of hurt, anger, and appear traumatized by experiences they have in their own homes, that they indeed do have both positive and negative feelings. Overwhelming clinical evidence shows they have memories of experiences which have been gratifying and loving as well as memories of experiences that have been painful, even though these memories may not usually be readily accessible to them, that they have become unconscious, until they are reactivated by some life event that resonates with those repressed memories. In other words, there are experiences both positive and negative that are recorded in the mind which the child may not consciously remember and yet one finds the influence of these memories to pervade the child's emotional life. Traces of negative experience memories may be seen in such problems as excessive anxiety, nightmares, or other adjustment difficulties; positive experience memory traces are seen in such personality strengths as a readiness to like, to love and trust others as well as self-confidence and the ability to work. One clinician puts it well when he speaks of those experiences in the first year of life as being at the same time "unrememberable and unforgettable".

Again as with other factors in development, the feeling tones which children exhibit in their behavior or in other words the affects of which they are capable, undergo significant development during the first year of life. The expressions of which the two week-old is capable are much more limited than those of the six month old, and these are fewer than the repertoire of feelings of which the twelve month old is capable. We find that as development proceeds the expression of any one affect becomes more complex, has greater variations, and is better perceived by the infant who experiences it.

In order to appreciate the fact that the infant experiences a cluster of different feelings it is important for the student to become an as unbiased as possible observer of children. Observing children with an open mind will reveal a great deal to the student who is attentive and much understanding of children will come with it. Because affects tell us so much about how a human being feels, it is an important and valuable exercise for the student to become a better observer of affects in children. In order to become a good observer several steps can be taken, which will be discussed in the next section.

We want to underline, even at the risk of being repetitive: affects are the window through which we can see and come to know and understand what a human being is feeling inside. Such looking for affects can increase our understanding of what is going on in a child about whom one is concerned, and for whom one wants to do the best one

can. Also worthy of emphasis is: empathy is one of the most useful instruments human beings can employ to understand what is going on in another individual. The child's affects, recognized by means of empathy, will help parents understand what is going on in their children and then be better able to respond to or deal with the child in accord with what the child is experiencing and be more likely to help the children grow in a healthy way.

Let us consider the various affects a two week old child can experience; then, compare those with the affects that a six month old can experience, and then with those that a twelve month old experiences. A two week-old is capable of experiencing feeling calm, excitement, satisfaction (as after feeding), tenseness, crying, agitation, rage. These are a few, and the reader may think of some others in addition. Note especially that we have not said that the two week-old can experience a clear sense of pleasure. Interesting and very important, the two week-old is capable of experiencing and of expressing, of giving evidence of pain and displeasure. But there is no clear expression of pleasure at or near birth. Rather one can find the expression of non-distress, namely, of calm and of satisfaction of need.

By the time the child is six months of age the number of affects of which the child is capable is surprisingly larger. The child now can experience not only calm, excitement, tenseness, crying, agitation, and rage, but in addition she or he can experience pleasure, cheerfulness, and smiling, fear, anxiety, panic, anger, hostility, rage, and temper tantrums; the six month old also shows low-keyed or sad feelings, and feelings of attachment and the beginnings of affection for parents, siblings and caregivers.

The one year old can not only experience all of the affects already mentioned, but, in addition, can experience different levels of all these. In addition, the one year old begins to be capable of experiencing sadness, grief, and marked depression. She or he also can express affection for persons he or she values, especially for the mother, father, siblings, and other valued caregivers.

In the chapter on the development of human relationships during the first year of life, some of these affects will be highlighted as we talk about various forms of anxiety a child may experience, different reactions of affection, excitement and pleasure, experiences of anger, of sadness, of grief, and of separation reactions as well as reunion reactions.

We cannot emphasize too strongly the importance of recognizing affects in children from the child's first days of life on. Of course, those parents and other caregivers who exercise their observational skills and learn to recognize affects in the first year of life will be able to do so with older children as well, when the recognition of affects is just as important as it is for the first year of life.

1.224 CHILD REARING: What can the Parent Do That is Growth-Promoting Regarding the Child's Affects?

At any given time, when we know how a person feels we know better how to interact with that person. When parents and caregivers can tell how a child feels it will help them

know better how to respond to or interact with and what to do to help the child in a growth-promoting way.

Human beings are born with the ability to feel what others seem to be feeling. This is what we call empathy. This ability operates at a gut level and operates at both a level of awareness (at a conscious level) and at a level of non-awareness (at an unconscious level). When two persons are deeply emotional meaningful to each other, this ability becomes amplified. Over time many people either lose or inhibit this inborn ability to feel what another feels. This occurs especially when one is excessively hurt by others or finds one's own feelings to be too painful or frightening to endure. For instance, a young child being hurt by his father may feel very angry in reaction and feel pressured from within to lash out at his father or to bite him. But he knows that this could get him into deep trouble. As a result he may suppress or deny the feelings of anger he has. In order to succeed at denying his own feelings, he will not let himself feel what his father may be feeling.

Infants can feel what the caregiver who is interacting with him or her feels. In turn, sensitive mothers, fathers and other caregivers can feel what the baby is feeling. It is not an intellectual process; it happens at a gut level. It is mutually felt; it occurs at an emotional level. It is intersubjective, we say. But because many children and adults have trouble with their empathic ability it may be useful to do things that can bring out this very valuable capability.

We can tell how a baby feels much of the time. If one has doubts about it, we suggest the following exercise. Some of what we will now say is readily known and is automatically done by most of us when we try to register how another person, in this instance, an infant, feels. We suggest four steps:

1. Look at the infant's facial expression, the eyes, mouth, cheeks, and forehead.
2. Look at the infant's body posture and movements.
3. Listen to the infant's voice sounds, including moans, sighs, cooing, etc.
4. Then, imagine yourself feeling the way the infant seems to feel.

In trying to sort out what the infant is feeling, a parent does not have to be absolutely sure that he or she knows what the infant is feeling; just imagining that one feels the way the infant is feeling, making a good guess at it is often very useful.

Each of the feelings that we enumerated in the above section will always be caused by something, and they often also can be stopped by something. For instance, any experience of pain will cause feelings of distress, or anger, or sadness. These feelings will usually stop when the pain stops, unless the pain went on too long.

In general an optimal balance of feeling good, feeling comfortable, with temporary periods of feeling uncomfortable, feeling some distress, will lead to good development. We cannot and should not overly protect our children against feeling uncomfortable or feeling pain. However, excessive periods of distress, of anxiety, of pain, tend to be detrimental to the child's development and should be prevented when possible. Parents cannot be indifferent to the way their infants feel, and fortunately, most parent are not.

Bernie's 30 year old mother was quite stressed when 3 weeks old Bernie continued to be very upset during and after feedings. She just didn't find any way to prevent that from happening. He would start feeding fine, after he had slept for about 2 hours, would feel

relaxed as mother held him to feed him. But he would soon suddenly stop sucking, his body would stiffen, stretch and then his knees would come up and his back arch forward, and he'd let out a rather strong cry, cry plaintively giving mother the feeling that he was having stomach pain. Mom was not sure, but it felt like that to her. Then, she'd be able to calm him a bit; he'd suck some more, and again the same twisting and crying would happen. Although she was pretty sure that Bernie was having a stomach problem, she was not sure whether he had some kind of virus or if maybe she was not feeding him well. She was tense because she and Bernie's father were fighting a lot, and he would tell her she is a bad mother and Bernie's fussing and crying were proof of it. She was angry with Bernie's father and tried to fight off the feeling she was a bad mother but now she was not sure. When the pediatrician saw them, seeing the way mother was with Bernie and hearing her good description of Bernie's starting to feed calmly, then suddenly stopping to suck, twist his body and let out a cry that made her feel he was in pain, he told her that Bernie could be allergic to the regular milk mother was using and recommended one of the milk substitutes. Mother was relieved to hear that because it meant that maybe she was taking good care of Bernie, and thought she could trust herself to know how he felt. But she was really angry with Bernie's father for telling her she's a bad mother.

When Suzy was about a week old, her mother and father both could see that she often did not feel good. Her face would look upset, her mouth stretched, and her cheeks tight and pulled up, her forehead even wrinkled. And she would whimper and then would cry in jerky sounds, some strong, some not so strong, and she "sounded" irritable and even angry. At times she looked frazzled and angry. That was very upsetting to Mom and Dad. But what made both of them feel worse was that they could not calm her easily. Dad found that when he held her against his shoulder and walked back and forth slowly between the bedroom and the kitchen she would calm. But when he tried to put her down often she would start to fuss again. Unfortunately, as this continued, Dad began to blame mother (even though his own efforts often failed to calm Suzy too), and mother soon began to feel she must be a bad mother. When we saw Suzy and her parents at 3 weeks of age, we observed that mother was really good at reading how Suzy seemed to be feeling and reacted quite well to her. We told both parents that they really did read Suzy well, they were right (we believed) about what she seemed to be feeling and that any good parents would find it difficult to calm Suzy. We worked with them, encouraging them to persist in trying to calm her, that it was Suzy's immature nervous system that made her irritable. And we found a way of telling father that blaming mother was unwarranted and certainly did not help Suzy or them.

When we saw Richie at 14 months, he not only looked like an 8 month old (because he was failing to develop at a normal pace), he also looked very sad and very frightened. His eyes were wide open, had a flat expression of pain and fear, his mouth was drooping at the corners, his cheeks flat and immobile. He conveyed a feeling of intense pain and hopelessness. The contrast with pictures of him when he was 5 months was amazing. At 5 months he was smiling broadly, his eyes sparkled, he gave the impression of communicating with you warmly, cheerfully, and with confidence that he was lovable. To go from looking like this at 5 months to looking so depressed at 14 months, Richie

must have felt and looked confused, bewildered, angry, furious, perhaps enraged, to be sure sad, frightened, and eventually depressed and hopeless. His 17 year old mother got to a point where, abandoned by her boyfriend, bewildered, furious and depressed, she could not tolerate her beautiful baby's becoming upset, demanding of her attention and care, crying in pain and probably in rage, and she would put him in the hall until he cried himself to sleep. And one has to wonder what feelings 9 month old Richie had when at one moment of uncontrollable despair and rage in reaction to his own pain and distress, his mother "dropped" a pot of boiling water on his back. The evidence was large that Richie went from being a child who felt cheerful, joyful, felt good, valued, and loved by those he valued and needed, to one who felt dread, continual pain, rage, depression and hopelessness.

The student will come to recognize that affects tell us much and often quite clearly about what the young child is experiencing, when the young infant cannot talk. That young children cannot talk makes parents often feel helpless to understand what the infant is experiencing or what the infant's needs are. But the expression of feelings makes a large contribution to our understanding not only children, but adults as well. Young children automatically express feelings. They are born equipped to do so -- and we assume they are so equipped to insure their survival and well-being. However, if what they express goes unrecognized, not responded to, or discouraged -- for instance, some parents discourage their infants expressions of feeling hurt or angry -- young children may learn to suppress the expression of feelings, only specific ones or all of them, and come to believe that having feelings leads to nothing good, or that feelings are bad and create problems. In time then as they grow, friends and later mates may never truly know what the person is experiencing no matter what the person says. Feelings give weight and meaning to our words; they make what we experience clearer to ourselves and to those around us. It is, therefore, important that parents allow their infants to express whatever feelings they have, expecting that expression to be done in reasonable ways. Parents help when they respond or react reasonably to their children's expressions of feelings. In fact, it is helpful to the young child's emotional development to encourage their expression.

Understanding the infant, of course, will make it much easier for the parent to see to it that the child's feeling tone is mostly one of reasonable pleasure and comfort. Of course the reason it is in the infant's best interest to feel comfort rather than discomfort and to feel good rather than in pain is that, as most people understand intuitively, good feelings lead to the development of good feelings about oneself and love feelings in relationships, and bad feelings or feelings of excessive pain generate hostility (and later hate) in the child, which then become part of the child's self experiencing and of the child's experience of the parent-child relationship. The feelings of the very young child become organized and registered in the child's psyche and will stay with the child and become part of his or her personality for years to come if not forever.

In summary then, the parent can help the young child by observing, listening, and responding empathically to the child. Experience will make one increasingly adept at "reading" the child's affective (emotional) signals. It is important to help children under 1 year express their feelings since this promotes good mental health and enhances good

human relationships. It is important to note that the feelings young children have may stay with them for many years if not for a lifetime.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.251 HUMAN DEVELOPMENT: Attachment Behavior

The infant's attachment to his or her mother and father is probably the most important mental health determining experience the child has during the first year of life (and beyond). Attachment is a relatively complicated emotional (psychological) process which begins from near-birth. Looking at attachment from an evolutionary standpoint, it is an essential mechanism whereby the young of a given species attaches to members of her or his own species. We know that the mechanisms for attachment are inborn, are part of the individual organism's biological make up. And we know that it is secured by very strong psycho-biological mechanisms. Of course, the purpose of attachment to members of one's own species is that of protection of the individual, and of the preservation of the species by means of reproduction. With this in mind one can begin to understand the importance of attachment (and bonding) for both the individual and the species, and that strong mechanisms activating attachment would have to operate to insure its occurrence.

Attachment is the process implemented by the human infant in the formation of the earliest emotional relationships. We hold that there are mechanisms for species attachment available to the young of other species that seem not available to the human infant. Konrad Lorenz and many other students of animal behavior have found that the young of many mammals are equipped with an inborn attachment mechanism that Lorenz has defined as imprinting. Imprinting is activated by an instinctive mechanism whereby the young of certain bird species as well as certain mammals, within the first 48 or so hours after birth, will attach to organisms that bear a particular pattern on their bodies. This specific pattern, say on the parent bird's head, triggers the attachment mechanism and the infant bird will from that time on be attached the particular organism bearing that pattern.

Relative to other mammals, we assume that the immaturity of the human at birth, during the first weeks of life, makes for that infant's not being able to make so rapid (within 48 hours) and firm an attachment. Although there is evidence of the newborn being equipped to distinguish a pattern of the human face from a scattered broken line abstract pattern, the newborn's cognitive and locomotor immaturity lead many of us to assume that the human newborn may not have this imprinting instinctive mechanism to secure his or her attachment to the humans in the environment.

There are, however, specific indicators that some inborn psycho-biological mechanisms exist (which are complex instinctive mechanisms) that initiate attachment to the parents and, more slowly than in other animals, facilitate the attachment of the human infant to its parent organism. We will be talking about this in a moment. The important thing we underline here is that although the human infant is primed to attach to individuals in his environment, it is necessary that the environment facilitate a positive attachment, by the parent's responding adequately to the overtures and signals coming from the infant. Extremely important is that the nurturing environment itself positively

induce attachment with behavior that is affectionate and responsive to the infant's attachment overtures (staring at the upper part of the mother's face, eventual smiling, etc.) as well as the infant's needs for physical and emotional nurture and protection.

The need for emotional attachment in humans--and in most living species of animals--is in-born and powerful. It is also enormously important in that a child's mental health and eventual personality is built on it. Triggered and sustained by powerful biological and psychological mechanisms from the first days of life on, attachment will occur even when the infant's needs are barely met. However, it is important to know that attachment may be growth-promoting or it may be growth-disturbing. In order to form a growth-promoting attachment, the nurturing environment must be sufficiently loving and reasonably responsive to the infant's needs for nurture and affection, as well as for food, shelter and protection.

The newborn will also attach to caregivers who are not loving enough and whose behavior is not favorable for the formation of a growth-promoting attachment. The newborn will equally attach to the parent who is rejecting, hostile and unresponsive, but this attachment will be negative in quality, will lead to the development of basic mistrust rather than basic trust, to experiencing human beings as rejecting, hostile, and hurtful rather than accepting, friendly, and when needed comforting. The tragic aspect of what happened to Richie is this. At 5-6 months of age he was well on the way to developing a very positive attachment, good basic trust that he is lovable and those around him are worthy of trust and love. He was then surrounded by caregivers who were ably growth-promoting. Then when he was about 7 months old, his care was completely changed and became increasingly and seriously growth-disturbing. As a result, by the time we saw him at 14 months his attachment was filled with hostile feelings, suspicions and serious mistrust of others, expecting to be rejected and hurt.

It is important to know that, in general, the attachments we make in subsequent human relationships, the expected quality and character of these later relationships will be modeled on our earliest original attachments. In addition, the internalization (taking into one's mind) of the quality of the attachments we make in childhood, be it predominantly good, loving and respecting or hurtful, hostile and depreciating, that quality will enter into our skills and patterns of coping (our modes of adaptation), and into the formation of our self esteem and moral code, that is then, into the formation of our conscience. It is, therefore, highly probable, and sociological and psychological studies have shown this to be so, that a common consequence of the formation of highly negative or hostility laden attachments, is antisocial behavior and maladaptation to society. The consequences of such negative attachments to oneself and to society are very large, very painful, and very costly.

Rarely and tragically, due to a still unknown inborn disturbance in the brain an infant may not be able to achieve a sufficient emotional attachment. The insufficient or seriously deviant attachment is highly detrimental to psychological-emotional development. This is found only in severely disturbed individuals who suffer from a biological developmental disorder called autism. Such an infant requires skilled professional help, and even then may not be able to develop the ability to attach in a normal way. We say this to inform students that such a condition exists which is highly

detrimental to the critical role played by attachment in mental life and personality development. Fortunately, this is a rare disorder.

The Development of Attachment

Attachment develops over time. Research by a number of mental health specialists has revealed that it begins during the first days of life, and must be well underway during the first year, in order for the child to develop age-appropriately well psychologically-emotionally, to develop a good sense of self and the capability to relate to other humans. There are 2 most commonly used well developed models of attachment: one by psychoanalyst John Bowlby who developed an ethological (based on the study of animal behavior) model, and one by psychoanalyst Margaret S. Mahler whose model was developed using ego psychological theory (a psychoanalytic theory). Both were child psychoanalysts who made years-long studies of young children and their mothers. Although there are some theoretical differences in their explanations of how attachment occurs and develops, study of either one comes up with the same basic and enormously important understanding: that a good attachment is necessary for good emotional-mental health, development and adaptation.

We shall use the model developed by Dr. Mahler for a number of reasons but especially because our own studies support her observations, ideas and explanations. This model holds that attachment develops during the first three years in a process Dr. Mahler identified, described and labeled the separation-individuation process. We shall talk about the beginnings of separation-individuation, and of the attachment process it contains in a moment, as well as in Unit 2 when we cover development during the second and third years of life.

Since attachment is a developmental process, we see different aspects of it at two weeks of age, at six months of age, at 11 or 12 months of age, and at two and three years of age. There are several emotional-behavioral indexes of attachment. Recognizing these indices is important because they tell us about the state of the development of attachment, and whether or not the infant is forming healthy attachments to those the infant values in his or her immediate environment. The indexes in question are the social smiling responses, stranger responses, separation responses, and reunion responses. Let's also add, although we shall discuss it separately, subsequently, clinging reactions.

Social Smiling Responses:

From the work of Dr. Rene Spitz (like Dr. Mahler, a pediatrician, psychiatrist, and psychoanalyst) as well as others, we know that the "social smiling response" begins to emerge during the second or so month of life. Many infants, of course, smile from even the first weeks of life on; but the smiling then seems fragmentary and does not give the impression of being a social communication as does the social smiling response which we will describe in a moment. Fragmentary smiling of a very early kind is often seen in reaction to the sound of the human voice and especially to the sound of the mother's

voice. Because some mothers are hurt and worried that their two week old infants do not smile at them yet, it is important to underline that the social smiling response does not make its appearance until the second, third or even fourth month of life. With respect to the earlier fragmentary smiles, it is difficult to ascertain whether or not they are simply a reflex-like reaction to body sensations (like a gas bubble in the stomach) or if they represent a degree of attachment.

This is not the case with the social smiling response which emerges by a readily discernible and specific inborn mechanism. Spitz showed that this mechanism is activated by the presentation to the infant, of a face, face-on. When looking at the face, the 6 to 12 week old infant will react with a bright smile. When the person turns his or her face to the side so that the infant sees the face in profile, the smile fades and, indeed, the infant may frown. Spitz, furthermore, showed that the infant would smile in response to seeing not only the face of a live human being, but equally by seeing a face that is line-drawn on paper (face on) and even on seeing a face covered with a mask. The critical factor seems to be that the infant is primed by this psycho-biological mechanism, to respond by a smiling response to seeing a face configuration, especially the area of a pair of eyes and a forehead-hair line. There now is evidence that this configuration already elicits a gaze response in the newborn. It suggests that this mechanism seems to be built-in, seems to be akin to that which causes the much more rapid imprinting found in birds and mammals, that it serves the important function of the child's attaching to the members of the child's own species, and eventually, of course, the child's own parents. The social smiling response, we can therefore say, in its earliest manifestations is triggered by the presentation of a face, face-on. In the early weeks after its emergence, the social smiling response is extinguished (stops) by the withdrawal of that face from the child's visual field.

In its first appearance, then, this is a non-specific response. What we mean is that the infant will indiscriminately smile at anyone or anything that presents the proper facial pattern of two eyes, a nose and a forehead-hair line, whether that image is on a piece of paper, is that of a total stranger, or is the infant's own parents or caregivers. This tells us that a priming mechanism is at work, is being released but that no specific emotional attachment to a specific person or persons has yet taken place.

By the second and third months of life, the infant has formed a bond and is beginning to attach to his or her own caregivers. This is evident in the fact that many a one-month old when in need of feeding, will quiet on hearing mother's voice, while the mother readies herself to feed the baby, telling to him or her that she is coming. Similarly, a one-month old will calm as soon as he or she is picked up by the nurturing person who usually takes care of the infant. Furthermore, some infants will not calm when picked up by someone other than the usual nurturer, indicating that bonding is experienced and has sufficiently developed, that the caregivers usual vocalizations, movements and body smells and feelings are being recognized by the infant, and that the infant "knows" that care (whether for holding or feeding) is coming.

But let us come back to the question of social attachment. The non-specific smiling response means that the priming for attachment is activated but that a specific emotional attachment has not yet been formed. What follows then from about the second and third

to the fifth to eighth month of age is critical for optimal attachment and general emotional development. It is that the non-specific social smiling response becomes organized in the child's mind as a specific social smiling response.

Here is what we mean. In the course of the three to six months that follow on the emergence of the non-specific social smiling response, the infant will gradually, day by day, moments of feeling emotionally valued one after another, or feeling the emotional warmth that comes from a mother and father who love, adore, their baby, nurturing event by nurturing event, feeding by feeding, more and more the infant will recognize that the nurturing, the loving warmth, and the meeting of the baby's needs come from one or two or three specific individuals in his or her environment. With each event of caregiving, of feeling that loving handling, the infant will internalize, that is will take into his or her psyche the memory of that experience, a memory which will include what the nurturing person looks like, feels like, smells like, moves like. In other words, what is taken into the psyche is the entire constellation representing the nurturing event, including especially the self and the person who is doing the nurturing and the emotional atmosphere, feelings, in which it occurs.

Of course, the more positive (gratifying, loving, and pleasant) the events of nurturing, the more these will elicit in the infant a feeling of well-being and the more it will facilitate the smiling, pleasure experience. Where the events of nurturing are devoid of loving feelings, are too frustrating, too painful, where the feeling of deprivation and pain occurs too often, and for too long, the events that will be internalized are ones in which the experience is unpleasant and causes pain. What is internalized then is a representation of an episode of life with the self, a mother (nurturer), and feelings that are painful; such experience will not reinforce a smiling response but rather will tend to induce sadness or low-keyedness, or even gaze avoidance (avoiding the mother's eyes and face), withdrawal from emotional interaction and eventually, depression. What we are saying is that the better the nurturing experiences, the more likely the smiling response will be facilitated and become attached to the individuals who nurture the infant. The smiling then becomes more and more "specific"; it is elicited by specific persons, not by just anyone; the "specific" person is now special for the young child. A fascinating phenomenon then occurs which is the complement of the specific social smiling response, it is the emergence of stranger responses.

Stranger Responses:

As the infant three, four, five, six months of age begins to form specific attachments to those nurturing him or her, the infant begins to have reactions to unfamiliar people, which show that some degree of distress is experienced by the child. The stranger response ranges from a curious staring at the face of the stranger, to quizzical tentative efforts to explore that face, to acute reactions of anxiety, and even of panic or terror at seeing that unknown face. While the stranger response is a normal and desirable reaction, when it is excessive and creates a panic state, it suggests a problem or sensitivity in attachment and warrants professional attention.

When Jennifer was 6 months old we did a non-intrusive experiment to evaluate how

her attachments were developing. We simply scored the ease with which and the intensity of her social smiling responses to various people around her. The greater the ease and the more intense (largest) her social smiling the higher the score from 0 to 6, a 7-point scale. By 6 months, we found that her mother got the biggest smiles of those to whom she responded and we scored those smiles a "6". Two of her older siblings, a brother and a sister, as well as the research staff with whom she had come into twice-weekly contact since her first weeks of life, and one of the other mothers who quickly had become good friends with her own mother got a "3 to 4" response. And when the very friendly Chief of our Division of Child Psychiatry happened to come in to see how things were going, he (a man who was very good with children) got no smile at all. In fact, he got a mild stranger response. At this time we did not have occasion to test her reaction to her father, but when we did at a later time, he too got a very big smile from Jennifer.

So we found that Jennifer smiled most readily and broadly at her mother (we later saw and had learned from mother that she did so as well with her father). Then she smiled less broadly and less predictably at her siblings and other adults she saw frequently since near-birth. And she had a stranger response to a very nice man she had not seen before. The social smiling response was already specific, one could score its greater intensity with mother by which we could infer that she was most attached to her mother, we could infer some degree of attachment to her siblings and other adults, as well as no attachment to the Chief of our Division. We later confirmed a good attachment to her father as well.

The stranger response was equally important as were the social smiling responses in telling us with whom Jennifer was forming emotional attachments. Children vary in the quality and intensity of their stranger responses. Two factors contribute to this variance in responsiveness. One is that some children appear to be more shy than others, a factor that we believe is inborn. This shows itself very early in these children and usually leads to heightened stranger responsiveness -- which can be thought of as shyness in the face of a new or unknown person or situation. These children may have very good attachments, yet they experience acute stranger anxiety. The second factor is the quality of attachment itself. An unstable attachment, or a too hostile attachment, may intensify anxiety in the face of an unknown person or situation.

The stranger response is a highly useful response because it tells us that the infant is beginning to form or is now capable of forming specific attachments to someone other than a stranger. That, of course, confirms what we learn from the specific social smiling responses which is, that the infant is attaching emotionally with a specific individual or set of individuals. In other words, then taking social smiling responses and stranger responses together we have indicators and measures of the development of human emotional attachments the 6 to 10 month old infant is developing. And, we often find that the principal nurturer of the child, the mother, is the one who gets the broadest, the most easily elicited social smiling response. During this early phase of attachment formation, the father may get a nice social smiling response which, however, is not as easily obtained nor as broad as the mother's. Then the siblings may get a social smiling response perhaps somewhat weaker than that which father gets, and then individuals who

are seen by the child for the first time will get no smiling response but rather a stranger response. In fact, the stranger who pushes himself or herself on the infant too strongly may induce in a normal child an acute stranger response which may in some normal children lead to sharp crying and even to a panic state.

Separation Responses:

A further indicator that allows us to evaluate the process of attachment and which is clearly evident in behavior, is the separation response or reaction. Close observation reveals that separation reactions begin to become evident in 5 to 8 month old children when the social smiling response begins to become specific. In other words, the experience of specific social smiling responses, stranger responses and separation responses all become evident in conjunction with each other, at about the same time. And indeed it is so because all three result from and are indicative of the status of the same emotional attachment process.

What causes the separation reaction is that the infant is alert to and distressed by the fact that mother is leaving or has left the infant. When mother leaves the infant, the anticipation of her absence is experienced by the infant as distressing. We now assume that, during the first year, the infant is beginning to form a memory-representation of the person(s) to whom the infant is attaching which becomes recorded in his or her brain (and mind). But at the age of five to eight or so months, as Jean Piaget has taught us, this image seems to not yet be accessible to the infant when the mother is not within his visual field. In other words, from the infant's behavior we have come to learn that when the child sees the mother leave him or her, he or she gives the impression of experiencing this as a threat that mother will disappear and will be lost to him or her forever.

We say "forever" because the infant's immature mental functions are such that she or he cannot yet perceive or feel time duration and is capable then of only a limited type of memory which Piaget and his colleagues have called *recognitive memory*. *Recognitive memory* means that a child will remember a face (or an event) which he has recorded in his brain before, only when the infant can see that face when it is in the infant's visual field.

Some child development specialists believe that the infant acutely experiences the dread which, if he or she could speak would be like this: "If you leave me I will never see you again", or "What will happen to me if I need you and you are not with me?" An experience of this kind might be what triggers the acute reaction of pain that the 6 to 12 month old child shows in the crying and fussing one sees when mother is about to and leaves her child.

In the section on child rearing we will talk about how to handle unavoidable separation reactions. Here let us say that, of course, it is important for the child gradually to learn that when the parent leaves, the parent is not lost to the child forever, that indeed the parent does return. It is also important, for our present concern, to understand that the separation reaction like the stranger response has two paradoxical sides to it. It is a painful experience but it is also a positive one, in that it tells us that an emotional attachment process is taking place, that good attachment capability is developing, and

that the child is forming human relationships. We emphasize again, that forming good enough relationships is imperative for emotional health and good total emotional development. Therefore, the moderate crying of the separation reaction which requires due attention and may be troublesome is, nonetheless, a positive indicator that the child is forming an emotional attachment, is coming to know who his or her mother is. Of course, the crying should be dealt with in a constructive and growth-promoting way.

It is exactly because forming good enough attachment is imperative for good emotional health and total emotional development that the way Jennifer was forming attachments was a very hopeful beginning for her. Richie was not as fortunate as Jennifer whose attachments and relationships continued to develop well. Although he had shown very strong evidence of forming good emotional attachments up 6 1/2 months of age, there was a severe breakdown in his young mother's relationships and home life, which led to a severe deterioration in his everyday experiences and in his attachments. Much effort was required to try to recover what he had lost in so short a time -- and regrettably we lost him (he left our program) to our efforts to help before, we believe, he recovered as much as we thought he could.

Reunion Reactions:

Reunion reactions are the complement of the separation reactions. By reunion we mean the visible response evident in the infant's behavior in reaction to the parent's coming back into the child's visual field. Again, we are speaking especially of the child during the period extending from about the 3rd to the 12th month of age; but these reactions occur later as well, indeed even for years to come. The reunion response again will tell us something about the quality of attachment. It will tell us the extent to which emotional attachment is taking place and it will tell us how the infant is feeling at that given moment. The quality of the reunion reaction can, in general, also tell us much about the extent and quality of the child's attachment.

Reunion reactions are for the most part of two kinds. There are the pleasurable reactions, and there are the unpleasurable reactions. In addition, they may be mixed, have both pleasurable and unpleasurable parts. It is important to recognize that any reunion reactions, be they pleasurable, unpleasurable or mixed reactions, are indicative of relationship formation. If there are no reunion reactions during the second half of the first year of life, close examination of the other three attachment indicators are required to determine if attachments are being formed. We can readily recognize the pleasurable reunion experience: the big smile, the excitement in the infant's behavior on seeing the mother tells us that the infant "values" the person to whom he or she is reacting. This means, of course, that an attachment to that mother has taken place. Mothers have no difficulty with that reaction and accept it, as a sign of affection and of being valued by their baby.

Not so simple is the unpleasurable or angry reunion reaction which nonetheless is a positive indicator of developing attachment. The unpleasurable reunion reaction is one where on the mother's return, the infant reacts to the mother with anger, or with totally ignoring mother, or a mixture of the two. This reaction is a way of saying, if one can

verbalize what might be going on in an infant's mind: "I am angry with you because you deserted me", or "I want nothing to do with you and I will ignore that you are here", both of these also indicating an attachment to the parent. Therefore, both the unpleasurable and the pleasurable reunion reaction are indices of attachment and are valuable. In the section on the child rearing we will talk about how to handle, especially, the angry reunion reactions.

These indices of attachment then can be readily observed, and are valuable to parents in understanding what is going on in their child, and in ascertaining whether or not a good emotional attachment is taking place. We cannot overstate the importance of forming an emotional attachment in the first year of life, as it makes an enormous contribution to the development of the self as an individual, the development of basic trust, the development of relationships to others, the establishment of the individual as a member of her/his own species, the development of total personality and the development of well being, to mention an incomplete list of its influences.

Clinging Reaction or Pleas for comforting and help on the part of the Child:

Reactions of clinging to the parent, especially to the mother are common in children in the first year of life. Interestingly, they are more common during the middle and the latter part of the first year of life than they are in the first months of life.

Children always cling for a reason. Of course, a child may cling in play, because of some pleasurable feeling the child experiences; but this is not the kind of clinging reaction about which we are concerned here. We are speaking of the clinging reaction which is the result of some stress, fear, or anxiety. This kind of clinging begins to be experienced by the child from the fourth or so month of life on and intensifies, especially during the middle and latter half of the first year of life. Parenthetically here we might mention that there is a second peak of clinging during the latter part of the second year of life, about which we will talk in Unit 2.

Clinging is a plea for help, for protection, or for comforting; foremost it is a plea for help to cope with a feeling or experience that is difficult to tolerate, be it pain or some dreaded fear, whether the fear is realistic or not. Clinging can be of different intensities, from mild clinging associated with a stranger response, to more intense clinging associated with separation responses; in some instances, where intense clinging occurs, it results from panic and terror.

Because clinging is always, except in play, the result of pain, stress, fear, or anxiety, clinging indicates two things: one, that an attachment reaction is activated, and two, that a potential trauma is experienced by the infant. If the perceived threat is strong, the child may even cling to an available person to whom he has not developed an attachment. Close observation will show that non-play clinging is always due to an emotionally painful experience.

Two factors intensify clinging during the first year. One, when an actual event that produces increasing pain, stress, fear or anxiety continues unattenuated over time; and two, when the parent rejects the infant's plea to be held. What decreases or extinguishes the need to cling, is the parent's protecting and emotionally nurturing response which can

calm the infant's stress, fear or anxiety. We will talk more about this in the section under child rearing.

We have said that clinging is an attachment phenomenon. We find that an infant chooses to cling to individuals with whom the child is forming an emotional attachment. Often one finds that the infant will accept only the most valued person to cling to, namely, the mother. Quite common, is the experience of an infant eight or so months of age, demanding to be held by mother and clinging to her tightly even though the child was being held very nicely by father when a stress, fear, or anxiety appeared. This indicates only that attachment to the mother is ahead of that with the father and its quality is more intense at this age with the mother than with the father. This finding is quite normal and need not alarm fathers or mothers. We will talk further about this too under the child rearing section.

Clinging has its origins in two basic reflexes of early infancy and tends to appear as these two reflexes tend to wane. Those reflexes are the Moro (startle) reflex and the grasping reflex, both of which we described briefly in Section 1.11. The grasping reflex is probably stronger for much longer than is the Moro reflex and indeed the grasping reflex is still quite strong when clinging reactions begin to occur around the third, fourth, and fifth month.

What we want to emphasize here is what the clinging reaction highlights, as do the Moro and grasping reflexes, that there is an adaptive inborn system which under certain conditions gives rise to a need within the infant to be in actual physical contact with the person with whom the child is forming an attachment. Work with infant monkeys first carried out by Dr. Harry Harlow and his colleagues has shown how very important a role physical contact with the nurturing individual plays for the normal growth of that primate, and let us remember that humans are primates, too. Stated very briefly, Dr. Harlow showed that infant monkeys who are deprived of physical and emotional contact with their mothers by being reared in isolation become emotionally crippled both as infants, as adults and as parents.

Another startling sign of the need for physical contact in monkeys comes from the fact that young infant monkeys will cling to a surrogate inanimate substitute for the mother -- a wire cylinder covered with a soft cloth and containing a feeding bottle. The need for close contact is inborn and so great that the infant monkey will cling even to this inadequate substitute for maternal emotional contact.

Another finding of Dr. Harlow's is that when infant monkeys are reared in a group but without parenting monkeys, they will cling to each other in a variety of ways for long periods of time, especially when they are frightened (which, of course, induces a profound need for physical contact). The clinging reactions show us that certain conditions heighten the need in infants for emotional contact. But this clinging reaction also highlights the need within human infants, as within monkey infants, to be held, to be in contact with the mother's body or the father's body; to be cuddled, to be touched, to be physically comforted. In fact, this need for emotional and physical contact, child development specialists believe, is as basic a need as that for food and fluids. This, we cannot overstate. Indeed physical contact, touching and holding, are needs which, except when they are excessively suppressed, continue throughout life.

1.252 CHILD REARING: What Can the Parent Do That Is GROWTH-PROMOTING Regarding the Child's ATTACHMENT?

Because attachment is so important for the child's emotional development and personality formation, it is important that the parent know the value of this process and how it shows itself in the child's behaviors, so that the parent can optimize its development. By attachment, we mean that activity within the child's psyche (mind) which makes him form an age-appropriate emotional relationship to another person.

One of the major ways in which parents can promote the growth of the child's invaluable attachment to them is by valuing the child, by attaching emotionally to their child and responding affectionately and reasonably to the child's expressions of attachment to the parent. Let's take up, in turn, how parents can enhance the child's expressions of attachment, the social smiling responses, stranger responses, separation responses, and in reunion responses. And we will also talk of reacting to the child's clinging or its milder forms of turning to the parent for protection and for help.

Although we are focusing a great deal on what the four indicators of attachment tell us about the child's attachment, these can also tell us much about what the parent is doing, whether facilitating or making more difficult, the developing attachment process in her or his child. We want to focus here on what the parent can do to foster a good attachment process.

Smiling Responses:

As noted in the preceding section, in many children the social smiling response begins to emerge during the second month of life. It is remarkably facilitated by the person's smiling back and responding verbally and gesturally to the child's smiling with an appropriate emotional tone. The smiling response -- which comes from within the infant -- is essentially an expression of emotional feeling that will later become affection and love. And it is reinforced when the parent is able to respond affectionately, tenderly, to that emotional communication. At the risk of being accused of reading too much into the infant's behavior, the infant's smile seems to say "I am ready to love you; do you love me?" Actually infants are not yet able to love, but this is where that emotional experience, that critical question of loving and feeling loved begins.

Obviously, parents should not smile to an infant when the infant is angry or upset, nor when the parent does not feel like it. Again, it is important for parents to know that this emotional communication on the part of the infant is an expression of emerging, beginning feelings of affection and that these are more likely to stabilize in a healthy way when the parents react to the infant by smiling and responding verbally and gesturally with affection, warmth and pleasure. Faking it, will not work to the child's advantage.

Stranger Responses:

As we proposed earlier, while the social smiling response can be said to mean "I recognize your face", "I value you", the stranger response can be said to mean "You are not a face I know, yours is not the face of a person I value; I'm upset, I need the face of the person that I know." In other words, the stranger response means that the infant is beginning to sort out the persons the infant knows from those he or she does not know.

One common instance where parents can help their infants who are experiencing a stranger response is as follows. It happens commonly that grandparents who live far away will visit their 6 to 10 month old grandchild perhaps for the second or third time. Under such conditions it is likely that many a well developing baby on seeing these grandparents will have a stranger response. Indeed, the infant may cry and scream at their loving and excited approach. The common reaction in the family is for the mother or father to become quite upset because the child is supposed to smile at her or his own grandparents! If the mother understands that the stranger response is a normal one, which indicates something like: "I have not yet begun to form an attachment to you whoever you are (grandfather), and at this time seeing your face causes me great distress and I prefer to be with my mother or father", the mother will be in a position to help her infant as follows. She can explain to the grandfather or grandmother not to press himself or herself onto the baby, but rather allow the baby gradually to warm up to him or her. Babies do usually warm up to grandparents, but only after they have familiarized themselves with them sufficiently. By doing this, the mother will be protecting her infant against the stranger response; if it becomes too intense, it can cause great distress to the infant. If the stranger response is mild, the mother's presence and her being a go-between can facilitate a rather quick warming up of the baby to the grandparents. We have seen children in great distress being virtually attacked affectionately by their grandparents, who insist that this baby is going to like me and is going to smile at me! The key issue to bear in mind is that the stranger response has an element of anxiety in it and that excessive anxiety can be traumatizing to children and may, in fact, delay the infant's attaching to the grandparents.

6 month old Victor became acquainted with his grandparents in a very nice way. Grandparents (Dad's parents) had first met him a few days after he was born. Of course, he did not get to know them yet since the process of attaching had barely begun and they were not immediately involved in feeding, diapering, or bathing and dressing him.

When mother and father now decided that Mom would go back to work when he was 6 month old, they worked it out with Dad's parents to come and live with them and help take care of Victor. They moved in when Victor was 5 months old, in order to give the baby and grandparents time to form a comfortable relationship before Mom would go back to work as planned. Both grandparents became quite involved in his care. Somehow, Victor really tuned into his Grandpa, and it was clear that Grandpa really tuned into Victor. The relationship with Grandma was very good too, but somehow, he and Grandpa really hit it off well! It was very clear how Victor formed a very warm and good relationship with his mother and grandfather, he seemed to prefer them, although he also was attaching quite nicely with his father and grandmother.

Not all children attach this easily to 4 adults in their early lives. A child who is born

shy may be slower to do so. Parents tend to worry when their young (or older) children are shy (have painful stranger responses to persons or novel situations). Forcing young children to not be shy or to face anxiety-producing strangers is quite undesirable. Most shy children tend to overcome initial shyness after a needed period of time for "acclimation", for getting used to the new person or situation. Forcing them to not be shy tends to intensify and prolong shyness or it may pressure the child to deny his or her feelings and develop ways of accommodating to them that may not be desirable. Patience is needed with shy children, as is reassurance.

Separation Responses:

Like the stranger response, the separation response has a component of anxiety in it and it is well to try to protect children against excessive anxiety. The separation response means that the infant is experiencing as painful the mother's (or caregivers) leaving the infant. Let us remind the student that between five to eight and more months of age, children often experience the mother's moving away from them as the threat of being left by the mother forever. A number of factors we described in Section 1.215 under "Separation Responses" operate to make the infant vulnerable in this way at this time.

Of course, there are a number of instances in which it becomes necessary for the mother or the father to separate from the child for shorter or longer periods of time. This was the case with 6 month old Victor whose mother went back to work 3 days a week. Mother and grandfather worked together very well on helping Victor handle his separation anxiety. They talked to him about where mother was going, when she would be back, tolerated his initial complaining sympathetically and reassuringly, and then made a nice fuss about mother's being back. They even took him to see where his mother worked.

It is important to know what the individual child's responses and reactions to separation are in order to help the parent understand how to best deal with that separation. When 8 month old Suzy's mother went back to work for 5-hour days, 5 days a week, Suzy would get very upset. Her substitute caregiver Mrs. Sander knew that Suzy had been a very irritable baby and that it would take a good deal of effort to calm her when mother would leave for work. Suzy did get to the point of accepting mother's leaving after about 3 weeks. It helped a lot that mother and Mrs. Sander worked well together. Mrs. Sander came in about 1 hour before mother had to leave for work. Even though Suzy cried when she first sensed that mother was leaving -- which mother initially was afraid to tell her in advance -- she did accept Mrs. Sander's holding her. Mother recognized that she was getting worried when it was time to come home, because she was afraid that Suzy would be mad at her -- even though she couldn't wait to see her and hold her. But because Suzy seemed very happy to see mother, mother's fear went away. During the second week, though, Suzy began to cry when Mrs. Sander would come in. Mother and Mrs. Sander tried to calm Suzy, which worked even though Suzy would cling to mother, but would soon accept being held by Mrs. Sander who could be quite sympathetic and gentle.

Near the end of the second week, 8 month old Suzy seemed to not notice when

mother came home. Mother was shocked and her heart sank, she said. Twice she seemed to turn to Mrs. Sander when mother came home, and she fussed when Mrs. Sander was about to and then left. We saw Suzy's mother being upset about Suzy's not even noticing that she came home and her not wanting Mrs. Sander to leave as a welcome reaction for both Suzy and her mom. It was an opportunity for both of them. Mother could see, we told her, that Suzy is very upset at mother's being away and that she was trying to cope with that pain by shifting her attachment to Mrs. Sander. We told Suzy's parents that the pain probably was generating anger in Suzy toward her mother. It would be (and it was) very helpful for mother to hold Suzy and tell her: "I'm sorry you're so upset at my having to go to work and be away. But I'm here now, I'm your Mommy and I sure missed you too." This type of reaction by mother quite quickly brought up in Suzy the feelings of attachment to her mother and led to Suzy's molding into her mother's arms appearing to be fully re-engaged in her attachment to Mom. It surprised mom that sitting like that with Suzy for about 5 minutes, telling her how much she loves her, how she missed Suzy while at work, that she thought about her often, how effectively it calmed Suzy and made her smile and comfortable again. By the end of the 3rd week, not yet 9 months old, Suzy seemed accepting of Mrs. Sander, of Mom's going to work and she was usually now not upset when Mom came home.

It may not always be this easy with many children. It is important to be aware of the infant's reaction and to deal with it again and again. Also, parents should know that there are periods when an infant is much more vulnerable to the separation and experiences the separation as more traumatizing than at other periods. For example, the 5 to 12 month old and the 16 to 28 month old generally will find separation more painful than the one or two month old or the 34 month old or older child.

With the average five or eight month old, who is at a peak period for the separation reaction, it is especially important that the mother, like Suzy's mother, be open and honest about the separation. This means that the mother should tell the child that she is going to be away, when and for how long, even though the infant has no concept of what two hours or five hours might mean. It is often useful to anchor time around such issues as eating or going to bed times.

Many people might feel, "Good heavens, a six month old wouldn't understand if I say that." The fact is that we really don't know how much of spoken language children under one year understand. We know that they understand a great deal of feeling tone, of emotional language. But we can say, as observers of infant behavior, that we have found young children to understand a great deal more of verbal communication than most people and many parents assume. It is our impression that if one is going to make an error, it is better to err on the side of telling a child what one is going to do, rather than assume the child may not understand. Indeed, the child may.

With this in mind, we suggested to Suzy's parents that they tell Suzy for how long one or the other is going to be gone, when Mom and/or Dad is going to come home and to be truthful about it. If Mom expected to be away for two hours and it turned out of necessity that she was away for five hours, then we suggested that she express regret about being away longer than expected and that she explain to Suzy what happened. It is important for parents to know that excessively long separations can be very worrisome and painful

for children up to 3 years of age, and even beyond that age. Separation of several hours during the day can usually be reasonably well tolerated by the less than one year old. Separations for days can be quite traumatizing to an infant up to 2 1/2 or 3 years of age. Consequently parental vacations away from the less than 2 1/2 year old should be taken with caution and alternative and substitute care should be of good and familiar quality. It is then also advantageous if the infant stays in his or her own, familiar home.

It is extremely useful with respect to both separation responses and stranger responses, that the parent allow the child to express whatever feelings the infant has. Parents should not disregard feelings the child expresses, whether they are crying or clinging or simply giving the parent a quiet look of distress. It is helpful to acknowledge those feelings, to put them into words like: "Oh, I see that you feel sad at Mommy's going away"; then try to calm the infant as best you can, explain that you must leave and know it causes the infant worry and anger but right now mommy has to go. "But, I'll be back before it's time to eat" -- and then go ahead and leave! That is, of course, assuming that the proper caregiving is provided. Then when the parent returns, it is important again to allow the infant to express whatever feelings she or he has, and if these are feelings of anger or of rejecting the mother, to respond to these in a reasonable way, allowing the infant to have the feelings of anger and to reassure him or her, as Suzy's mother did, that mother is back and mother is staying.

With all expressions of feelings, if we can allow our children to express them, nonverbally when they cannot yet speak and both nonverbally and verbally when they can, we will open channels of communication which will lead to the development between parent and child of an emotional verbal dialogue which will cement their relationship, facilitate the child's learning to accept certain realities, to accept certain inevitable frustrations as well as pleasures, and learn to make reasonable compromises. It is always disadvantageous and it can be harmful to disregard the expressions of feelings by young infants. It will make the infant feel uncared for, not valued as a person, not understood; the infant will eventually feel that no one can relieve pain or provide comfort, all of which are detrimental to his or her psychic development.

In trying to deal with the difficulties their young children's separation reactions causes them, one thing many parents believe is that if the child doesn't see the mother leave, the child will not feel the absence of the mother. That is absolutely wrong and it creates its own difficulties by intensifying the young child's "magical thinking", -- that things can happen by magic, just by wishing them or fearing them -- which in turn, intensifies separation anxiety. It is much better to face the child's probable distress at mother's leaving and to deal with it as best one can. Another thought to be mentioned here is that the feeling of guilt the mother experiences at leaving her child even when leaving is necessary, may prevent a mother from helping her child tolerate the unavoidable separation and learn to deal with it in a reasonable way. If one has to separate from the child to go to the dentist, or to the doctor's, or to work, children can learn to deal with these reasonable absences and the parent can greatly help the child cope with them. Like Suzy did, children can accept and adapt to reality. They can better accept needed separations when the separations are acknowledged as painful to the child, and the parents try to help the child cope in an adequate and reasonable manner.

Reunion Reactions:

During the first year, as we said earlier, reunion reactions are for the most part of two kinds, the pleasurable reactions, and the painful and angry reactions. The pleasurable reunion reaction clearly confirms the infant's valuing the mother and reveals the child's beginning feelings of affection toward her. Speaking of the six to 12 month old infant, let us say again that the painful and angry reaction, is equally a confirmation of the infant's valuing the parent.

Because it is a painful (unpleasurable) or negative emotional reaction the parent may not recognize it as a positive indication of attachment. It is, however, a welcome response not only because it confirms attachment but because it allows the mother an opportunity to speak with her infant as Suzy's mother did about why she had to leave, how sad the mother is that the child was so upset by her leaving, and that the mother is now back and that mother is staying. In other words, it is an opportunity to work through the child's feeling angry toward the mother for having had to leave. The mother who responds to an unpleasurable (painful and negative emotional) reunion reaction by rejecting the child or by a counter-reaction of being angry is doing herself and the child a great disservice. This mother is reinforcing anger between the two of them, intensifying it rather than lessening the pain of separation in a reasonable and growth-promoting way. Under these conditions like under any conditions that cause the child to be angry with Mom or Dad, it is better to say to a child something like, "I know you're angry with me, that I upset you by having to leave you to go to work. I'm sorry it hurts you. But look, you and I can be angry with each other. But you know that even though we're angry now we love each other a lot too." Parents need to speak to a young child using words that reveal such understanding and permit the child to express hurt and angry feelings and by acting in a conciliatory and accepting way, one can get this type of message across even to as young a child as one six or eight months of age. And, of course, this message can be further conveyed with a warm hug.

Clinging Reactions or Pleas for Comforting and Help on the Part of the Child:

As we said before, children usually cling because of acute feelings of distress. When the parent recognizes that the infant is in distress, the parent is more likely to try to find out what is causing the distress and either eliminate its source or help the child tolerate it in a growth-promoting way. The parent who rejects clinging will intensify the need for clinging. This has been discussed before in Section 1.221.

Children do not appeal for help unless they need it, unless they feel threatened and unable to cope alone with a particular situation. Sometimes the appeal for help is one that needs to be talked about as well as complied with, depending on what is causing the stress. There are instances where reasonableness tells us appealing for help ought to be talked about with the child but ought not to be complied with. For example, when a child turns to the parent appealing for a toy with which another child is playing. Here it is important that the parent deal with the child's appeal by telling the child that she or he

cannot have the toy at this time because another child is playing with it, and the parent can offer another toy to her or his own child in a supportive and comforting but firm enough way. One can be supportive and comforting without giving the child everything the child demands even when what the child's demand is reasonable. Obviously, it would not be helpful to comply with the child's demand if that demand is unreasonable.

This topic brings us directly into another major one that is a source of distress for parents and where parents can be very helpful to their children. That is the area of self-comforting. Children have ways to help themselves already during the first year of life. In one of their first problem-solving and creative acts, children use devices whose value is often misunderstood by many parents. We are speaking of thumb sucking, or the use of a pacifier or some other comforter, usually a favorite blanket or soft toy.

It is important for parents to understand that when a less than one year old child sucks his or her thumb or uses a pacifier, or when the child attaches to himself or herself a particular comforting blanket, the child is attempting to master a state of internal tension. Many people seem unaware that children under one year of age already make large, indeed, remarkable efforts to master their pleasant and unpleasant experiences and environment. Children in the first year of life suck their thumbs as a means of comforting themselves without having to appeal for help from their caregivers. When an infant sucks his or her own thumb the infant is acting in a self-reliant way; and this is most likely one of the first acts of self-care, of mastery, and autonomy.

A second note for the parent is that thumb sucking occurs because, at least in part, the mouth as an organ of comforting plays a very large part in the child's first year of life as well as beyond. As a result, finding security by some activity of the mouth is not surprising. No one needs to be informed of the resemblance that the thumb has to those basic feeding mechanisms, nipples, and that children turn to the thumb as a substitute for a nipple.

Research has shown that the security blanket becomes meaningful as such because it is part of the mother-child comforting experience. For example, it is especially when the mother is preparing to put the infant to bed that, as the soothing-seeking infant is falling asleep he or she is in a state of being comforted and gratified and that touching the blanket becomes a part of that experience. The infant seeks soothing whether or not the parent is effective in doing so. The infant finds one or another "thing" that works in self-soothing. Usually it is a particularly soft corner or edge that the infant uses to self-soothe, often the blanket being used to rub against the mouth or against the cheek as the infant is falling asleep. In other words, both thumb and security blanket have their origin in experiences that lead to comforting, like eating and falling asleep in a state of satiation.

The most important issue is that the thumb and the security blanket are means that the infant has devised for reducing tension within the self. It may surprise some people that children in the first year of life experience a great deal of tension but all one need do to check this out is to look closely at children, and one will find that tension is a normal event, a normal state of affairs for the average, normal, less than one year old infant. To reduce tension, of course, is often essential to adapt well; and when the infant finds means of reducing tension on his own, she or he is making efforts to adapt to his or her own life stresses and strains.

On this basis, when parents try to discourage their children from using self-comforting devices, they are in effect interfering with the child's efforts to act self-reliantly and to adapt constructively. It is in the child's interest for the parent to permit these efforts. Most children, we find, soon enough stop using their thumbs and security blankets or soft toys, when they are permitted to use these devices until they become able to adapt satisfactorily without them to the stresses they experience daily.

An additional note to be made about the security blanket is that because of its being handled by the child under so many different conditions, including, for example, while feeding, walking and toddling around and dragging the blanket on the floor, security blankets tend to become "dirty and smelly". The parent experiences it as being dirty, not the infant. Often a well meaning parent will sneak the blanket away from the child in order to clean it. Unfortunately that cleaning process changes the character of the blanket, by eliminating those familiar smells. A number of children become distressed when their blanket is changed (cleaned) by the parent's good intention. Obviously there does come a time when a blanket may just get too filthy, and may have to be cleaned in spite of the child's objections, but such cleaning ought to be carried out recognizing that it may have a negative influence on the infant. As with many other things it is much better to tell the infant that you are going to wash the blanket and do so while you try to comfort the infant if he or she complains about your taking possession of his or her comforter.

What Could We Do To Help Richie:

At 5-6 months Richie gave strong evidence (reported by those who knew him and recorded in a series of photographs that showed him smiling, engaged with others, healthy in appearance, vibrant in mood) of beginning to form attachments, we assume to his mother and mother's aunt; possibly also to his young father. The quality of his experiences, of the care he got, and of his environment changed painfully when he was about 7 months old, when we saw him at 14 months his attachments were very poor: he was afraid of people, suspicious of what they would do to him, yet he seemed to plead for what we came to see as a long lost feeling of being tenderly cared for. It was clear to us as mental health clinicians of infants, children, and adolescents, that all efforts should be made to repair the damage to his relationships to others (caregivers) because so much depended on it: his emotional (and physical) development, his self development and his ability to become a socially adapted, responsible member of his community.

We first tried to find out all we could of how he interacted with mother's aunt (now his primary caregiver), with his occasionally visiting mother (to whom he reacted with fear), with neighbors, and with children. This included especially what we observed when he was brought to our parent-child group which met twice weekly for 2 hour periods. As we came to understand his behaviors, we shared our understanding (those who observed us said that we did so in a "physicianly" manner, with respect, thoughtfulness and sympathy) with the aunt and the parents in the group. When we do this work we are especially sensitive to the feelings of the parents and of the young children. We emphasized his mistrust and fear of being hurt.

Secondly, we tried to help the aunt understand the damage to Richie's attachments

and to his total development, especially his failure to develop physically and emotionally as resulting from the effects of the severe traumas he had experienced since he and his mother left the aunt. Following his behaviors, his reactions to being handled, his reactions to other children, we tried to explain what seemed puzzling to the aunt. We also tried to clarify what handling might help and why, and what was not helping and why.

Third, we took care to explain as it emerged, why, as he began to feel more and more safe and trusting, he would have outbursts of throwing toys, and even tantrums and rage reactions. We explained how we find clinically that when children (like adults) begin to recover from depressions, from abuses, and even from painful physical illnesses, the rage the pain generated in them begins to come out. People are surprised by this. Parents are shocked by it. It is important to guide the child to express these feelings in acceptable ways. By crying, complaining, talking if the child can talk. It is important to set limits constructively on throwing things and on rage reactions, but to not block or inhibit the anger, the rage from coming out (see Section 1.323).

Fourth, hand in hand with setting limits constructively (which is a very challenging task) it was important to help Richie feel valued, wanted, loved; it was important to not reject him, to set limits on his behavior. With this his feeling in a world of caring people would revive his feelings of trust. And, indeed, this we saw.

Gradually, slowly, Richie's rage reactions, his outbursts of throwing toys diminished, his suspicious of others decreased. He slowly began to smile again, at times sadly. He began to be physically more active and began to interact with other children. Slowly he showed pleasant feelings in interacting with his aunt and some other mothers in the group. Slowly he began to show evidence of feeling safe. With all this, we inferred that his attachments were becoming more positive again. According to his great aunt, he was much more upset when his mother visited and continued to be afraid of her. Much repair work needs to be done to get such a child back on track toward healthy development. And to think that all this damage could have fairly easily been prevented!

Many children have taught us the sad and costly consequences that come from child abuse, abuse even of children less than 1 year old. And they have taught us also the large value of secure and loving attachments.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.261 HUMAN DEVELOPMENT: Exploratory and Locomotor Activities -- The Beginnings of Autonomy

We will talk here about the beginning of autonomy, of doing things oneself. This shows itself especially in two major aspects of behavior during the first year of life. One aspect of this behavior comes under the heading of sensori-motor activities, especially exploratory, and the second under the heading of locomotion or bodily movement. Although these are inter-related activities that serve the beginnings of autonomy, their functions are different and can usefully be described separately.

The body system that makes locomotion (movement) possible develops gradually although quite rapidly during the first year. In the first few months physical movement from one place to another is very limited; infants are not yet able to crawl, although by large movements of their bodies some will be found to move from one side of the crib to another. For the most part, the earliest efforts at what can be considered to be an effort at locomotion consists of seemingly uncoordinated movements of the legs, arms, torso, and head.

At the middle of the first year of life, many infants are able to roll over, some doing so earlier than others. Many infants are then also able to sit and some begin to show signs of crawling. Crawling, the first important mode of moving from one place to another, becomes especially evident from the middle to the later months of the first year of life. It gives the infant the ability for self-initiated movement, to go toward things that catch the infant's interest, distance himself or herself from them, giving the infant a very new and very young degree of autonomy. Although for the most part crawling tends to develop during the second part of the first year of life, again as with other developments, some infants do so earlier and some later than others. Occasionally one finds a normal infant who for one reason or another may not crawl at all.

Although crawling is a large achievement in the infant's ability to move from one place to another, no locomotor achievement, however, is as dramatic as the infant's being upright and learning to walk. If we take it from the infant's and the parent's reactions, upright locomotion seems to be an exciting and important event in the child's life. This is amply evident not only in the great efforts the child makes but also in the excitement and glee one often sees on the child's face when she or he begins to walk. During the middle of the first year of life, and often quite earlier, some infants convey to their mothers and fathers that they want to be held upright; they seem determined in this and become quite excited when they are so held, and show annoyance and frustration if they are not. Some infants may begin to walk from about 9 months of age on, but for the most part walking begins around the end of the first year to the beginning of the second year of life, again each infant according to his or her own schedule of development.

Somewhat troublesome for parents is the great push within the child which not only propels locomotion as well as exploratory activity we shall soon describe, but also seems

to compel the child to climb onto things including chairs, and up the stairs. This activity commonly occurs in the later phases of crawling and in association with beginning to walk. For reasons we shall detail in a moment when we talk about exploration, infants seem to be driven from within their own bodies to climb and will do so even -- without seeming aware of it -- at some risk to themselves; in this activity parents do need to keep an eye on the toddler and set reasonable limits. Climbing especially demonstrates the tremendous inner pressure, the energy and effort that are exerted by the six to twelve month old infant in learning to move about, in the use his or her legs, arms and body for the purpose of getting from one place to another and, eventually, in doing so in a manner that will allow freedom of his or her arms and hands. The large efforts to learn to control the body, to develop its capabilities, to master its functions, are easily observable in the six to twelve month old infant. Close observation of the less than one year old's face and body movements often will show how serious the infant is about this business, how persistent and how hard he or she is working at it.

Exploratory Activities

Much more complex than locomotor activities, is the cluster of activities we want to describe now, under the heading of exploration. Exploratory activity is a large sector of what Psychologist Jean Piaget called sensori-motor development. By this sensorimotor functioning he proposed is how the development of intelligence begins. Here we will focus on exploratory activity only because of its tie-up with locomotion and, because both are vital to the beginnings of autonomy and both produce the troublesome and salutary need for limit setting.

Exploration develops hand in hand with the development of locomotor skills, these skills enlarging dramatically the infant's sphere of exploration. One readily observes a strong pressure arising from within the child to explore the environment as well as his or her own body and the bodies of valued caregivers and members of the infant's immediate family. As with all other activities, exploration becomes more complex as development proceeds and the two week old infant will explore in a simpler manner than does the six month old and, of course, the 11 to 12 month old. Surprising as it may seem to some students, one can observe days old and weeks old infants already looking about themselves, beginning to explore, to learn about their world. Especially important is that the infant will begin to explore not just when awake, but especially when in a state of sufficient satiation, rest, and calm. We find that the infant whose needs for feeding, holding, or rest are frustrated too often and too long will exert most of his or her energies accommodating and reacting to distress and will in the process exhaust his or her limited energies to the task of feeding and undoing his or her distress. That infant will learn to clamor for food and to undo distress among other things, but will be robbed of the opportunity for beginning to explore and to learn about the world around her or him, early in life, in a state of sufficient calm and well-being. We do not mean that there is a need to rush the infant to explore but simply that reasonable gratification of an infant's needs will allow the infant the use her or his energies for developing needed skills, such as to begin to learn about the world around him or her. And it is most likely of great

advantage to begin to learn when feeling in a positive and comfortable physical and emotional state which best sets the ground work for adapting to this world with the infant's full potential.

From about the third month of life on there is a gradual increase in exploratory activity. As the infant is awake for longer periods of time after being fed and made comfortable, he or she will spend more time visually exploring his or her own hands, and feet, the mother and other persons, will look about the crib, look at high contrast patterns such as lights, or a light-filled window. At this period one can also see the infant respond more alertly to sounds.

Hand in hand with beginning crawling skills the three to five month old infant is attracted to things in the environment and drawn to them seemingly for the purpose of exploration. Close observation of exploratory activity shows several striking features. One, the exploratory activity is not an accidental activity but rather seems to result from a large inner pressure, and inner drivenness, which seems to push the infant into action. One can see the infant scan the environment, a function that serves a strong need to test, to learn, to master all kinds of things so as to know what they are and what they do.

Secondly, this exploratory activity of itself seems to be made possible by and, at the same time, demand that the child begin to organize his or her movements so that they are no longer just random movements but become purposeful. The infant's movements now begin to serve the functions of exploration as much as do the hands and the eyes. In addition, crawling becomes organized into efforts to move the self from a point distant from a particular object that has gotten the child's attention, to that object. If the student is skeptical of these statements, observe an infant before he or she is yet able to crawl, and look at the infant stare at an object several feet away which has caught his or her attention; then observe the infant's body as the infant tries to move to get hold of the thing that has drawn his or her attention. Some infants become frustrated and cry because they cannot reach the object which they are trying very hard to get hold of. During this developmental period, note the gradual integration of body movements that one day do, in fact, become crawling.

Again we note that the infant's exploration is not altogether willed activity. It is not based on "Now, I will explore this or that". Rather it seems to be driven from inside the infant. The infant is as much the victim of this inner pressure (inner drivenness) as is the parent who at times has to intervene to protect the infant against hurting herself or himself. One gains the impression that this inner drivenness which motivates and initiates the infant's explorations is in the service of the child's becoming acquainted with his or her own body, the bodies of the people valued by the infant, and the infant's external environment (see our further discussion under Aggression, Section 5.313).

In line with these thoughts about infantile exploration, we say that not only does this exploration organize locomotor and sensorimotor function and activity but it actually propels the development of new skills. Of course, new skills cannot develop until the body's maturation makes the relevant body parts and organs capable of putting the new skill into action. The interplay of two facts, the progressive maturation of the child's own body and the intriguing inner pressure to explore and master one's self and the environment, propel the development of specific new skills that make exploration and

what grows out of it possible.

This is in line with what Piaget conceptualized as the development of intelligence which begins during the first year of life as "sensorimotor intelligence" (see Section 5.41). To make a point here briefly, consider how by means of explorations and the development of new skills the infant is beginning to learn that what he does causes certain results. We speak of this recognition of the effects of action as "causality". Close observation of a child shows that the infant at times tries to test what effect he or she can have on the environment. For instance an infant may take a toy and strike something with it and then look to see what happens. We have, at times, seen an infant less than one year old take a toy and strike another infant with it, seemingly not with the intention of harming the infant. Seeing the other child's reaction, the 10 month old will do this again, and then again, if not stopped.

When Jennifer was 11 months old she was a very busy child. She had started to be a very active explorer at 15 weeks. We know this date because we filmed her exploratory behavior then. At 15 weeks, after being fed, and taking a good nap, Jennifer, on the floor on her abdomen, became preoccupied with a set of thin plastic rings joined together on a string like a necklace. She examined them, pulled on them, slammed them together, pulled them apart again, brought them to her mouth to explore, pulled her head up as she stared at them, over and over for an uninterrupted period of 20 minutes. After a brief break, she went back to them for another 4 to 5 minutes. She looked like a hard working, patient and determined student of the world into which she was born.

This type of busyness became typical of Jennifer. At 11 months of age she made a new discovery. She happened to be near 11 month old Johnny whom she had known for months now. This time she became interested in Johnny with his trusty pacifier well planted in his mouth. She reached up to it and just brusquely pulled it out of his mouth. Johnny and those of us observing this were a bit surprised by this. Jennifer's mother too was surprised, took the pacifier from Jennifer who was just standing there with it in her hand, put it gently back in Johnny's mouth and told Jennifer "Don't do that; that's not nice. Don't take Johnny's pacifier." Jennifer did not seem at all troubled by what Mom just said. She paused for a moment and with seeming simple curiosity, just reached up at Johnny's mouth and again plucked the pacifier from it. Now Johnny got a bit upset. Jennifer's mother was more surprised, a bit puzzled and annoyed, returned the pacifier to Johnny and said to Jennifer: "Heh, don't do that; that's not nice. That pacifier belongs to Johnny." Jennifer did this twice more, each time Johnny and Jennifer's mother getting more upset and annoyed with Jennifer.

The observers felt that Jennifer's behavior just did not seem to be motivated by ill intentions. She did not at all seem to be then, nor before, angry with Johnny or anyone else for that matter. We gained the impression that this was done to see and to learn what the effect of this action is going to be and if it continues to be the same. The infant, like Jennifer seemed to, learns from it. Whatever else she learned, she found that she could upset Johnny and her mother. Of course, one needs to sort out this kind of activity from hostile acts in which the child intentionally tries to hurt someone.

We cannot emphasize too much that that while all children have the same general patterns and the same general schedules of maturation of physical development,

psychological and emotional development, that nevertheless within certain ranges each child has her or his own personal schedule of maturation. Certain functions will develop before others in different children. For example, some children will learn to speak earlier than others. Some children will learn to walk earlier than others. Of course, where parents are very worried about the rate of development in their children, consultation with their pediatrician or another child development specialist can benefit the parent and the child.

One of the inevitable results that comes from the just less than one year old explorer's activities is that this highly adaptive activity at times is rightly experienced by the parent as presenting a threat to the child. For example, climbing the stairs alone at ten months of age is a hazardous undertaking. Similarly, the young explorer who reaches for the hot cup of coffee that mother has left on the table is in danger of getting himself/herself burned, as unfortunately we all have seen from time to time. What inevitably happens where there is a danger is that the protecting parent intervenes and prohibits the infant from pursuing the exploration which the infant seems pressured to undertake. Understandably the infant then experiences frustration and may become angry with the parent for what the parent knows but not yet the child, to be a protecting prohibition. In time, this necessary intervention will lead to the development of conflict-producing feelings within the child toward the caring, protecting parent. On one hand, the infant is pressured from within to explore and, on the other hand, is prevented by the person he values most in the world, namely his mother, from exploring. This sets up a conflict within the child, evidence of which will be apparent in the child's behavior. Before proceeding to describe this conflict let us take another commonly found puzzling phenomenon which occurs during the latter part of the first year of life.

Quite commonly at this time an infant explorer is drawn to many things in the environment that he or she finds attractive. We thought this was just what Jennifer did with Johnny and his pacifier. For reasons which are not clear to us, wanting what another person has, be it a toy another child is playing with or the cup of coffee mother is holding, the ten, eleven month old child seems to be more attracted to what the other person has than to other things around and available to him or her. One mother, who has twins, recognizing this as a source of conflict, attempted to deal with it by buying her twins identical toys. She discovered with some dismay that this did not solve the problem. Not uncommonly, one of the twins, her toy in one hand, would reach for the same toy that belonged to her twin with the other hand.

Why an infant wants something that the other person has remains unsatisfactorily explained. It probably has to do with the common painful experience that the "Grass is greener on the other side, or "Wanting what the Jones' have". This "Wanting what the other kid's got" seems to begin from the end of the first year of life, and continues to some degree throughout adulthood. Here again, in order to help an infant socialize in a reasonable way, the parent will have to intervene and prohibit the child from taking what belongs to someone else. We find that by helping a child know that something belongs to another person and cannot be taken from that person, the child becomes secure that the parent will not allow another person to take away what belongs to the child. The upshot, however, of the parent's prohibiting her own child from taking what another child has like

Jennifer's mother did, can lead to a reaction of annoyance on the part of the child, and then anger toward the beloved parent. Therefore, again we have an instance of an internal pressure that is making the child act in a way that comes into conflict with the person the child loves most. This then sets up a conflict with which the child and mother (caregiver) have to cope.

In this section we have talked about the development of locomotor and sensorimotor activities, have found that these are pressured from within the infant, that they unfold gradually, and that they serve adaptation to the child's new world. We also found that these bring about two critical phenomena which arise particularly during the latter part of the first year of life and extend through the child's second and third years: (1) the need for the parent to set limits on her child's hazardous or unacceptable exploratory behaviors, and (2) the development of a conflict experienced by the child because of inner pressures to do, and external pressures by the beloved mother to not do. Let us talk about these, as we turn to Child Rearing considerations.

1.262 CHILD REARING: How to Optimize the Beginnings of Autonomy

Most parents enjoy helping their infants learn new things, develop new skills. And most know that once their infant begins to crawl they have to make home a safe place in which to crawl. Pediatrician-Psychoanalyst Ben Spock called this "baby proofing" the home. In addition, because exploring his or her universe is among the child's earliest learning experiences, it is important to not have to thwart explorations too much or it may thwart the inner pressure and desire to learn. Therefore, parents must make it possible to explore safely. Too many breakable knick-knacks within an infant's reach will require too many "NO's". Too much use of a play pen will inhibit explorations and make many children feel caged in and cast aside.

Of course, parents are great helpers to learning new skills both by giving a hand at them, but especially by approving of them. Helping an 11 month old to walk is "appreciated" by the infant and mother's sharing of his or her excitement in doing so is enriching-- to both.

And similarly, the parent can be helpful to the child's development by fostering his interest in the world around him or her. Responding to signals that he or she wants to interact, and naming body parts and objects the infant looks at or picks up are among the many ways of doing this. Allow the infant to explore so long as conditions for it are safe. Important is this: that one allow the infant to do her or his own exploring and discovering as well as, at other moments, to be available to become involved with the infant in those explorations especially where the child brings something to mother or father.

It is well to add here, that the latter half of the first year of life is when becoming a student begins. Let us clarify. The exploring infant is experiencing interest in things the infant does not yet know; by that exploration, the infant is learning about that not yet known object. She or he is learning about herself or himself, is learning about others and

about the environment in which the infant lives. In this sense the infant is not just being busy but also is learning as does a student. In this sense too, parents should make themselves available to their children as teachers. Where the learning and teaching experiences are pleasurable, parents can lay down the foundation for the child's enjoying learning at home and eventually in school. <NOP> Conversely, if for any reason, the child is too often restrained and discouraged from exploring, his inner motivation to learn may diminish or become conflicted.

It is well for parents to remember that children have their own schedules of maturation. Especially in the area of the child's developing locomotor and sensorimotor skills, parents tend to compare and become distressed when their child does something a bit later than another child may. We tend too often to equate more rapid development with greater intelligence; but that is not always the case. We cannot overstate the importance of recognizing that each child has his or her own schedule and also his or her own modes of developing which can be enhanced by parental support and reasonable encouragement.

Setting Limits:

We have suggested that to optimize the less than 1 year old child's beginning autonomy and making the earliest learning experiences (explorations) positive and safe, parents should "baby proof" the home, or at least the areas where the young child will be. There is another, much more complicated thing, parents would be well advised to learn to handle in growth promoting ways, that is limit-setting. Both the inner thrust to explore and the development of locomotion, first crawling and then walking, which are important parts of the beginning sense of autonomy bring much pleasure to both child and parents. But they also bring with them some hazards. For example, a 10 month old crawling or walking up the stairs is hazardous -- unless he or she is supervised. So are the child's reaching for a hot cup of coffee, or on top of the stove, etc. All of these present a threat to the child and elicit in parents the need to intervene to protect the child. That intervention is limit setting.

When 11 month old Jennifer experimented with 11 month old Johnny's pacifier she seemed to have discovered the principle of causality and wanted to test her ability to make things happen. But what she did upset Johnny (because he felt at least unpleasantly manipulated by Jennifer), and it upset Jennifer's and Johnny's mothers (because what Jennifer did was not a proper or socially acceptable thing to do). To help her, Jennifer's Mom had to set limits. And so did the mother of the twins who, like most if not all children, wanted the toy the other one had even though she had one of her own.

Jennifer's mother automatically reacted to Jennifer's pulling Johnny's pacifier as to an undesirable act committed by her daughter. First she told Jennifer: "Don't do that; that's not nice". The second time, Mom was more annoyed and more emphatic: "Heh, don't do that; that's not nice. That pacifier belongs to Johnny!" The third time she did it, Mom got angry and told her "Jennifer, cut that out." And she again, put the pacifier back in Johnny's mouth. The fourth time, mother had all she would take. "Heh, you're being a bad girl"! Can't you see you're upsetting Johnny! Now you stay away from him!"

Jennifer saw, it seemed that Mom meant it. She turned away and moved away from both Johnny and mother. Mother told us that on the way home she told Jennifer that what she had done was not be done again.

Setting limits plays an important part in promoting the healthy development of autonomy in the child. The ten and eleven month old child has not yet learned the range of his or her capabilities, nor has the child learned the risks that he or she may take; nor the full consequences of her or his explorations in terms of danger to the self, others and to things. The infant, in other words, cannot yet evaluate the consequences of her or his actions and until that is possible, needs the protecting parent to act in his or her behalf. Setting limits means that the parent acts on behalf of the child where the child cannot yet act appropriately himself or herself. This act may have to do with (1) protecting the child against danger to the self or another, or (2) protecting the child against breaking something that the parent or someone else values, or (3) it may have to do with helping the child learn social rules and reasonable behaviors. In other words, then, the parent is acting as a reasonable and more mature extension of the child's own adaptive capabilities.

We distinguish the concept of setting limits from that of discipline and punishment. In contrast to the way we have just defined limit-setting, we define discipline as a complementary process: 1) the development within the child of inner controls, and 2) as the parent's efforts to help the child develop such inner controls. It is exactly where the child lacks inner controls in dealing appropriately with a situation that the parent needs to set limits. There is a reciprocal relationship between parents setting limits and children developing inner controls. By the parent's setting limits appropriately, with explanations for these limits, with firmness and respect for the child, and with reasonable persistence, the child begins to internalize these limits and to develop inner controls which in effect will make the child able to eventually set limits upon herself or himself. Where limits are set well and reasonably -- which includes anger but not harshness or abuse -- the child tends to develop good inner controls. In this, the conflict we will discuss in a moment also plays a very important part.

Setting a limit, acting as an extension of the child's own adaptive capabilities, requires explaining to the child in a simple way what is desirable and what is not desirable, what is permitted and not permitted. Besides stating these, even with very young children, it is useful to say why it is not permitted. As we have said earlier, it is better to explain even where the child may not be able to understand fully what is said than to assume that "there is no point in explaining because my kid won't understand what I am saying". Setting limits requires that the parent use reasonable judgment about what is allowed and what is not allowed and that once the limit is stated to the child then, for the most part, the parent ought to stick to the limit imposed. We are not speaking of rigidity on the part of the parent. If a parent finds that the limit the parent has initiated is really not necessary, the parent can change her or his mind, say to the child, "I've changed my mind, it is OK for you to do this or that", and discontinue the limit. If, however, the parent finds that the limit is reasonable and will be helpful to the child, then it is important to stick to it.

All parents know that when she or he sets a limit, often a 6, 8, 10 month-old infant is going to be angry with the mother/father for setting that limit. It is not always so. For

instance, Jennifer did not get angry with her mother when mother told her not to pull Johnny's pacifier from his mouth. Nor did the twins always get angry with mother when she told one not to take the other's toy. In these instances, it seemed as though the less than 1 year old already could appreciate that it is not reasonable to take what belongs to someone else. We also thought that perhaps Jennifer was not angry with her mother even though mother got pretty angry with her, because her mother had convinced her that to take Johnny's pacifier out of his mouth was to be a bad girl and that it somehow made sense to her. More commonly though, when a parent sets limits with a younger child, it elicits anger toward the limit setter. In part, then, anger toward the mother will come from the fact that the mother is saying, "No, you cannot do what you want to do", and, of course, we all like to do what we want to do. This results not only from our inner sense of autonomy but also from our narcissism, a healthy normal inner feeling that one can do what one wants to do. We want to emphasize that, although such narcissism is healthy, it does not always have to be gratified by the parent.

Another factor makes the child angry with the parent when the parent sets limits. It is the conflict between the strong internal pressure a child feels to do something and the frustration felt by the "No". At times the child is pressured from within as if driven like a machine without having yet the capability of either steering it or putting on the brakes. Pushed from within this way, when someone interferes with his grabbing mother's coffee, for example, the child may experience this interference as a frustration of the inner pressured wish he or she is feeling. The frustration of that inner-pressured wish to a greater or lesser degree causes anger in all children. It is not uncommon for the child to go right back and do what the mother has just prohibited. The infant is driven from within and often, at this age especially, is just as much the victim of his own inner driven actions as is the mother or father. By the way, a note is warranted here. Although we all assume that father is the one who sets limits and punishes his children most in early years, the fact is that the responsibility of limit-setting more often falls to the mother who is with the young child much more. Therefore, the mother usually is the first disciplinarian although eventually the major job of disciplining, in most cultures, falls to the fathers.

Punishment, as we choose to define it, is the parent's acting upon the child with the withdrawal of a privilege or the inflicting of pain in retribution for the child's carrying out a repeatedly prohibited act. Limit setting has nothing to do with retaliation or retribution, or payment for an undesirable act; those have to do with punishment. Punishment is where the parent or the community acts as an external conscience, as a policing agency, in retaliation for misconduct. Setting limits is acting in behalf of the child where the child cannot yet act appropriately himself or herself. Of course, there is some overlap in acting as a punishing agency and acting as a protecting and adaptive agency. Acting as a punishing agency can, under desirable and optimal conditions, also help the child adapt more reasonably to our social universe. We want to say at this point, with much confidence, that there is no need for punishment during the first year or so of life. What is needed is limit setting.

Explorer Meets Prohibiting Mother (Protector), and a Vital Conflict Emerges

Again we say that the 11 month old child is not an explorer by choice but because a psychobiological internal pressure compels the infant to explore; we postulate this pressure serves the infant to learn about and master his or her environment as well as his or her own body and that of valued persons. The pressure that motivates the young explorer becomes especially visible, its intensity quite readily felt, when the protecting mother sets a limit on the activity which the parent feels is endangering the child. When the young child is stopped by the protecting parent who prohibits as is reasonably needed, he or she usually feels frustration of the pressured wish to explore. This often leads to the child's experiencing unpleasure which of itself directly causes annoyance and anger in the young child. In other words, simply the fact that an inner-driven act (or wish) is prohibited by an outside force (person) can generate anger toward the prohibitor.

What we shall discuss now will be more commonly found during and from the second year of life on; but it may occur earlier. Because it arises with limit-setting and limit-setting becomes necessary during the second half of year one, we believe it useful to understand the complex and important effects limit-setting has on the child.

Consider the all important complication in setting limits coming from the fact that the prohibitor is not simply anybody, but is the highly valued mother or father. Quite unavoidably then the feelings of anger aroused in the child are felt toward the persons she or he already values most in the world, his or her mother. This produces a conflict that we can best examine by looking at two different aspects of that conflict. First, it creates a conflict between the child and the mother, an inter-personal conflict. And second, it sets up a conflict within the child, that is, within the child's psyche (mind), namely a conflict of being angry with the person the infant values most in the world. Let us talk about both, one at a time.

The interpersonal conflict

When 11 month old Jennifer pulled Johnny's pacifier from his mouth <NOP> the third time, Jennifer's mother got angry with her, told her to "cut that out" and the fourth time, mother would take no more. Interestingly, as we noted, 11 month old Jennifer did not seem angry with her mother. This does not always occur. We felt that Jennifer was not angry because she somehow put it together that what she was doing was not desirable; or it seemed that her mother's protest made sense to her. In fact she half-smiled and walked away. This though did not happen when she insisted on going into the hall where, at 10 months of age, her mother felt she was too young to toddle by herself (without supervision).

Mother and Jennifer has already run into some limit setting when 9 month old Jennifer had tried to get hold of her cigarettes. They had recently gone back and forth on this when Jennifer was upset and angry with her mother for over an hour! But at 10 months, Jennifer's wanting to go into the hall (where there often was a cleaning cart) alone and her mother's prohibiting that led to a moderate struggle that lasted for 6 weeks. At 10 1/2 months Jennifer went to the doors to the hall about 15 times. After the 3rd time her mother pulled her back (quite gently but with determination), Jennifer had a mild

tantrum. She screamed and resisted; she was clearly angry with her mother. Mother had already explained a number of times that she is not allowed into the hall alone, that there was a cleaning cart out there where she could get hurt, and that's why the doors (which she could push open) were closed. Interestingly, although clearly angry with mother, she did not strike out at her. Jennifer's Mom had a pretty good feel of her daughter's hefty degree of determination; rightly, Mom valued that. So she dealt with it with firmness, without feeling she had a "bad" daughter. She just patiently told Jennifer that she cannot go out there alone.

It was remarkable to see how gradually, bit by bit, Jennifer's reaction to her mother fetching her before she reached the doors, repeating to her "You can't do that," or "No!" or "Don't do it!" (after she had explained a number of times why she was not allowed out there), how her reaction got less and less angry. We observed this struggle in our twice a week observational research and found it to continue until Jennifer solved the problem. At 11 months, as she persisted in trying to go into the hall alone, and each time her mother fetched her, for the first time, she began to smile as she teased her mother. She went toward the doors, turned her head toward her mother, an impish smile on her face. Her mother, nicely attuned to Jennifer, went to her and in a playful way this time, swept her up in her arms, with a big smile on her own face, saying "Oh no, you don't!" And she plopped her into her lap as she sat down and they hugged warmly. Jennifer repeated this, now a game, several times. She played this game then for 2 more weeks, and then it disappeared; and so did this struggle with her mother.

As with Jennifer and her mother, most visible when observing parent and child in a limit setting encounter is the interpersonal conflict. As with the twins, one child wants something that another child has; the concerned and thoughtful mother says "No, I can't let you take Johnny's toy." The infant, propelled from within again reaches for what the other child has. Again, a thoughtful mother would say "No, I wouldn't let Johnny take your toy, and I can't let you take Johnny's." We find that the average healthy infant 10, 11, or 12 months of age, quite propelled by the pressured wish inside him or her, may again reach for the toy the other child has. Again the mother, persisting reasonably, will say "No, you can't do that!" As this occurs, the child often becomes more and more angry with mother, and also commonly, mother becomes more and more angry with the child she loves. It is important for the parent to recognize that the child is not being a "bratty kid", but very much the victim of the autonomy pressure within her or him. Nonetheless the mother is quite right to set the limit that will help the child socialize in a reasonable way. This inevitable interpersonal conflict leads many a parent, misunderstanding the child's actions, to feel that the child is bad, and she will not only become angry with the child but reject him or her which creates a very unpleasant interaction between child and mother. This then, from near the end of the first year often leads to the second part of this conflict.

The Intrapsychic Conflict

Becoming angry with the person the child most values in the world begins to create a conflict within the nearly one year old which will consolidate during the second year of

life. We call this a conflict of ambivalence. This means that the child is experiencing feelings of anger and hostility toward someone the child highly values and to whom he or she is attached by deeply felt positive feelings. It is a fact of utmost importance, that from near the end of the first year of life on, under good, growth-promoting conditions of development, the average child begins to feel his first hostile destructive feelings toward the person or persons he most values in the world, his mother and father. In other words, most commonly the child's first hostile feelings are aroused unavoidably by the highly valued mother trying to protect the child. Let us look at the consequences to the child of the internal conflict created by this experience of ambivalence.

Observing infants closely one finds from the time the infant is 11 or so months of age, that infant is never indifferent to being angry with, to feeling hostile toward the mother she or he values (needs). Note that we have not yet said the mother or father the child loves or hates. That is because the ability to love and to hate does not develop until about the middle of the second year of life, from about 18 month of age on. Let us backtrack briefly.

Close observation shows that from the early months of life on, an infant will become very upset when conditions exist that cause the infant much pain. As we shall detail in Section 1.291, children are able to experience feelings of anger and hostility only from about 6 months of age on. Before that age, they can experience irritability, a more or less general state of painful distress. If the pain is felt as excessive, the infant will react with rage.

When angry with the mother, many a six month-old infant becomes upset, begins to cry, and turns to that same mother for comforting. This behavior is often misunderstood by parents who, rather than comforting the infant, regrettably reject the infant's need for comforting on the assumption that the parent's limits will then not be understood or accepted by the infant. (We will discuss this issue in greater detail when we talk about the development of this conflict and setting limits in the sections pertinent to this issue in Unit 2, when we talk about the second and third years of life).

What we want to say here is that the need for comforting is triggered by the intense state of discomfort and conflict that is created by the infant's feeling angry with the valued and needed mother; the infant experiences this condition as a danger. Some child development specialists infer from the 10 to 12 month old and older child's behavior that the young child is troubled by having feelings of wanting to destroy the prohibiting but also highly valued primary caregiver. These wishes to destroy the prohibiting parent comes into direct conflict with the great feelings of valuing that person to whom the 11 month old child is now strongly and stably attached emotionally. Wanting to destroy the person on whom the child is so dependent and whom the child values so strongly, creates a condition of anxiety within the child, causes the child to feel helpless, and it is then that the child wants to be comforted by the mother. Comforting reassures the child that his or her angry feelings are not destroying the valued and needed mother or their relationship. As we will explain in Unit 2 comforting the child at this point is generally growth-promoting whereas rejecting the child's need for comforting at this point tends to be growth-disturbing.

Suffice it to say here, that this is the beginning of what will in year 2 become the

child's experiencing ambivalence, namely feelings of love and hate toward the same person. The importance of understanding and handling ambivalence constructively is that this creates a conflict within a child's psyche that usually has significant consequences to the child's total personality development. The way in which this experience is dealt with by the parents, will have much to do with the way the child develops his or her conscience, the way the child will learn to feel about himself or herself, whether the child will experience the self as a bad self or a good self, whether the child will learn to experience persons as good persons or bad persons, and many other aspects of personality development which we cannot detail at this moment. We will pick up on the consequences of this internal conflict when we talk about it again in the second year of life at which time it becomes a much more prominent issue.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.271 HUMAN DEVELOPMENT: Developing BASIC TRUST as Compared to BASIC MISTRUST

Erik Erikson, a renowned Child Development Specialist, developed the concept of "basic trust versus basic mistrust", to describe a crucial quality of inner feeling that an infant acquires about himself or herself and others. Basic trust describes the quality of inner feeling and sense the infant develops gradually during the first year of life that his or her mother, or the nurturing caregiver, will meet his or her basic needs to a sufficient degree, that mother will sufficiently protect, nurture and give care. Hand in hand with progressively trusting that mother will care well, the infant begins to experience a sense of feeling worthy of being cared for, of being worthy of trust, of being valuable and lovable. In contrast to basic trust, basic mistrust implies the inability to trust that the persons in one's environment will be sufficiently protecting, nurturing and caregiving. It also implies a sense of not being valuable, of not being worthy of love and care. Erikson and other child development specialists emphasize that the sense of being a lovable and trustworthy person has its origins in the experiences of the first year of life. The development of basic trust or of basic mistrust has far reaching implications for the human being's personality development. We will discuss some aspects of the schedule of its evolving in a moment.

Here are only several of the many mental health contributions basic trust (or basic mistrust) makes to the individual's emotional and personality development. Because it is a development that occurs so early in life, that is forged by the infant's everyday experiences, it becomes deeply rooted in and gives this quality to the foundation of our genetically determined personality. This deeply rooted sense of trusting (or not trusting) the mother and the nurturing environment, as well as eventually the sense that one is worthy (or not worthy) of being loved and trusted, forms the foundation within the child's personality for his relating to others in the present as well as in the future. Child development specialists emphasize that when basic trust is sufficiently established early in life it will establish conditions within the child's psyche that make possible a life-long sense of inner security and well-being. A sufficiently good sense of basic trust is necessary not only for the development of good self-esteem but also for the development of respect for the self and for others.

Of the utmost importance, is the fact that, given a biologically normal enough infant, basic trust is a major determiner of the character of personality that develops strictly out of the quality of the child's relations to her or his environment, most especially from the quality of the relationship to the mother and/or the primary nurturers. It is now known that the child's earliest relationships to the human environment must be sufficiently good to secure a good beginning in her or his personality development and his or her ability to adapt to the world in which we live.

How and when does it evolve? What evidence of it can we see? Some of the

children we know in this Unit (and the others) were pretty lucky, others were not. 12 month old Jennifer had given the appearance of a well cared for infant from the beginning. She was biologically well endowed and was fairly easy to give care to. By 6 months we saw that she was well, positively attached to her mother. When she needed food or was uncomfortable she let her mother know in a straightforward, gradual, and eventually patient enough way. Mother seemed very aware of her even if she would be talking to someone else or listening attentively to us. By 12 months of age, Jennifer seemed to feel confident that her mother would pay attention to her. It was remarkable how even though their battles of will were pretty strong (as we described in Section 1.262) due to Jennifer's healthy and vigorous strivings for autonomy and Mom's being a pretty strong minded person herself, their trusting, being aware of, and being tuned to each other was quite positive, predictable and stable. Diane too was really lucky and developed a warm and progressively stable attachment to her mother and father (who had diabetes) so that by the time she was 12 months old her emotional dialogue with her mom was really good. Diane's mother had been fairly depressed after her own mother died just a few months before Diane was born. But after having 2 sons whom they really loved, Diane's parents were thrilled to have a girl. And during her first year Diane and mother got along quite well, so that her basic trust seemed very positive and, as is expectable, matched her attachment well. This helped them a great deal because when Diane's autonomy strivings began to show themselves strongly from about 10 months of age on, she and Mother began to have some struggles over Mom's limit-setting. Again in this, Diane and Jennifer were a good deal alike.

Things were quite good too between Johnny and his 36 year old mother who got married one year before Johnny was born. Even though she was quite anxious at first, Johnny's mom who worried she would not care for her baby well enough, in fact was quite nicely responsive and emotionally tuned in and available when she was with him. Because she worked part time mostly at home (a free lance newspaper writer) she needed a substitute caregiver; fortunately, this caregiver also was quite good with Johnny. Even though he did protest for a while when mother would close herself off for a few hours 3 to 5 days a week since he was 3 months old, he formed a very positive attachment to his mother and to the substitute caregiver too. Not surprisingly though, he was not upset when she left after mom would come out of her study. All in all though, we gained the impression that gradually he came to feel that someone would be there to take care of him. He was at moments subdued and a bit passive during the second half of year one, but seemed pleasant, warm and trusting. He did cling to his pacifier (which made him feel more secure). Doug also developed good basic trust. He managed pretty well his mother's going back to work when he was 6 months old, 4 hours a day 5 days a week. He too had a satisfactory caregiver (who, however, had to leave when he was 13 months old) and formed a nice attachment with her too.

Bernie's basic trust developed well too in spite of some real strains on his mother and on himself for a while. His food allergy caused both of them some distress during his first month, but mother's being very responsive to him and her patiently trying to comfort him made their passage through that difficult period come out quite well. A greater problem came from mother's often being upset by her quarrels with Bernie's father. Even

though both mother and father were good with him and were happy about Bernie's being their baby, their arguments caused them to be in bad moods quite often. It was especially important for Bernie that his parents' anger with each other didn't spill over onto him and was not taken out on him. This made it possible, at least he gave us the impression, for him to develop feeling that his needs would be met well and that he felt valued.

It was more difficult for Suzy to develop good basic trust, but we did feel that she did so to a very significant degree. We felt that it was due in large part to how well, persistently and devotedly both her mother and father tried. Suzy was born an irritable baby, very difficult to calm, had GI (feeding and digestion) problems and seemed to even sleep in fits and starts. We witnessed the parents efforts and saw how steadfastly they tried; we saw and heard about how mother and father relieved each other when one would get too stressed out (see Section 1.242). And then, in addition, when Suzy was 8 months old mother had to go back to work (5 hours per day, 5 days per week), which added a strain to both Suzy and her mom. But their efforts paid off, it seemed to us. We felt that most contributory to Suzy's developing a good sense of basic trust were her parents' commitment and devotion to her. Although her father sometimes lost his cool and blamed mother for Suzy's early problems, he was able to eventually recognize that it was really Suzy's inborn make up that made her so difficult to calm. He was then able to be a lot more helpful. But Suzy's mom just never stopped trying with Suzy, even though she at times lost her cool too. But she could remind herself pretty consistently that it really was not Suzy's intention to be a difficult baby. All in all, both parents got to be attuned to Suzy, were emotionally available to her when they were home, and loved her dearly.

Now, things were very different for Richie. He started out so well; this we deduced from the information we obtained and especially from the photographs of him when he was 5-6 months old. These suggested an infant who experienced good interactions and was on the way to forming good attachments. We would therewith assume that he was developing good basic trust. Then with the move away from security and stability with mother's aunt, then 6 or 7 month old Richie's father leaving, his 17 year-old mother became deeply troubled. A crucial piece of information told us a great deal: when 7 month old Richie would cry, his bewildered, probably depressed and very troubled young mother would put him in the outside hall to cry himself out. This oppressed young mother, deserted and ignored by her mate, (and who knows what more), deserted and ignored her own baby when he most needed attention, comforting, and care. The expectation of care and nurture was often frustrated, and disappointment and mistrust progressively intensified. Six weeks of such treatment by mother would erode whatever good basic trust had developed in an infant 6 to 12 months of age. Twelve weeks of it and Basic Mistrust would have stabilized significantly. Indeed, when we saw Richie at 14 months of age he was suspicious of people; mistrust was prominent. And with it, came depression, rage, and failure to thrive (physically and emotionally).

A child is not born with an inner sense of trust in the self or in the environment. This can only be achieved by the repeated experience that when the infant is in a state of need or feels pain, persons in the environment can gratify the need and at the very least try to undo that pain. When as happened to 7 month old Richie, an infant experiences pain too

long, too frequently, and when the nurturing environment fails to alleviate the pain satisfactorily enough, the infant will learn that he or she cannot expect and trust that his or her pain will be readily undone. By the experience that the mother can gratify needs, comfort, can undo, or at least alleviate pain, as was the case with Bernie (very early) and especially with Suzy, the infant more and more values the environment as well as the self. "If my mother soothes my pain she must value me", might be a way of putting into words what Suzy might have experienced. We do not mean that Suzy thought these thoughts, but that at some level of experiencing, this kind of feeling and memory will be entered into the child's psyche, and will influence his or her ongoing development.

What does basic trust look like? The infant's mood and feeling state, that is, how the infant appears to the observer, to the parent, tells us much of what is going on inside her or him. The infant's observable feeling state best tells us about the quality of his or her well-being. Does the infant's face and body activity convey a feeling of comfort? A feeling of restfulness? A feeling of well-being? A feeling of pleasurable activity and joy? Or on the contrary, does the infant convey a feeling of sadness; of persisting irritability, of distress like 14 month old Richie did? Positive feelings suggests the development of basic trust. By contrast, a preponderance of negative feelings and mood, if seen frequently, may well denote poor development of basic trust.

Another index of developing trust or mistrust is the child's giving evidence of developing the "confident expectation", as Dr. Theresa Benedek liked to say, that the mother will respond positively to the infant's appeals for help and nurture. For instance as we saw in Jennifer, Diane, Johnny, and Doug especially, after the infant begins to fuss when showing evidence of being hungry, when the mother talks to the infant, tells him that she is preparing to feed him or her, that she'll be right there, etc., does the infant stop fussing on hearing mother's voice? Although during the first weeks of life such a response seems automatic, it will not persist if the mother's voice does not become a reassuring signal that help is coming. The persistence of this response suggests that the child has learned that when he or she hears mother's voice, comforting and nurturing will soon follow. It allows us to infer emerging basic trust.

Another large cluster of behaviors that tells us much about the quality of developing basic trust is the set of reactions that pertain to the development of human relationships, namely, the quality of social smiling responses, the gradual evolving from the non-specific social smiling response to the specific social smiling response as we recorded on 6 month old Jennifer, reunion reactions, as well as signs of positive feeling and affection on the part of the infant toward the mother, father, and other nurturing persons. (These reactions are detailed under Attachment Behavior [1.251] and The Development of the Self and of Human Relationships [1.331].) For example, we do not expect to find a specific social smiling response in a one month old baby; but we do expect it to be stable in an eight month old. If it is stable by then, it will tell us that a good development of basic trust is in progress. If an eight month old tends to be depressed too long, too often, and seldom smiles at persons in his or her environment as we saw in 14 month old Richie, we would have to assume that a problem in basic trust development is occurring.

When might we expect to see evidence of emerging basic trust? Since it derives from the quality of the relationship to the principal caregivers, we can follow its development

along that of developing relatedness. Because we find only the very beginning of relatedness during the first 6 or so weeks, we do not expect the infant to yet know whether to "expect" or "trust" that he or she will be cared for. We also do not believe a 6 week old is capable of wondering if help will come. But, although during the first weeks of life we cannot yet expect social smiling responses some very early bonding occurs and under favorable conditions, conditioning type of learning will lead the three to five weeks old fussing infant to calm when the mother touches the infant even before the infant is picked up.

During the third, fourth and fifth months, we should begin to see the rich display of at first non-specific and then specific social smiling responses, which means that the environment is experienced as positively responsive to the infant. During these months, the gradual selection of particular persons who are smiled at preferentially gives evidence of the experience that these individuals become trusted to nurture, comfort and give care. Both during the earlier periods just described as well as during the third, fourth, and fifth months, the moods and the state of the infant both in interaction with these persons and when alone tell us about the inner quality of experiencing the infant is having.

Then from the middle and through the second half of the first year of life, one should see ample specific social smiling responses, separation reactions followed by positive as well as negative reunion reactions, and with it see signs of preference for the mother, then for the father and siblings over strangers. Where one then sees signs of affection, pleasure and warmth (positive feelings) expressed by the infant toward the mother and other nurturing persons, one can assume the stabilizing of basic trust. Where such signs of affections and pleasure at being with are not seen in six to twelve month olds, basic trust may not be developing and help should be sought.

In summary, it is the quality of the parent's attachment to the child, of the caregiving and of the nurturing that determine whether good basic trust or mistrust develops in the infant. In their functions of parenting it is important for caregivers to recognize that infants need not only food, clothing and reasonably good hygiene, but that they also have basic emotional needs. These consist of being held, cuddled, touched, communicated with verbally and emotionally. Of extreme importance in the development of basic trust is the mother's (and father's) being sufficiently emotionally available to her (his) infant, to respond with affection to the infant's emerging signs of what will become affection, with comforting to the infant's need for comforting. It is not necessary for a parent to be emotionally available 100% of the time, nor is it necessary for a parent to be affectionate with the infant 100% of the time. An infant requires a sufficient amount of the mother's affection, the father's as well; the infant requires a sufficient amount of emotional availability. Some infants need more emotional nurturance than others. It is important for each parent to learn what in her or his particular infant seems to be enough emotional nurturance and emotional contact to enable the child to feel good, usually be in a good mood, show pleasure in interaction with caregivers, and to offer the child what she or he needs to attain these. It is not necessary to be a perfect parent for an infant to develop good basic trust. We will have more to say about the development of basic trust in the child's rearing aspects of this issue which follows.

1.272 CHILD REARING: How to Optimize Developing BASIC TRUST as Compared to BASIC MISTRUST

Because the development of good basic trust positively influences the quality of the person's self esteem, conscience formation, the person's developing adaptive capabilities, indeed total personality development and all life experiences, it behooves all parents to nurture well the development of basic trust.

How can a parent secure a sound degree of basic trust. There are a number of things parents can do. Foremost is the parent's responding reasonably, not like a slave, to a child's expressions of need, of physical needs as for food and of emotional needs as for affectionate contact, comforting, and cuddling. It is important for the caregiving parent in responding to the child's expression of need to recognize that children differ in their ability to wait for gratification. It is in the child's best interest gradually to develop the ability to wait reasonably for gratification. Children like Jennifer and Johnny can readily accommodate to the mother's needing time to prepare for feeding. They quickly learned that it would happen and responded by quieting to mother's saying, "Mommy's coming", or to "Daddy's hearing you; I'm coming." This verbal reassuring communication while the parent is readying feeding often works well. This type of child is adapting in an age appropriate way to waiting for gratification and developing the much needed ability to wait in spite of being mildly frustrated.

With children like Suzy though, who along with much irritability had much difficulty waiting to be tended to, learning to wait required special efforts on the part of her parents. In helping a child learn to wait it is important to do so at a pace that the child can tolerate, one which the child does not feel as too painful. In other words, Suzy's mother had to get the feeding ready more quickly while talking to her and trying to help her tolerate the delay. It will be to everyone's advantage for the parent to read well the infant's cries of distress, to pace herself or himself and try to make as bearable as possible the delay for the child. If by chance the mother perceives that the child is very distressed by the time the mother gets the bottle or the breast to the baby it may be necessary to calm the infant before you start feeding. There were a few times when less than 4 months old Suzy got distressed so fast that by the time mother was ready to give her the nipple to feed, Suzy was so into her crying fit (infantile rage reaction) that she seemed to not be able to see that what she wanted was right near her mouth. We explained to her mother that a normal rage reaction cannot just be stopped at once by an infant. There are 2 reasons for this: (1) once a rage reaction gets going, it seems as though effort is required to stop it -- like stopping a big truck going down a hill; and (2) being in a rage state, the infant's seeing, feeling, and hearing senses seem taken over by the rage and are not able to easily perceive other events like mother offering the nipple. At such a time Suzy's mother held her close, rocked her gently, told her she was here, that Suzy could eat now, and she apologized for the delay saying: "I am so sorry it took me so long". All her efforts were useful we believed because they conveyed mother's comforting efforts to the infant. So too, Bernie's parents, mother especially, made significant efforts to calm him during

feeding before and also after his food allergy was identified and taken proper care of. This mother seemed to understand intuitively that it would help Bernie a lot if she made a special effort to have joyful interactions with him, and she turned out to be very able to play with him and to chatter with him gently, wonderfully. In other words, especially in the first months of life, even though the infant does not understand words, the child will emotionally perceive the message of care, of being valued, and of concern and will experience it as comforting. Communication cannot begin too early!

One more word about helping the child develop the ability to wait reasonably for gratification of his or her needs. Just the normal delays required to get things ready to feed the infant are enough to help the child develop this ability. There is no value to unreasonably waiting too long and frustrating in order to lengthen the child's frustration tolerance. Reasonable pacing of need gratification is what is most likely to help. It is important that the efforts to help the child be genuinely in the child's best interest and be reasonable.

A further step toward securing basic trust is to make efforts to discern and respond to the child's specific needs. Parents should try to sort out what the infant is asking for, e.g., is the infant in need of fluids as milk or juice, or of a diaper change, or in need of being held? One learns to discern what the child's need is at a given time by the quality and the character of the child's communications. We emphasize that meeting the child's physical needs are essential, but this is not enough to develop basic trust. Given that basic trust arises from being emotionally valued, parents also have to be emotionally available to the infant, must nurture the infant emotionally when the need for it is expressed. By emotional nurturance we mean being held by mother and/or father, being paid attention to emotionally, being touched, being talked in to a loving and respecting way, in a way which conveys to the baby that he or she is valued by the parent. If the parent listens with care to the infant, soon in the first year of life he or she will learn to discriminate between the infant's asking for milk as compared to the infant's asking for emotional nurturance. This is not so easy; especially, when the 4-8 month old awakens during the night and needs to be held and soothed but refuses the offer of milk. A soft toy to which the infant attaches or the infant's own thumb can help the parent in need of sleep.

Being emotionally available and emotionally nurturing is the most important ingredient required for the development of basic trust. Studies have shown that even when children in orphanages are well fed, well cared for physically, and living under good hygienic conditions, many children by the end of the first year of life and most by the end of the second year of life, show notable degrees of retardation in cognitive (intelligence), emotional, and even in physical development. Without emotional nurturance and without the development of basic trust, crucial potential developments fail to occur. We repeat that these include the development of the capacity to form good relationships, the development of intelligence and of learning, the development of conscience (moral responsibility), as well as the development of all-important adaptive functions. In other words, the total range of emotional and personality development is affected in a detrimental way. The great lack is the absence of an affectionate, loving, and appropriately responsive relationship being available to the infant.

Another factor on which securing basic trust depends is to be reliably present, with

the baby enough of the time. The most important ingredient in the parent-child relationship that will promote the development of basic trust is the emotional quality of the mother-child relationship and the father-child relationship. Nevertheless, the relationship must be experienced for a sufficient amount of time. For example, to be available to a less than one year old infant for only 1 to 2 hours a day is not enough for any child, even if that 2 hour period is of the most marvelous quality. On the other hand, being with the child for 24 hours a day and the quality of that relationship being poor will create its own problems too. The point we make here is that being physically present enough of the time is an important ingredient in being reliably, sufficiently emotionally available and experienced by the infant. Being reliable means to be physically present, to convey that mother and father (where possible) will feed, protect and care for the child, and it includes that the parent will explain when the parent is going to be absent and, therefore, will not be available.

We can look at this issue from another angle. We can ask what undermines the development of basic trust. Would it not undermine basic trust if a parent who needs to go away--to go out to work, or to an appointment or shopping--would sneak out while the child is not looking, without having forewarned the child, in the hope that the child will not be upset by the parents' having left? We have found well meaning parents who believed that this would truly protect their infant against experiencing separation anxiety. Actually, it makes things worse for the baby, and then it also does for the parents. To leave a less than one year old without telling the baby mother is going out for a while, is in essence a disappearing act. And disappearing acts undermine the development of trust that mother is going to be there when needed. If all of a sudden mother disappears, the child is not going to be able to trust and feel that she is reliable--because, after all, she does, suddenly, vanish! The average child can soon learn what mother means when she says "Sweetie, I've got to go, but I'll be back in two hours, I'll be back when it's time to feed you again." If the mother lives up to what she tells her baby, the child will eventually learn to trust what mother says. By contrast, disappearing acts tend to make the child hyper-vigilant, always be on the look-out due to the worry that mother is going to disappear again; and this condition creates undue anxiety and the uncertainty that mother can be counted on. This can lead to basic mistrust.

It is quite a challenge for both child and mother, when mother needs to leave her less than 1 year-old baby to go to work outside the home. The way this is done will have a large influence on the infant's evolving basic trust (or basic mistrust). From the time he was about 3 months old Johnny's mother needed to close herself off in her study to do her newspaper work (telephoning and writing) and at times had to go out as well. A college student helped her with Johnny. One week before the student began to take care of Johnny alone, she came to help Johnny's mother with his care. This gave mother the opportunity to not only see for herself how this substitute caregiver would relate to and care for him, it also gave her a chance to talk about what she would like for Johnny and how she wanted him to be cared for. They hit it off pretty well. Most important is that mother and her helper talked to Johnny about when mom needed to close the door and work. "I have to write now" Mom told him when she put him down for his afternoon nap. Janet will take good care of you, and I'll come out when it's time to eat." At first

Johnny would be fussy when he'd wake up and seemed to expect his mother. But he responded well to Janet who told him that Mommy was writing now and Janet would take care of him. She got into it well, telling him what a cute baby he is and how lucky his mommy and daddy are to have such a wonderful boy. Her tone matched the words well. In part because he was not at the peak of forming an attachment to mother, Johnny seemed to accept Janet -- who clearly really liked Johnny -- quite well. In fact, when Janet could no longer come to take care of him when he was 10 months old, he showed signs of missing her and it took some introducing him gradually to Mrs. Clark (a neighbor who had two young children of her own) where his mom took him for the afternoon after his nap.

It was more difficult with Doug, we think because he was 6 months old when mom went back to work from 9 to 1. At 6 months, Doug was well attached to his mom and seeing her go out at 8:30 a.m. caused him a moderate separation reaction. He was after all, at the peak of attachment formation. Nor did it help that the first woman who came to take care of Doug just thought he was a spoiled baby who always wanted to be held and she would have none of that. It did not take Doug's mother long (2 days) to decide that this is not how she wanted Doug to be cared for. It was especially the helper's telling Doug's mother that she was just spoiling him when mom picked him up again to give him another hug before she had to leave that decided her to get someone else. Mother had to do some repairing of the damage this unsympathetic substitute caregiver caused. She told Doug she was really very sorry to have made the mistake of leaving him with her and even promised her non-speaking son she would not leave him with someone mean. Fortunately, the next substitute caregiver seemed to like the way Doug's mother wanted for care for Doug and she fit in well. When Doug's mom picked him up one more time before she left, this caregiver came over and extending her arms toward them said "It's really hard to leave mommy, but she'll be back before your nap and I'll take good care of you. Heh, do you wanna go for a ride in your stroller? We can look at the flowers and maybe we'll see a squirrel." Even though that did not work like magic with Doug, it did with mom who was greatly relieved to have this kind of help. Before he was 7 months old Doug seemed to do nicely when mom would go to work.

Suzy's mother was very worried about how Suzy would handle her going back to work when she was 8 months old. Actually she was not so sure about how she herself would feel. But she needed to go back to the office. When it became clear that this was the case, 2 weeks before she had to go mother got a rather experienced older nurse to come in and become acquainted with Suzy, and Suzy with her. Mother made sure that Suzy was cared for well. She also explained that Mrs. Sander would help Mom take good care of Suzy, and as time came closer Mother began to talk about having to go to the office from 11 until 4 p.m. When the time came Suzy seemed shocked that Mother had been away from her for so long. Now the real explaining began. It seemed that Suzy had just not understood how long Mom would be away. Mother found the words: "I'm sorry honey, Mommy won't be home for lunch or your nap, but I'll be home before dinner." That did not cure the problem. More talking was needed from Mom and more explaining from Mrs. Sander. Interestingly, after about a week of painful separation scenes, Mrs. Sander told Mom that actually Suzy seemed fine until after Mom came

back. She could tell then, that Suzy was really angry with her Mom. We helped Mother tolerate Suzy's anger and told her to tell Suzy that her being angry with Mom is OK, that Mom is really sorry she's upset, that Mom misses her a lot too but that she has to go out to work in her office. This too then gradually eased and Suzy seemed to tolerate the separation satisfactorily.

In these 3 instances, basic trust was developed in spite of the stress on both children and mothers. Foremost, it was the mothers' recognition of the problem this created for their child and their dealing with it verbally and emotionally well that helped to secure good basic trust in them.

Another thing that will undermine the development of basic trust is when meeting the child's physical needs or the emotional needs are frustrated too much and too often. Now where occasionally, unavoidably the parent delays too long, or unavoidably a good nurturing parent frustrates a child, it is important that the parent acknowledge it and talk about it with the infant. For example, when a 8 month old Jennifer wanted something that belonged to her nearly 4 year old brother, Mike, in order to help her grow in a reasonable way, that is to not take what belongs to someone else, she had to frustrate her own beloved child. Talking about why the parent is frustrating the baby is very useful. Acknowledging that mother or father is causing the child distress because the parent really wants to help the child grow in a reasonable way is very helpful. The child will not be happy with mother then and there, but will come to recognize that the parent is frustrating him or her for a good reason, one that is genuinely and will eventually be in his or her own best interest.

Occasionally not being able to meet the infant's basic physical and/or emotional needs will lead to frustration, or a transient feeling of neglect and of hurt. It truly is unavoidable even in the best of circumstances. It is also unavoidable that good caring parents will at times do things that will go against the child's wishes and thereby cause the infant anxiety, or frustration, and therewith anger. This is unavoidable in at times having to separate from the infant, or in not being able to stop discomfort and pain as happened with Bernie and Suzy. It is unavoidable in setting limits that even protect the child (see Section 1.292). If these occur only occasionally and, by contrast, experiences of feeling well cared for, valued, gratified are frequent, basic trust can be well secured in normal children.

But when frustration, neglect, physical and emotional pain occur too frequently, as happened with Richie, basic trust can be severely damaged (if it got started as is did with Richie), or in its place, basic mistrust will develop.

It is useful for parents to ask themselves if basic trust is developing well? As we said before, probably the most important aspect of the child's functioning and behavior that will tell us about the quality of his or her developing basic trust is the state of the child's well-being. How does the infant look, how does he or she seem to feel? Yes, we are speaking of the child's state of well-being from the first days of life on! Basic trust of itself does not begin to be organized until about the middle of the first year of life, but one can measure its gradual emergence and development by ascertaining the quality of the child's mood and emotional appearance.

We emphasize the importance of learning to look for how the child may feel "inside".

In the course of growing up, many people learn to hide their inner feelings. Fortunately for parents and infants, during the early years the infant has not yet learned to mask her or his feelings and these show quite openly on the infant's face and in his or her behavior. As we said in the section on Affects (1.241), infants have feelings much earlier than we used to think and how they feel from the beginning becomes registered in their psyches; feelings are not just simply forgotten. The degree of a child's well being can be sorted out by checking to see if the child seems to be "feeling good" or seems to be "feeling bad". Parents who look for it can readily tell which is which. An average infant will show expressions of pleasure from about the second month of life on. Feelings of rage, on the other hand, are expressible from birth on. Obviously a child who is experiencing frequent rages is not in a good state of well-being. This state of feeling should not be disregarded by the parents. Because they can be traumatizing, one should make every effort to understand what is causing these rage reactions so as to prevent them or stop them reasonably as soon as one can.

The most convincing communication of a state of well-being is the child's social smiling response. What is the quality of the infant's emerging social smiling response during the 3rd, 4th and 5th months? Is it warm, is it rich, is it more a frown? If it is a frown, or a smiling grimace, it indicates tension. What is the quality of the 2 and 3 month-old infant's reactions to seeing the mother? To seeing the father? What is the quality of the infant's state when the infant is being fed? When the infant is held? When the infant is played with? Does the mother or father feel that the child is feeling good? What is the quality of the infant's reunion reactions especially during the middle and latter part of the first year of life? Are there signs of warmth, of affection toward the mother and father; is there pleasure, excitement on seeing the mother and father?

As we mentioned in the previous section, another useful thing to look for that will tell us whether or not basic trust is developing well from about the second month on is: Does the infant show growing evidence that he or she expects that the mother will meet her or his needs? Is the infant learning that when mother talks to the infant in response to the infant's expression of hunger that the mother will gratify her or his hunger? The increased ability to wait for a feeding on hearing mother's voice, is a strong sign that the child confidently expects, trusts, that mother will take care of her or his needs.

When an infant looks sickly, is often fussy, and crying, or appears sad or does not smile for too long periods of time, this infant is in trouble. Richie showed all these and furthermore, his development had dramatically slowed down if not downright stopped. Parents need to know that an infant who by six months of age never smiles at caregivers, especially at the mother, father, siblings, or others who tend to her or him, is in need of professional help. It is a serious sign of potential, if not existing trouble and its cause needs to be ascertained. Fortunately, very early in life some crippling disorders can be prevented or be remedied easily. Richie's serious problems most certainly could have been prevented. For that to happen, however, parents or other caregiving individuals need to avail themselves of a professional consultant.

Listlessness, sluggishness, poor appetite, failure to thrive, to develop age adequately can be visible from the third or so month of age on and reveal difficulty in beginning to trust. When infants show such signs of course, most parents know to consult a

pediatrician. Not as readily recognized though is that an infant who seems to be eating and sleeping well, although he or she may be doing too much to both, during the second half of the first year of life may be depressed. This was the case with Vicki (see Section 1.331 and 1.332). Such early depression also reveals difficulty in developing basic trust. Again, looking at an infant's face, imagining how one would feel if one looked like that, can be most instructive to a parent as to how the child is feeling; and if the 9, 10 month old child frequently looks depressed, the cause needs to be evaluated and taken care of. It is important to recognize that from about 6 of 7 months of age on infants can become seriously depressed, that something can and should be done about it, because such depression can have a detrimental influence on the development of that child for the rest of his or her life.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.281 HUMAN DEVELOPMENT: The ORAL STAGE of Emotional Development

Observing infants during the first year of life, one finds that many of the child's activities involve the child's mouth. During states of wakefulness, the child spends a great deal of time eating, drinking, and sucking. During the first weeks of life one gains the impression that in normal infants hunger and thirst are the greatest disturbers of sleep.

As weeks and months pass, however, close observation of the two, three, four month old reveals that the mouth serves not only eating and drinking, but that some sucking seems in and of itself to be a pleasurable activity. It seems at times as necessary for infants to suck in this manner, as it is for the infant to eat and take in fluids. One often finds that an infant discovers and makes good use of her or his own thumb or pacifier, where such is provided by the mother. Sucking for the sake of sucking is an activity found in all infants and furthermore, appears to bring comfort and calm to the infant.

Close observation reveals that from 3 to 5 months of age on, the infant will use the thumb or pacifier at times of stress or tension, in an effort to comfort himself or herself. It is an act initiated by the infant to comfort the self without needing to turn to the mother. It is, therefore, among the first efforts an infant makes to take care of his or her own needs. In fact, thumb sucking or an infant's use of a pacifier is an autonomous (self-initiated) activity which serves the infant to adapt independently to stresses of everyday life. Yes, infant's experience stress, as is amply evident in their crying and rage reactions.

In addition to the functions of feeding and of sucking for the sake of sucking and for self comforting, the mouth is important for the infant from about four and five months of age on, as an organ to explore what something feels like and how it tastes. Very much the way the infant uses his or her eyes, and gradually begins to use his or her hands for the purpose of exploring, so too the mouth is used for the purpose of learning about the self and the environment. This is why many times one sees an infant put things into his or her mouth neither for nutritional purposes nor self-comforting. Often, when an infant puts a block or a toy into his/her mouth, it is an effort to explore its qualities, its character, and its nature. Of course, one does have to exercise caution because small things may be swallowed inadvertently by an infant during the course of its being explored. In summary, the mouth is an organ that serves alimentation, sensory pleasures, soothing and comforting, and exploration.

Oral activity and the feeding experience go hand in hand, and just as the feeding experience is very important to the development of basic trust and human relations, to that extent is oral activity recognized as an important emotional activity in infancy. Furthermore, it behooves caregivers to insure that the infant's oral activity is sufficiently gratifying and pleasurable because of the contribution it makes to well-being and total personality development.

1.282 CHILD REARING: What Can the Parent Do to Optimize the Child's Oral Activity.

The child's experience in feeding is in the hands of the nurturing parent, the infant being totally helpless to provide himself or herself with food. All parents recognize this. Nevertheless many parents do not recognize the important part the mouth plays in the child's activity during the first year, which include its being a means by which the infant can be comforted, an instrument for exploring, for feeling things, and its providing a means by which the infant can comfort himself or herself without mother's help (by thumb-sucking).

There are several ways in which the parents can make the infant's oral activity growth-promoting. The principal one is by making the feeding experience an opportunity for a positive emotional interaction between parent and child. Making food and fluid intake emotionally gratifying helps to make positive the attachment of the child to the parent, the development of good basic trust, and good human relationships.

The second way in which parents can help their infant's healthy growth is by recognizing that when the infant puts things in her or his mouth, the infant is not necessarily about to eat that object, but rather, it often is due to the infant's exploring the characteristics of that particular object and becoming acquainted with its texture and its features. To discourage a child from using his or her mouth as an exploratory organ deprives the infant of a major source of exploration, adaptation and of learning. It is, of course, reasonable that parents intervene when an infant puts things in his or her mouth that could be harmful, such as a very small object which could be aspirated into the bronchi (the lung pipes) and cause a serious problem, or a handful of dirt or hazardous things (e.g., detergents). But otherwise, the infant's exploring the environment with his or her mouth is a normal screening device, and the child will usually not be harmed by the incidental germs which she or he may so pick up.

A third way a parent can help the infant to use its mouth in a growth-promoting manner, is to permit to a reasonable degree the use of the mouth as a comforting agent or pacifiers. This seemed to be the arrangement Johnny and his mother worked out; that he could have his pacifier when he felt he needed it. We do not urge that parents push the use of the thumb or a pacifier as a comforting device, but rather that the infant be permitted to find his or her own way of discovering a means of reasonably reducing tension within the self and thereby comforting the self. Many parents are concerned that thumb sucking may be harmful to the child in altering the shape of his or her mouth (make teeth protrude). In most instances, before the teeth are harmed, this device for self comfort will be given up spontaneously, when the child develops other resources and skills. Some mental health professionals believe that harm to the psyche is of greater consequence than harm to the teeth in this instance because depriving thumb-sucking or pacifier-use too vigorously interferes not only with the child's first efforts at self-

comforting but also at self-reliance and at autonomy.

A further way in which a parent can be helpful to the growth of the infant brings us back to the question of the role and the function of feeding in the course of a child's development. What we have in mind here is the overuse of the mouth and of feeding an infant who is in need of some other nutriment. Parents should sort out whether the infant is in need of milk or fluids in contrast to the infant's being in pain, being anxious, or being in need of everyday, down to earth emotional contact and comforting. In this regard, feeding milk or food when the need is for emotional sucking or emotional contact and comforting often leads to the misuse of food and organic products for the purpose of self-comforting; it discourages the infant from learning to turn to human relationships for emotional comforting and can set a pattern for later maladaptive food and other oral abuse. Overuse of food, as well as other organic products, can of course be detrimental to healthy growth just as much as can depriving the infant of basic human needs for emotional comforting and emotional contact.

1.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.291 HUMAN DEVELOPMENT: Aggression

One sees much evidence of aggression during the first year of life. Because it is a complex and vital inner force that motivates much adaptive, creative as well as destructive activity in humans, it is in the child's best interest that parents understand what it is, what promotes its development into constructive and destructive inner forces. The consequences of that development are far reaching for the child, the family, and eventually for society.

To discuss this critical subject, let us draw attention to the fact that, during the first year, aggression is visible in at least 4 major forms. First, in its hostile destructive form, that is, in destructiveness linked with hostile or hate type feelings, which is readily seen in infantile rage reactions, as well as in milder acts of anger and hostility. Second, in its non-destructive form best exemplified by the large inner push to reach and get hold of things, to crawl and walk to gain control over and, in general, to master things. Third, is in the destruction of things without being angry or hostile, as in biting into food, and clearing it in order to tear it down for the purpose of eating. And fourth, in its hostile form in which the just about to be 1 year-old child seems to enjoy hurting, teasing or taunting another.

Hostile Destructiveness:

From birth on every infant is capable of reactions of rage. Some researchers of aggression say that rage is a physiological (bodily functioning, built in) reaction to what the body (the child) experiences as extremely irritating, painful, or life threatening. It does not require thinking. It is like a complex, inborn reflexive behavior. During the first months of life we believe that when the infant has a reaction of rage it does not mean that the child experiences a wish or has the thought to hurt or destroy anyone or anything. But it indicates that already at birth each human being is equipped to react to excessively painful experiences with rage feelings. But, child development specialists say, infants are not capable of having specific person-directed hostile feelings in the first months of life. They are only capable of experiencing and expressing global, general feelings of a negative kind as in fussiness, irritability, in crying and in rage reactions. Gradually, during the second half of the first year of life, the child now begins to be able to cognitively perceive, organize and express anger and hostile feelings with thought and intention. Development specialists tell us that the ability to put experience into thought, to perceive cognitively, to see cause and effect (which we call causality), to organize into meanings, to reach with intention. All these become possible at around 6 months of age in the normal child. Thus, in the second half of the first year of life, it is not uncommon to see an infant strike out with intention at a specific person who is upsetting him or her.

What we mean by "hostile destructiveness" is this. When an infant from birth on

experiences mild unpleasure (or displeasure), be it mild annoyance (such as due to noises that are a bit too loud), or irritation (such as due to tiredness or to a scratchy piece of clothes), or mild pain (such as due to beginning hunger pangs), the infant will feel mild level negative feelings and may become fussy or whimper. As these feelings become more intense, the infant becomes irritable and may whine/complain or cry. In the less than 5 or 6 month old, the irritability and crying will become more intense as the unpleasure continues and mounts. Once the unpleasure reaches a level felt by the baby as "too much" (excessive), as unbearable, a rage reaction will occur. The rage will begin at a moderate level (for rage), and if the source of excessive unpleasure (by now felt as much too much pain) is not stopped (such as by "finally" getting fed), the rage will progressively reach its highest peak and only gradually decrease as the infant becomes tired and then exhausted. It may be that a global feeling of hopelessness and giving up begins to be experienced even before 6 months of age. We do see infants give up (and probably feel hopeless) when 3 months old, when they smile at mother (or father) and the caregiver does not smile back (as with a depressed mother or a mother who does not want her baby) for even only a few days. That infant may from then on avoid looking into mother's eyes, often by looking away.

From about 5 to 6 months on, feelings of the hostile destructive kind develop so that now the infant seems able to feel anger and hostility. With the ability to think sufficiently developed to organize the experience of feeling hurt into a thought, and the attachment to a specific person well underway, when a 6 (or more) month old feels hurt there, will, as before, first be irritability. As the hurt continues (be it physical or emotional -- as mother rejecting the child's wish to be held), the child's negative feelings will be and sound more like anger. Anger results from experiencing hurt that does not yet reach the point of feeling "This is too much". The pain is not yet unbearable but it is enough that the child wants to be rid of it and complains with force at the caregiver (who the child believes should make the pain stop -- something that in fact, caregivers do for children) to rid him or her of the pain (unpleasure).

From about 6 months on, when the unpleasure gets to the point of being "too much" for the child, anger will turn into hostility. Hostility is felt when the pain (physical or emotional) goes beyond what the child can readily tolerate, when it feels like "It's too much". Now when the 6 month old (and beyond) feels "excessive unpleasure", at those times he or she will feel hostile toward the caregiver and the world around. Anger makes a child demand that the hurt stop; he or she feels "this has to stop". When a child feels hostile, the pain has gone too far and makes the child want to hurt or damage someone or something. It makes the child want to inflict pain on someone or something else.

Note that we believe that the infant cannot yet feel hate. Hate is an enduring, stable feeling of intense hostility of which the infant becomes capable only from about 18 months of age on. On the other hand, when hostility becomes very intense, the 6 month-old may experience rage or begin to have temper tantrums.

Rage Reactions and Temper Tantrums

Rage reactions are not uncommon during the first year of life. They always mean that

the infant is experiencing too much pain (physical or emotional). Children vary in their experience and their expression of rage. Quick-reacting infants have a lower threshold for experiencing excessive unpleasure (too much pain). Their rage reactions will occur more easily and more rapidly. Usually, in the average normal infant, rage will follow a period of irritation that has not been attended to by the caregiver, or the caregivers attention was not able to sufficiently lessen the infant's pain.

Fortunately for him and his parents, 2 weeks old Bernie got quite irritable with his feedings -- due to his food allergy -- but he did not go into rage reactions. He got quite close to having rage reactions, but his mother would already be holding him for feedings, handle his outbursts better and better, and the pediatrician was consulted quickly. With Suzy though, things were more difficult. She was a quick-reactor and on top of that, she was difficult to calm. Because she was difficult to calm, even mother's good efforts could not prevent Suzy's pain from mounting and she did have rage reactions for several months quite frequently, and thereafter from time to time during the first and second year. We shall describe what Suzy's parents did to handle these in the Child Rearing Section (1.292).

From all the information we had, Richie had been a very well put together baby, was easy to care for and calm prior to 6 1/2 months of age. We did not see him until he was 14 months old. It is, however, reasonable to assume that he not only developed rage reactions -- in fact, we saw at 14 months how easily these could not be triggered in him by even the slightest hurt --, but that he had tantrums from about 7 months till after 9 1/2 months when he was placed in a shelter. We shall talk about how to handle a temper tantrum in Section 1.292, but here let us say more about what causes a tantrum and how a tantrum is structured given that knowing how it is structured can guide the parent in handling tantrums constructively.

As we described extensively in our book *Aggression In Our Children: Coping With It Constructively*³, a temper tantrums looks like a series of rage reactions, generally appearing and sounding like one rage reaction after another, increasing in intensity, reaching a peak of intensity, and then getting weaker and weaker till it stops with the child exhausted. Like a rage reaction, a temper tantrum is caused by the less than one year old child's experiencing an excessively painful event which just does not stop and goes on much too intensely and too long. Although Suzy had much trouble calming, her mother's caregiving especially seemed to keep the intensity of her pain down sufficiently so that she had long periods of irritability but these did not organize into tantrums.

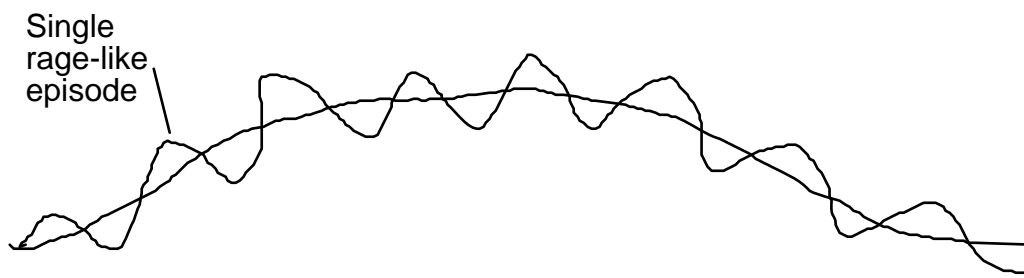
We propose that temper tantrums, like anger and hostility, do not begin to occur until the infant is about 6 months. Actually we have not seen a full blown temper tantrum until about 12 months of age. Nonetheless, we believe they can begin to occur in children 9 to 12 months of age. Prior to 6-9 months depending on the child, extreme pain (unpleasure) cause rage reactions. After this period extremes of unpleasure will cause a rage or a tantrum depending on how badly the child experiences the unpleasure.

³ Authored by Henri Parens with Elizabeth Scattergood, William Singletary, and Andrina Duff. Published by Jason Aronson, 1987.

A temper tantrum usually has the following structure:

DIAGRAM A

TEMPER TANTRUM MODEL

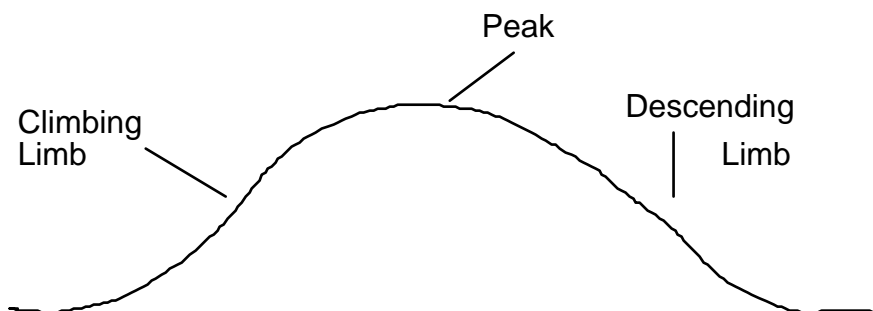


It has a climbing limb, which means that the rage reaction starts (usually) with moderate intensity, then climbs (intensifies), until it reaches a peak of intensity, and then, as tiredness sets in, continues but with lessening intensity until it stops seemingly due to the child's exhaustion. As we said before it may also stop due to a feeling of hopelessness and giving up. We shall explain in Section 1.292 what this structure means in terms of handling these reactions.

A temper tantrum is a series of such rage-like reactions with pauses in between. Furthermore, the intensity of the single rage-like reactions usually mounts and after a peak of intensity, the rage episodes become weaker. In a diagram, it would like this:

DIAGRAM B

COMPONENT WAVE OF SECONDARY CURVE



Prior to 6 months of age, rage episodes seem to be experienced in a completely consuming way. If the mother offers the nipple to the infant who is experiencing a rage reaction, the infant will not take the nipple (which may be what the infant has been clamoring for) because his or her entire being is taken over by the rage feelings. By gently touching the infant's mouth at its corners with the nipple several times, the infant's attention usually is obtained and the rage will stop fairly quickly and the infant will suck.

From 6 or so months on, the higher level of psychological and physiological development and functioning brings with it what we view as tantrums. Another important distinction exists between rage reactions and tantrums. We believe that tantrums are more intensely experienced than single rage reactions. This is why we assume them to be more traumatizing for the child and why, therefore, efforts should be made to prevent them. In Section 1.292 we shall detail how to handle rages and tantrums but let us say here that it is easier to stop a rage reaction and a tantrum just before or at the point when it is beginning and then when it is in the descending limb than at other times. It is most difficult to stop these when they are into their climbing limbs and their peaks.

It is critical to consider what causes expressions of anger, hostility, rage. When we observe the rage reactions of infants, one gains the impression that these reactions do not occur spontaneously. Rather, whenever a rage reaction occurs one gains the impression that something is causing it. Observation of very young children suggest that whatever experiences cause rage, one common ingredient seems to exist in all of them: the experience of excessive unpleasure (too much emotional or physical pain). In fact, whenever an infant has a rage reaction, it is normally assumed by the caregiver that something is causing it, usually the cause is searched for, and often what is causing the excessive pain can be found and when it is removed the rage subsides.

This is of great importance for the following reasons. Infants are not born with a load of hostility or rage that they must experience in relationships. Hostility and rage are generated in infants; as we have emphasized they are produced by experiences of excessive unpleasure. Any experience that is felt by the child to cause too much pain, which is what we mean by "excessive unpleasure", will activate the inborn mechanism that generates hostile destructiveness in each of us. These experiences may be too much physical pain (as an ear ache or intense hunger pangs) or too much emotional pain (as neglect, frustration, harsh handling and abuse, etc.), either one or both. The implications of this are that if we can protect our children against experiences of too intense pain or distress, too prolonged unpleasure, we can prevent the excessive development of hostility and rage within them and avoid creating an individual who is overly hostile, one who will have problems with hostility and hate throughout life. These experiences in the first year of life enter into the formation of the character of each individual and therefore can become a part of the individual's total personality.

An important complication arising from the child's expressions of hostility, anger and rage, comes from the reactions of the environment to them. These expressions of feeling lead to counter reactions on the part of others. For several reasons, such hostile reactions require that parents set reasonable limits on their expression. We will talk more about

this matter under the section on child rearing.

Non-destructive Aggression:

The second form of aggression found in the first year of life, shows itself in the inner push and pressure that children exhibit when they want to make something work or make something move, or when they seem very intent on getting where they want to crawl, or on getting their hands on things that attract their attention.

We are referring here to a non-destructive type of aggression, an aggression that seems to serve getting hold of, clutching onto, having control over something that has drawn the child's attention and interest. As time passes from the fourth, month of age on, this type of activity increases in frequency, in intensity, and begins to play an important part in the child's actively interacting with her or his environment, both animate and inanimate. The pressure that is evident in this type of aggression, seems to be what fuels much of the child's exploration--which we have talked about before (Section 1.261).

Let us look in on infant Jennifer to illustrate what we mean. 15-weeks-old Jennifer is being fed by her mother. She makes her first attempts to control the spoon that mother puts into her mouth. One can see the effort she puts into this self-feeding. Mother integrates her feeding efforts with those of her daughter. Jennifer then sleeps for 25 minutes lying on a cover spread on the floor. Here are excerpts from one continuous 30-minute period of the activity we are talking about.

Within minutes of waking Jennifer looks at her mother and others. She smiles broadly, already (at 15 weeks) focusing on her mother. She then looks around at articles on the floor, looking at several quite intently as she briefly fixes her attention on these in passing. She now turns her attention to a set of plastic rings on a string, which she very busily explores. She begins by pulling them apart, mouthing them. The sensorimotor effort is visible on her face (see Section 1.261); one soon also hears vocal concomitants of that effort. She moves the rings back and forth while she looks at them, a serious look on her face, and a good deal of pressure can be inferred from the way she seems to be "working". She waves her arms as she attempts to reach the rings that she inadvertently just pushed out of reach. Her mother (cooperating with her) then advances the rings so that she can reach them again and Jennifer does so promptly, her attention continuing to be focused on those rings. The affect associated with the effort she makes to bring the rings to her mouth, the effort with which she pushes and pulls them, suggests that this pressure is in the service of learning what these rings are. At this point, activity is interrupted by physiological needs (a bowel movement), as well as by socialization. She looks around and smiles at her mother. She then returns to the rings. Notable is the intent, work-like affect, the constancy of the effort she makes in exploring the rings, the inner-drivenness of that activity. Much energy seems to be invested in the exploratory mouthing, pulling and pushing the rings. Repeatedly she mouths the rings, sometimes with simultaneous pulling movements of her arms and lifting of her torso; her legs kick up as well, and indeed her entire body is involved in her effort. Her facial expression and entire body posture indicate the tension of, and the large effort invested in this prolonged activity. After 18 minutes of nearly continuous effort, she pauses, lying down on the mat.

One sees she is tiring. She pauses for about 15 seconds, looks up at her mother, smiles softly and returns to the rings, at once very busy. Soon she pauses again, and one begins to see signs of unpleasure on her face. She cries as if annoyed and stops her exploratory activity, rings in hand; and now, for the first time in a 20-minute period, she puts her thumb in her mouth and lies quietly. She returns to the rings. The effort continues to be strong but one now sees unpleasure, as she seems to experience some distress. From here on she alternates between exploration of the rings and thumb-sucking. While she sucks her thumb she lies rather quietly on the mat, giving the impression that she is recovering from the tiredness and unexplained distress. Her body curls up again, her legs kick up, and she sucks rather vigorously, experiencing some frustration in that too. She stops the thumb sucking, cries momentarily, and looks up at her mother. She pushes the rings away from her. The noise of the rings being pushed away seems to make her again turn her attention momentarily to those rings. She spits up a bit. Her mother picks her up to comfort her. Jennifer has now been awake for about 25 minutes and has been continually busy. We have seen this kind of activity in infants from 8 to 16 weeks of age on.

What is especially important, we believe, is that the inner pressure and activity we just described marks the beginning of the push and energy the child will utilize later in school as will the adult in her or his work. This inner pressure and the activity it seems to fuel, in other words, can be very productive and serve the child's adapting to everyday life, the demands of work and of the environment.

What causes this activity? We have already implied and stated that it arises from some inner force and pressure which seems to arise spontaneously. Indeed one gains the impression that it is part of living organisms, that it is a force that motivates the individual to act, to control, to adapt and to master himself or herself and the environment. It is an inner force with which every infant is born. Of course, it will show itself to a higher degree in some children than in others, this being strictly part of the infant's biological make-up. It may be a new thought to some readers that the constructive activity just described is a form of "aggression". Because of its easily visible negative aspects, aggression is a frequently misunderstood term. An important role for the parent, as we will detail in the next section, is to foster the exploring-learning-achieving aspects of aggression, while helping the child learn to contain, control, and express appropriately his or her own hostile and destructive aggression.

Some child development specialists propose that this form of aggressive pressure fuels the development of locomotor and cognitive skills and contributes importantly to adaptation. We have said that non-destructive aggression can be very productive. During the first year of life, especially from the fourth to sixth month on, it can also begin to be troublesome. Take, for instance, a very curious five or seven month old crawling toward another infant and grabbing a toy or a cracker that the other infant has in his or her hand. We have described this kind of event when we talked about the exploratory activity of the one year old (Sections 1.261 and 1.262). Or recall 11 month old Jennifer taking hold of Johnny's pacifier and plucking it from his mouth. She did it 4 times, each time against her mother's increasing disapproval and even anger. We think that Jennifer's inner push to do what she did was large (it could not be stopped even with her mother's initial disapproval), and that she made a discovery of interest to her, namely, that she

could make Johnny feel upset. We saw no evidence of her being angry with Johnny or that she was getting back at him for hurting her. In other words, we saw no evidence that she was motivated by hostility. Of course, this troublesome intrusiveness, which seems to arise from the exploration push, and the push from within to master the environment around, requires reasonable limits when it intrudes on other human beings. And indeed, Jennifer's mother immediately set limits. It is important to remember, however, that this form of pressure and activity is in the nature of self-assertiveness, is an extremely important positive attribute of psychic development and needs to be nurtured, as well as appropriately directed. (We shall talk about ways in which this can be done in the following Child Rearing Section 1.292.)

Non-Hostile Destructiveness:

The third major form of aggression observable during the first year of life is that which accompanies biting and eating. When an infant bites into food the aim is to tear the food apart so that it can be digested. That act, however, is not motivated by anger or hate toward food, rather it is motivated by hunger and the need to quiet hunger and to provide the body with nutriment it requires. This form of aggression, therefore, although it leads to the destruction of things, is not motivated by hostile feelings and we, therefore, say it is a non-hostile form of destruction which serves self-preservation. Of course, this is a necessary destructiveness which is well known throughout the animal kingdom as prey aggression.

One place where we see this form of activity serving hostile aims is where an infant bites in anger. There, of course, an appropriate limit is required. A closely related form of biting which leads to a reaction on the part of the mother is that which results from painful teething. It is common for an infant who is teething, because of the pain caused by the teeth pushing through the gums, to tend to bite. We all know that pressure on or near a body part that hurts makes the pain feel less intense. We know that there are "pressure points" which alleviate all kinds of body aches. Infants soon discover this when they are teething. Not uncommonly the mother's body may become as much the victim of the biting as a teething ring or some other object. One should distinguish this biting from a hostile attack by biting. It is important, however, to recognize that in both the biting due to teething and in hostile biting, an unpleasure experience motivates the biting activity. Of course, the biting of teething tends to gain our sympathy much more readily than the biting that comes from a child's pain at not being permitted to have the toy she or he wants which belongs to someone else.

Pleasurable Hostility:

The last large category of aggression which we can observe during the first year of life is that of enjoying hurting others, of teasing and taunting. We do not see teasing and taunting in the first months of life, rather these begin to be observable in the infants from about the 10th to 12th month of life on. Teasing and taunting belong to a more complicated form of aggression than the others we have discussed.

Years of study of the development of aggression in early childhood, have lead us to propose that teasing and taunting, an expression of hostility which is often accompanied by pleasure on the part of the perpetrator, is the following type of phenomenon. We shall discuss this more extensively in Unit 2. Here we shall say only a few words. An experience of intense pain, of excessive unpleasure, will generate hostile feelings in a child. When the child has not been able to express these feelings (in reasonable ways preferably) these feelings will be stored in the psyche. Later, whether a few moments or even days later, a child will express that stored hostility using two mental maneuvers: (1) the displacement of that hostility onto another person or thing than that which originally stirred it up; and (2) the feeling tone of unpleasure may have been changed into one of pleasurable hurting of another thing or person. The latter, in other words, is the changing of an experience of unpleasure into one of pleasure. What causes teasing and taunting is an initial experience of excessive unpleasure (pain).

One can assume that something necessitates the delay of expressing hostility as well as necessitating the displacement of this hostility. Infant observations have taught us that the major factor in causing both the delay of its expression and the displacement of hostility is most commonly experiencing hostile destructive feelings toward a much needed and valued parent. In other words, from the latter part of the first year of life on, when the child experiences hostile feelings toward his or her parents, a conflict is set up within the child. We described this conflict earlier when we spoke of the development of ambivalence (Section 1.261). Most singularly, it is when the nearly one year old child experiences hostile feelings toward her or his mother, feelings of wanting to "destroy" that mother, that these are arrested by the feelings of valuing and needing that mother. This is what prohibits, from within, the expression of these hostile destructive feelings. These destructive feelings are then stored and may eventually be displaced onto someone or something other than the original person toward whom that hostility was initially intended. We might note here that we are talking about an adaptive mechanism that unfortunately sets the stage for the development of prejudice. In this, of course, the mechanism of displacement and the conflict of ambivalence are extremely important to psychic development and to socialization of a normal child. We will speak about handling teasing and taunting in Unit 2.

Here is a simple example. Jennifer's mother told her 11 month old not to grab a toy from another child. Jennifer persisted and, as she should, so did mother. Finally, Jennifer yielded. A few minutes later, while playing with block, she picked one up, with a smirk on her face she raised her arm and, as she was about to let go of the block toward her mother, she veered slightly and struck another mother on the knee. When her mother scolded her for it, Jennifer repeated the act, this time clearing aiming the block away from her mother, toward and striking the floor. Frustrated and angered by mother's reasonable prohibition, she initially threatened to hit her highly valued mother, hit mother's neighbor instead, and with mother's disapproval and admonition she further displaced her hostile feelings onto the floor.

1.292 CHILD REARING: What Can the Parent Do That Is Growth-

Promoting Regarding the Child's AGGRESSIVE ACTIVITY?

In order for parents to help their children cope optimally with the development of aggression within them it is crucial that they recognize the different forms of aggressive activity we see during the first year of life. There is aggressive activity easily recognizable as having to do with anger, hostility, and rage; there is aggressive activity that has to do with seemingly being pressured from within to grab things, with beginning self-assertiveness and wanting to reach one's goals (already by 12 months of age); there is aggressive activity which has to do with sucking, biting, eating, and chewing; and in the last part of the first year of life there is aggressive activity that has to do with enjoying hurting others as in teasing and taunting. Let's take coping with these, one at a time.

Helping Children Cope with Their Hostile Destructive Feelings:

We emphasize that parents must know that their infants' experiences of hostility, of rage reactions and tantrums are generated by experiences of excessive pain (excessive unpleasure), whether that pain (unpleasure) is physical or emotional. As we discussed before, a child's crying and reaction of anger are always produced by some form of pain. Sometimes the source of pain is readily visible; sometimes it is not. Excessive pain, when the child feels "this is too much", intensifies anger into hostility and this hostility then unavoidably becomes part of the child-parent interaction. The more such interactions persist over time, the more they will become part of what the infant expects and become a routine part of the parent-child relationship. Occasional feelings of anger are unavoidable in infants and in relationships, and will cause no harm. We cannot always give our children what they want or even need. Dealing with such experiences in growth promoting ways will in fact, help the child learn to cope with life's unavoidable frustrations and disappointments. Similarly, occasional reactions of rage on the part of infants may be unavoidable, and when these are handled well will cause no harm, and are part and parcel of healthy growth.

It was painfully difficult for Suzy, for her mother, and also for her father that because of her low threshold of irritability and difficulty in calming down -- even though these were developing gradually to function better -- by 8 months of age, separation from mother caused quite a reaction of anger and distress in Suzy. This occurred even though Ms. Sander, the substitute caregiver, was already known by Suzy given that she had been coming to help Suzy's mother for a couple of weeks. Fortunately, Suzy's mother had learned that separation would make Suzy feel threatened that mother would totally be lost to her -- remember that Suzy could not yet recall at will from her mind the image of her comforting and nurturing mother --, and although she was not taken by surprise, it did make Mom feel awful. She had told Suzy for the past days that she would have to go to work for 5 hours and that nice Ms. Sander would take care of her till Mom came back. Nonetheless, as was expectable, when the time came Suzy became quite upset when she saw mother get ready to go and when mother hugged her before she left, Suzy clinged to

her tightly. Mother said: "Sweetheart, Mommy has to go now, but I'll be back after you take your nap". And she gently pulled Suzy's arms from herself, handing her to Ms. Sander who was very nicely, soothingly inviting and then reaching for Suzy to let her hold her. At one moment, unexpectedly, Suzy's arm swung and she hit her mother on the shoulder. Mother told her: "I know you're mad at me for leaving, but please don't hit me. It's ok to feel mad, but it's not OK to hit me". Suzy then turned to Ms. Sander, crying angrily while holding on to her. Mother left feeling sick to her stomach, she said.

Suzy's expressions of anger around separation took a variety of forms, from crying angrily, a couple times hitting mother, to ignoring mother when she came back. We encouraged mother to tolerate Suzy's expressions of anger that were verbal but not allow her hitting mother. And we encouraged her to say these things: "It's OK to feel angry with me, but it's not OK to hit me." To being ignored by Suzy, we encouraged mother to tell Suzy she was "sorry that her having to go to work at the office upset Suzy and made her angry with Mom. Mom sure is glad to be back home with Suzy and she thought a lot about her when she was at work. She hopes that Suzy won't stay angry with her too long; it's a lot nicer when Suzy feels happy with Mom." By this time Mom had come to see how Suzy really seemed to understand Mom when she told her these things and was able to really say what she thought -- even though Suzy could not yet say even one word.

What the child needs to be protected against are experiences of repeated and prolonged excessive displeasure (including frustration) which generate hostile feelings and rage that are too intense, last too long, occur too frequently. This is especially so when these are not well enough prevented due to the parents' insufficient or inadequate responses to the child. In short, the parents need to learn how to protect the infant against too long, too frequent experiences of excessive displeasure.

An important concern for parents is to find a reasonable position between two points: (1) responding to the infant's demands and needs too slowly, which produces excessive pain, and (2) responding to the infant's needs too quickly or even before the infant expresses a need. The parent who reacts too quickly may not give the child the opportunity to develop reasonable capabilities for tolerating delay and frustration, capabilities which are necessary for comfortable-enough adaptation. No one is always gratified; nor is this needed in order to feel reasonably comfortable. Nor is one often fully gratified. This is why we say that it is important for young children to learn to tolerate less than the total satisfaction they wish for, in order not to take disappointments and frustrations too personally and to adapt reasonably to the unavoidable disappointments of everyday life.

We emphasize that there is no need to experiment with "toughening up" the child by exposing him or her to unnecessary delays or frustrations. Life being what it is, normal, loving and respecting parenting will fall short of the young child's wishes for perfection and constant satisfaction and comfort. When a young child is angry it is well to first try to know what is causing the anger, what pain the child is experiencing. Similarly when the child is experiencing a rage reaction the parent can assume that a painful experience has been too sharp or has been going on for too long. Again here, the cause of the rage needs to be understood and if reasonably possible, be removed.

Especially from 6 months of life on due to the higher level organization of the brain,

the ability to understand "cause and effect", to think thoughts, to feel intention, and to feel anger and hostility, an angry reaction on the part of the infant may trigger the infant's built-in reaction of striking out or biting the mother. This may also happen when an infant is feeling angry with another child. A reaction of this kind is a hostile act. As we described in the Human Development section (1.291) on aggression, anger is experienced when the child feels unpleasure (pain) that is not yet felt to be excessive. Anger is in the mild range of the hostile destructive range of affects (feelings). Aggression in the form of hostile destructiveness is an unavoidable experience of every child and one which, more than other behaviors, will require the setting of limits on the part of the parents. Setting limits on the way hostility and anger are expressed in the first year of life is a moderately complex matter. Of course, each family has to decide its own philosophy regarding the ways anger, hostility, and rage can be expressed. We say again that when normal children experience unpleasure they will become angry, and if that unpleasure becomes experienced as excessive, the anger will intensify, and that mounting hostile feelings will be generated and may lead to rage. Experiencing hostility is a normal reaction produced by experiencing excessive pain (physical or emotional) and does not mean that a young child is a nasty person, a "bad seed" or "has the devil in him or her".

However, what one does when one's child, and for that matter when the parent, is angry requires thought, understanding and a viewpoint. Aggression research leads us to understand and take the point of view that: it is normal to feel anger and hostility, there always is a reason for it, but one has to express these feelings in reasonable, acceptable and controlled ways. Infants are not born with inner controls for the expression of their anger and hostility. These inner controls must be learned and they are learned better and more quickly with the help of those caregivers whom the infant progressively values and to whom the infant becomes attached.

One particularly important and sensitive area in setting limits when the child expresses anger is when the child strikes out at the mother or the father with whom the infant is angry. In order to help the child socialize well and because hurting someone we value and care about eventually leads to guilt, it is best if parents set limits against the child's physically striking out at the parent. Experience teaches us that helping a child verbalize feelings of anger, to express feelings of anger in a nonphysical way toward her or his parents or others, socializes the child much more positively and tends to prevent undue and excessive feelings of guilt in the child. Experience also has taught us that when parents express their feelings of anger toward their children in verbal, non-insulting and in nonphysical ways, they serve as such a model for their children, and they prevent feelings of guilt and shame within the child and themselves. Furthermore, they then prevent child abuse, one of the most harmful experiences parents inflict on their own children. Let us talk about setting limits with children during the first year of life.

Setting Limits:

First, we are often asked when should parents begin to set limits. Setting limits begins when it is required, that is, when one sees the need for it in a young child's behavior. Striking out against the parents, whether it is by hitting with the hand, the

head, or by biting, requires limits no matter what the age of the child.

Bernie's mother was very troubled when her 2 weeks old baby suddenly became irritable during feedings and would squirm suddenly and at times even flail his arms and kick up his legs in acute pain. At first mother thought it was just a GI "bug"; but it persisted for a few days before she called the Pediatrician and soon his milk allergy was diagnosed. At first mother just did not know how to react to Bernie's flailing and occasionally hitting her. Even though we knew Bernie could not help flailing and we knew his irritated state to be the natural reaction to excessive abdominal pain, we encouraged mother to tell him in a calming voice that she was sorry he was feeling so upset, but to please not hit Mommy, even though we knew that his hitting could not yet be intentional. He was much too young, too far from being 6 months old, to hit with intention; he was just reacting to pain the way our bodies naturally react. Furthermore, we did not believe that Bernie would understand his mother's words. We did assume he would probably feel what mother felt when she said "I'm sorry you feel so upset" and the different tone that comes with "please don't hit Mommy". Long before babies understand words, they communicate with and "understand" feelings. It is through feelings that the first limit-setting is communicated to the baby who is doing something parents experience as unacceptable or harmful to the baby or themselves.

Fortunately, Bernie's mother did not feel that Bernie was suddenly being a bad or evil baby. She did not feel offended by his distress and flailing and did not feel provoked by his behavior. Unfortunately, with parents who are in much pain themselves and/or who were abused as children, they may become provoked by the kind of reaction 2 weeks old Bernie had and they then react to the infant with resentment, hostility and even physical abuse. Richie's 17 year old mother, we believe, got to this point a while after her boyfriend left her. We assume she became depressed, hopeless, and the normal demands of her then 7-8 month old baby became intolerable to her. This is when an otherwise potentially decent and good-enough young mother may lose control over the inner pressures of her own hostile feelings and rage and then attack her own baby. This is what the Emergency Room staff at our hospital believe happened to Richie and the evidence was large. We also believed this to be the case when we saw Richie at 14 months and saw the marvelous pictures of him at 5 months of age. The consequences to Richie and to his mother of abusing him were enormous.

Second, a limit is best set by the mother or father by a firm enough verbal prohibition. When needed, accompany the firm statement that the infant is not permitted to hit mother (or to bite), by a firm but not pain-intended physical holding of the hand (or jaw). Setting of limits with a normal young child never succeeds in just one effort. Characteristically, setting limits has to be repeated over and over because a normal child does not learn so hard a lesson in just one try. Here are two major reasons the child cannot learn such a lesson in one effort: (1) that the inner pressure of the normal child's aggression is powerful and one over which the young child at first has no control; and (2) one's healthy narcissism (self love, self valuing) makes it such that, at times, none of us likes to be told what to do nor do we easily accept being frustrated. It is in fact the parent's setting of firm and kind limits that helps the child develop the needed inner controls over the very powerful pressures of aggression, especially in its form of hostility; and in addition, it

helps us accept and learn to do things that are ultimately in our best interest which at the time of limit setting we would rather not do. The young child is at the mercy of the inner pressure of what she or he experiences as a need to have or to do, and requires the parents help to learn to put the brakes on the expression of angry feelings by striking out (i.e., expressed in unacceptable ways).

Third, when an infant less than 1 year of age experiences excessive anger or rage, or even milder forms of anger, it is advantageous for the mother to set limits while also trying to calm and comfort the crying or upset infant. Trying first to remove the source of anger and hostility where indeed it can reasonably be removed, followed by or accompanied by the setting of limits, and then thirdly, efforts to calm the baby can act together to achieve a very good result.

When 2 week old Bernie had abdominal distress he at times would flail his arms and on a couple occasions hit his mother. Mother was right when she told me that did not hit her intentionally. As we have said the infant does not truly experience intention until about 5 to 6 months of age. But Bernie's mother was also right to say to him, while holding him: "Oh, I'm sorry you feel so bad, but don't hit Mommy". She both was comforting him and setting limits, even though she felt (rightly) that Bernie's hitting her was not done on purpose.

Comforting the young child is commonly needed when setting limits. This is because setting limits often upsets the less than one year old (and older) and when the child is upset, he or she naturally turns to the valued caregiver for comfort. But comfort is not always needed by the child. For instance, we saw that when 11 month old Jennifer pulled 11 month old Johnny's pacifier out of his mouth, Jennifer's mother set limits with her and Jennifer did not turn to her mother for comforting -- something she often did do and her mother would then, indeed, comfort her well. We described how Jennifer's mother set limits in a very natural and, we believe, quite effective way. She first simply said in a tone of surprise something like: "Jennifer! Don't do that, it not nice!" The second time she said with some firmness and a little louder something like: "Heh, that's not nice. Don't do that. That belongs to Johnny!" The third time it was even more firm, louder, conveyed disapproval and anger on mother's part. The fourth time, mother was even more firm, scolding, let Jennifer clearly know she was angry and warned her that she and Jennifer would be very unhappy if she did it again. Each time mother's tone increased in firmness, increased in loudness, conveyed increasing disapproval and went from surprise to anger at her child not complying with what mother said. The fourth time she warned Jennifer that mother would do something (punishment) about which Jennifer and mother would be unhappy. Notice, as we discuss more below (under Handling Nondestructive Aggression) that Jennifer was not angry with Johnny, nor with her mother we thought, but that what was pushing her from within her mind to continue to pull Johnny's pacifier from his mouth did not, perhaps could not be stopped by her, immediately. The activity, the inner pressure had been turned on and she did not or could not yet put on the brakes.

Although Jennifer did not require it, we assumed, because she did sense that what she was doing (pulling Johnny's pacifier from his mouth) was not nice indeed, it is most important not to withhold comfort when the child asks for it while one is setting limits. This is because the parent's efforts to comfort and to calm reinforce the parent's

constructive efforts to set reasonable limits. They will also make the infant feel that whatever pain he or she is experiencing is not intentionally produced by the mother, but that the mother indeed wants the child to feel protected and comfortable. The child will gradually learn that these are the aims and these are intentions of the mother and will begin to cooperate in gradually developing internal controls over her or his own expressions of anger and hostility. When comforting, the parent can express sympathy with the child's feelings while at the same time explaining and underscoring the need for the limit. We cannot overstate the usefulness of comforting the child who is upset by the limits set by the parent to whom the child is attaching or already attached.

We say again: comforting helps the setting of limits rather than interfering with them. We have found many parents who believe that, if while setting limits they also attempt to comfort their child, the child will misunderstand the parents' intentions. Without explaining it further here (see Limit Setting in Unit 2), suffice it to say for now that it will enhance the child's accepting of the limits and the child's developing positive, reasonable internal controls.

Handling Rage Reactions and Temper Tantrums Constructively⁴

This is one of the most difficult challenges of parenting. Let us start with a few observations about rage reactions and tantrums that can guide a parent in handling these. First, tantrums are more intense, last longer, and are more traumatizing to the child and the parent than rage reactions. Efforts to prevent these are much easier and cost emotionally much less than having to handle them. With this in mind, it is important for parents to learn the signs their infants show that they experience unpleasure (pain of emotional or physical origin). It is a simple principle that the more the unpleasure is intense or continues, the more will simple irritability intensify and eventually go into rage. Of course it is easier to deal with irritability than with rage; therefore, it is sparing of pain and effort for both child and parent to intervene to undo the source of irritability than to deal with rage. But infants vary in how easily and how quickly they experience pain and in how quickly they go from irritability to rage. For example, as an infant Suzy was more likely to be irritable than Jennifer just by virtue of her inborn disposition (her biological endowment). She had a lower threshold for irritability (which means that lesser intense stimuli irritated her than Jennifer, like intense noises, or father handling her brusquely) and was a quick-reactor, that is she would move much more quickly into rage than Jennifer. This is what we mean by "temperament"; it is the type of reactivity with which we are born. And it is important then for parents to learn how their babies are likely to react to all sorts of experiences and what signs to look for. It is wise for parents to accommodate reasonably, as best as they can, to their infant's inborn dispositions, in order to engage in a loving emotional dialogue with their babies. But how does one deal with a rage reaction or temper tantrum that could not be prevented? Knowing the stages of a rage or tantrum, that is knowing the structure of

⁴ See *Aggression In Our Children: Coping With It Constructively* by H. Parens with E. Scattergood, W. Singletary & A. Duff (Aronson Press, 1987) for greater detail.

these, can be very helpful. As we said in Section 1.291, a simple rage reaction has a threshold, a climbing limb, a peak, a descending limb, and ends in exhaustion unless the source of the rage can be stopped. The structure of a temper tantrum is similar except that the tantrum is a series of rage-like reactions. The best stages to help the baby are at the threshold and during the descending limb of the rage. The most difficult stages to deal with are the climbing limb and the peak. Here is why. Observation of less than 6 month old children in rage suggests that once the climbing limb is set in motion and while it goes into the peak stage, the infant's cognitive and emotional experiencing are overtaken by the experience of extreme pain reaction and the infant cannot pay attention to or feel the caregiver's efforts to help. As we said in Section 1.291, if an infant has gone into a rage due to his or experiencing the delay in feeding as unbearably painful, the infant will not be able to accept the nipple that is offered because the rage experiencing floods the infant's perceptual and reactive systems. The caregiver will have to intensify the presentation of the nipple by gently rubbing it against the raging infant's cheek or corner of the mouth to over ride the experience of rage. The less than 6 month-old's adaptive capabilities, while they are magnificent, they are also very limited. The caregiver's efforts will be more easily perceived by the infant before the physiological rage reaction is set into motion and then not until the rage reaction begins to weaken (to descend).

This is what we found in Suzy and what we told her mother (an eventually also her father). We told her these thoughts so that she could (1) help Suzy cope better with these painful experiences and (2) so that mother could better understand why her good efforts at times did not work. Because Suzy was difficult to calm (due to her inborn reactivity) mother often could not prevent a rage. Mother saw Suzy grimace, look as if in pain, and she would then try to gently soothe her, talk to her and cuddle her as best she could. And we could see mother's distress mount as at times she did not succeed in calming Suzy. Once less than 6 month old Suzy went into a rage we encouraged mother to continue to hold her, or at times, when it was too much for mother, to put her down, to stay with her in a holding stance, telling Suzy she was there right next to her. Once Suzy's rage seemed to become less intense, we suggested that mother then renew her holding and soothing talking to calm Suzy down. We told mother she was right to be sympathetic when she talked soothingly to her baby because she could now hear her better and would eventually calm.

These reactions, rage and tantrums, become more complex once the mid-first year developments we have talked about are beginning to organize and become functional. With beginning adaptive capabilities of intentionality (to act with intention), causality (recognizing cause and effect), the consolidation of attachment, the ability to experience anger and hostility, a difference commonly found in a rage reaction as compared to a tantrum emerges. With better adaptive capabilities, a 9 to 12 month old will be able to experience rage without being completely flooded by it; this will make it possible for the child to hear and feel what mother or father is doing to help calm the child. Although the intense feelings of hostility experienced during the climbing limb and the peak stages will be very difficult for the child to control, usually the parent's efforts will be registered. We believe this is not so with a tantrum. During this more intense series of rage-like

reactions, the 9 to 12 month-old's newly developing adaptive capabilities will be flooded with feelings of hostile destructiveness during the climbing and peak stages of each rage-like episode. During these stages, the 9 to 12 month old will usually not be able to hear or feel the parent's calming efforts.

Again, because they cause intense distress and often traumatize the child, we recommend that parents try to prevent tantrums. We also add that when a tantrum is set in motion, recognize that efforts to stop it during the climbing and peak stages are likely to not work because the infant often cannot register the parent's efforts to calm, and the best strategy then is a holding maneuver. That is, put the tantrum child down if he or she flails and squirms too much to be held, talk to the child in a calming voice saying something like "Come on Suzy, try to get a hold of yourself; I know you're really upset." And prevent the 9 to 12 month old from hurting himself or herself, from kicking or striking you, someone else or from breaking things. Isolating a less than 3 to 4 years child who is having a tantrum is undesirable because it commonly brings with it feeling abandoned and rejected. The only time a less than 4 year-old child who is having a tantrum should be isolated (put into a room alone), is if the parent fears she or he will lose control and harm the child. The times the parent will best succeed in calming the child who is having a tantrum is during the descending limb and during the pauses between tantrum episodes. Comforting, holding, explaining why Suzy could not be allowed to do harmful things usually helps. Scolding, rejecting, insulting the baby (like telling him or her he or she is evil), add insult to injury, and make things worse, not better, between child and parent.

With regard to his rage reactions and tantrums, we cannot say just what happened to Richie during the period from when he was 6 to 14 months old. When we saw him, from 14 months to about 24 months, Richie would have sharp outbursts of rage. When we first saw these, they took our mothers by surprise. He was depressed, very sluggish in movement and rather quiet at first. It is when he began to be more responsive, less depressed, that bursts of rage would erupt. Because he had been severely traumatized and we knew that he has much accumulated hostile destructiveness in him, we knew (from clinical experience) that rage and destructive feelings would come out once he began to recover from his heavy depression. We therefore, welcomed these expressions of hostile destructiveness, but knew only too well that we would have to help Richie's caregiver (his great aunt) help him express anger, hostility and rage in acceptable ways.

We explained this to Richie's great aunt and the other mothers. Then we recommended that great aunt set limits quickly, firmly but kindly when Richie suddenly threw hard toys around. We encouraged her to tell him that he can't throw hard toys, but that he can complain and tell her or whoever upset him to not do that. We encouraged her to not tell him he was bad or evil, but rather to say that what he was doing came from his feeling hurt and that he was not allowed to throw things but, as he began to talk, that he could express anger by complaining and by saying what he felt and thought. It soon became possible to predict when he might have an outburst of rage and to (1) help him tell another child he or she can't take what he is playing with, and (2) for great aunt or her friend to pick Richie up when he was beginning to be upset and to comfort him. We believe that it was his good beginnings (up to 6 months of age) that made it possible to be

so effective in helping Richie deal with rage reactions. Although his progress was expectedly slow, his rage reactions diminished over the 10 months we saw him and were milder and quite easy to deal with. Only continued good care can help such a child, or any child, learn to progressively control the hostile destructive feelings that experiences of severe pain generate.

Another word is warranted still for the parent regarding the child's expressing angry and feelings. That is, that on the one hand some parents feel that the child is hostile when at times a child is not, and on the other hand, some parents cannot tolerate the idea of their infant experiencing hostility and they will deny that the infant is hostile. Let us give an example of each.

A commonly misunderstood action on the part of an infant which a parent may believe is hostile and which is not is the one we gave before, when an infant less than 10 months old gets hold of the mother's hair or another child's hair and seems to not want to let go. As we said before, during much of the first year of life, the child may not be nastily pulling someone's hair, but rather, having activated a grasp reflex, the infant is not yet able to stop the grasp reflex and release at will what is grasped. Or, take the child who keeps throwing things off his or her highchair after mother or father has picked them up already several times. Here, the child has devised the well-known game of making things disappear and reappear which, in children throughout cultures, is motivated by separation anxiety. Like all peek-a-boo type games making things disappear and reappear at will serves to lessen the child's feeling of helplessness and anxiety in the face of separation. The parent may feel the child is teasing and being hostile when he or she is not. It is important not to ascribe hostility in young children's actions when none is there because it will defeat the mastery effort in the game and also undermine self trust and basic trust in the child. However, even though the child is not necessarily being hostile, limits may well be required on a game that the parent finds irritating.

On the other hand an example of hostility which may not be recognized as such by the parent could be the infant's lashing out at mother with a fist, or biting the mother, which may be experienced by the mother as "accidental" or "unintentional". Sometimes in reaction to angry feelings toward the mother the infant will lash out and, on many occasions, we have seen mothers deny that their infant's action was one of hostility. We repeat that children are not born nasty or evil. However, as infants we all had the capability of becoming angry and hostile. As we have indicated, these feelings invariably are in reaction to an experience of excessive pain, and it is in the child's best interest that the parent recognize that her or his lovely and healthy infant is capable of such anger and hostile reaction. After all, it is only by recognizing that something exists that one can try to deal with it in a reasonable way.

Some students may feel that we are spending too much time talking about helping our children cope with their reactions of hostility. We cannot overstate how important it is to help children learn to deal constructively with their hostile feelings from their very beginnings. This is because excessive hostility in children can be highly detrimental to the development of their psyches, to the development of their human relationships, of their self esteem and their feelings about themselves, to the development of their consciences, to their ability to resolve differences with others constructively, to mention

only a few of the important ways in which hostility influences the child's development and adaptation.

Helping Children Cope with Their Non-Destructive Aggression:

As we discussed in the Human Development section above, another important way in which aggression manifests itself from the first month of life on is in the form we identify as nondestructive aggression. We described how 15 week old Jennifer could become very busy for quite a long period (for her age) in explorations of things around her. We described the persistence of her efforts. Did you get the impression that she was trying to assert herself on her environment? Did you get the feeling that she was beginning to try to master her environment as well as her own arms, hands, legs, and body? The child's first efforts to master the world in which he or she lives as well as to master his/her own body requires this inner pressure most of us recognize as non-destructive aggression, the form of aggression that fuels assertiveness and mastery of our developing adaptive capabilities.

We consider this to be a form of aggressiveness much needed for healthy adaptation, healthy self-valuation and sense of worth. We are not speaking of excessive self-importance, but of a reasonable self-respecting degree of self-importance. We are speaking of what so many people have come to recognize, these days especially, as a much needed healthy degree of assertiveness. For example, the conviction "I won't let anyone take away my voting rights" is held by all of us to be very important.

This form of aggressiveness, of assertiveness, of self-protectiveness, begins to be evident in infants' behaviors from the first months of life on. It is important that the parent recognizes this in his or her own infant and that this form of healthy assertiveness be protected. Notice how 15 weeks old Jennifer's mother appreciated her daughter's curiosity and interest in the rings she was exploring; when Jennifer inadvertently tossed the rings out of her reach, when mother saw her stare at them and reach for them, she spontaneously put them back within Jennifer's reach. Of course, this does not mean that an infant should be permitted to explore just anything and everything that the infant wants to get his or her hands on. We saw how 11 months old Jennifer's plucking Johnny's pacifier from his mouth quickly set mother into motion to set limits on her taking what belonged to Johnny as well as on her causing him distress. Similarly, everyone knows that in no way is it to a young child's advantage to get hold of a very hot cup of coffee. Nor is it to the infant's advantage to get hold of detergent that is in the kitchen cabinet, nor be permitted to play with an electrical outlet. Nor is it to the child's advantage to get hold of your jewelry, or your eyeglasses, etc. In other words, while it is important to protect our children's explorations and efforts to discover what the world in which they live is like -- remember that the infant is born into a world the infant does not know, has never learned about before --, it is also important to protect infants against doing things that will either be harmful to themselves, or others, or to something valued by others. We are saying that, on one hand, it is important to protect the infant's efforts to appropriately gain mastery over himself or herself and his or her environment, but that it is equally important to set limits where those efforts may cause harm to the infant, to

another, or to valued possessions. Thus, it is important to set limits where they are needed in relation to this form of aggressiveness, too. It makes the task easier if the parent bears in mind that this form of aggression leads to the development of a healthy degree of assertiveness. (We shall further discuss the setting of limits in relation to this and the other forms of aggressiveness in Unit 2).

In addition to the central part, this form of non-destructive aggressiveness plays in the development of assertiveness, it also is of enormous value to the growing infant's developing sensorimotor intelligence (see Section 1.261). This type of aggression, which fuels explorations and asserting the self upon one's own body and the environment in which one lives, plays an important part in the development of human intelligence. Jean Piaget has shown and taught all of us that intelligence in humans, and probably in other animals as well, begins in the form of combined sensory (seeing, hearing, touching-feeling, etc.) and motor (movement, muscular coordination, holding and manipulating, etc.) exploration, and thereby coming to learn about the world in which we live. In these explorations and efforts to assert himself or herself, the infant is being a student, an explorer of the world into which the infant was born. (We shall talk further about this in Section 1.321 of this Unit when we talk about the development of intelligence). Besides its enhancing the development of intelligence, parents should recognize that this exploratory activity enhances the development of the infant's becoming a student. To enhance our children's becoming good students in school, it is well to bear in mind that becoming a student begins in the first year of life.

For this reason, in setting limits on explorations that may be harmful to the child or that may cause harm to things that the parent values, it should be done in such a way as to not stifle the infant's natural interest in explorations. Therefore, while parents must mean what they say and be firm enough to be effective, they should not be too harsh, should be selective and thoughtful, respecting and considerate of the child in the course of setting limits (see Setting Limits under Helping Children Cope With Their Hostile Destructive Feelings, above). Unavoidably, all parents tend to get angry with their very young children when they resist limit-setting. We want to emphasize that it is insulting and generates hostility to convey to one's child "I am the boss and you will do what I tell you because I am bigger than you are". Rather, one set limits in the spirit of helping and protecting the child against doing things that may be harmful. In this sense it helps to say something like "I am telling you can't play with stove because you're not yet able to realize that it can really hurt you"; this is assuming authority with the child not because the parent is the boss, but because the parent's judgment of what is dangerous or unacceptable is better developed than the young child's. Nobody likes to have a limit set in the spirit of "I am bigger than you are and I am going to tell you what to do." Whereas setting limits with due explanation and the understanding that the limit is set because one does not want the child to either be harmed or cause harm, will eventually help a child understand that the limit setting is in fact in the child's interest.

One further note is needed for the parent with regard to the child's non-destructive aggressiveness. The exploratory activity we are talking about gives the parent an opportunity to become the child's first teacher. We have talked about the less than one year old exploring and being a student of the world into which she or he she is born. The

complement to that, of course, is that it gives the parent an opportunity to become the child's first teacher. There is much to be gained by the child's having a good student-teacher experience in relation to his or her own mother and father. If the mother-child relationship is sufficiently loving and affectionate, the child will develop the model of having a positive attitude toward teachers and in the future is more likely to appreciate what teachers try to do for her or him and this is likely to enhance the youngster's becoming the best student he or she can be.

In addition, for those parents who enjoy teaching their children, the opportunities are many even during the first year of life including teaching one's children their first lessons in "physics", in "mathematics", as well as in locomotor activity, in language and communications, to mention only a few.

Helping Children Cope With Nonhostile Destructive Tendencies:

As we noted in Section 1.291, biting associate with teething occurs due to the experience of pain, and may become especially troublesome during breast feeding. Of course, since it can be very painful, it requires, and always provokes a limit on the part of the mother. As we said before, where biting is an expression of hostility, which is often caused by the pain of not being able to get what the infant wants, limit setting is warranted. It is, of course, also necessary to help children under one to learn that they cannot tear certain papers -- which they may do while exploring them excitedly -- like the telephone book or other books, etc. Again, constructive limits are needed.

Helping Children Cope With Their Pleasure in Hurting Others:

The fourth form of aggressive behavior which we discussed before begins during the latter part of the first year of life; it is that exemplified by teasing and taunting. Here the infant seems to enjoy causing pain, and seems to plan to cause pain. This is a complex behavior which we will talk about during the second year of life material since it is an activity that occurs quite frequently from the second year of life on.

1.3 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.311 HUMAN DEVELOPMENT: Dependence

Dependence, to need and rely on others for the fulfillment of one's own normal needs, is a normal and unavoidable condition of humans from birth through the entire span of life. Of course, the dependence experienced by an infant is vastly different from the dependent feelings and needs experienced by adults. During the first year, dependence is at its peak, the infant being absolutely dependent on her or his external environment for survival.

When we consider the question of dependence, of our reliance on others, we must ask at least two questions that reflect two aspects of dependence. One is “dependence on whom?” And the other is “dependence for what?” When we consider our dependence on whom, we recognize that we are dependent on different individuals in the course of our lives. The infant is especially dependent on mother and father, the older child is especially dependent on his or her parents but also on school (or special) teachers and on peers. The adolescent is dependent heavily on peers as well as on school and other teachers but is still quite dependent upon her or his parents. In adulthood our dependencies shift to peers and other persons, particularly to one especially selected peer as a mate.

When we consider our dependence for what, we can list that we all have physical needs, and psychological needs that we can consider as emotional needs and adaptive developmental needs. For example, when we speak of physical needs of the infant, we think of the need for food, shelter, good hygiene, etc. When we consider the emotional needs of the less than one year old, we think of needs for being loved, valued and respected, needs for comforting, for physical contact including touching emotional and verbal communication, and being shown affection. When we consider adaptive developmental needs we think of the need an infant less than one year has to learn how to explore the environment safely, to learn skills as walking, begin some self-feeding, play peek-a-book, etc.

With respect to physical needs in the first months of life, because the child is totally unable to move or to negotiate the necessary steps, he or she is totally dependent on the mother or nurturing person for nutrition. Also, of course, the infant is totally dependent for the changing of his or her diapers and numerous other crucial basic care needs. Interestingly, as the infant grows, although he or she becomes less helpless, the need for parent care and protection does not decrease. For instance, the home must be child-safe for the six and 11 month old, but there is no such need for the two-week-old. Needs change during year one, but they do not become less. In fact, they become greater after about 5 months.

Generally, the more an infant can do for herself or himself, the less the parenting environment will be needed for those particular, most commonly adaptive, functions. This is true not only for that aspect of the child's adaptive functioning that has to do with

developing physical capabilities, but also for the need to develop internal controls over powerful inner pressures and behavior, as well as for the development of reasonable social conduct which especially begins to be necessary from the latter part of the first year of life. Already then, Jennifer's mother, and the other kids' mothers had set limits on socially unacceptable behavior such as Jennifer's grabbing Johnny's pacifier from his mouth, and the twins' mother having to tell both of them to not grab the other's toy.

From the beginning of life, of enormous importance to healthy physical and emotional development, we need another or others to gratify our basic emotional-psychological needs. In spite of the fact that it is a universal biological condition, dependence on another person for the fulfillment of our emotional-psychological needs is often insufficiently understood, appreciated and acknowledged. Indeed, many people disclaim having such needs, to their own detriment. Let us amplify on these dependency needs.

In the infant, emotional-psychological dependence on others is evident in two major needs categories: the first category is of emotional needs such as for comforting, holding and touching, and for the expression of affection, of being valued and loved. The second category is the adaptive developmental needs, as the child's needs for parental help in learning to adapt to the environment, to solve problems, to socialize satisfactorily, and the gamut of skills as in learning to walk, talk, eventually to read and write, to catch a ball, ride a bicycle and many other skills in which learning plays a large part in adaptation and mastery of our bodies, ourselves, our challenges. Imagine a human being having to learn to speak or read from the beginning without the help of a teaching environment. He or she would learn much more slowly, taking much longer in developing the skills human beings need to adapt well in today's social environment.

In the first year of life, in speaking of the child's dependent needs, we emphasize especially the need the infant has for human contact, for emotional interactions with the persons in her or his environment and for comforting. That these emotional needs must be reasonably gratified cannot be overstated. From the beginning of life on, and especially during the early years, we all need an emotionally available nurturing parent (or substitute) to whom we can turn and on whom we can reliably count. Fulfilling these basic emotional needs contributes importantly to the development in the child of basic trust in contrast to mistrust, and an inner sense of security and well-being in contrast to a pervading sense of insecurity and ill-being. We emphasize, furthermore, that contrary to what many parents believe and hear, the better the infant's emotional dependence is gratified, the less is that infant likely to become an overly dependent adult. In the section on child rearing which follows we will call special attention to the fear many parents erroneously have of just this, that if they gratify sufficiently their infants' demands for comforting, for being held, they will develop into overly dependent children and adults. This is wrong.

1.312 CHILD REARING: What Can The Parent Do That Is Growth-Promoting Regarding The Child's DEPENDENCE?

Parents know that the child in the first year of life is at her or his peak of dependence on the adult world for survival. Parents know that their infant has physical needs that require the parents attention. There are still too many parents who do not know that their infant also has very important emotional needs, needs for comforting, for physical contact and communication, and for affection. Parents also know and many really enjoy the infant's leaning on the adult environment to develop adaptive skills including learning to do things, to solve problems, and to adapt socially. It is a remarkable fact that insufficient gratification of any one of the three categories of needs will adversely affect the physical and emotional development of the child.

For a number of reasons, many parents grasp more easily the fact that infants are dependent on them for food, shelter, and good hygiene than for their emotional needs. Because sufficient emotional gratification is so important for good emotional and psychological as well as physical development, we emphasize that from birth on the infant has large emotional needs for which the infant is totally dependent on the parent(s). Of importance to the parent's understanding, is that the gratification of these early emotional needs will influence positively the degree to which the child learns to adapt to his or her world in a healthy manner.

With these thoughts in mind, it is especially troublesome that many parents worry that if they gratify sufficiently their children's dependency needs, even during the first year of life, that the child will want to remain a baby for the rest of his or her life. This is a gross mistake. The more reasonably the infant's dependency needs, especially the emotional needs, are met during the early years the better will the child's own adaptive functions grow, and the more ably self-reliant will she or he become.

We have seen many times parents push away infants who show signs of wanting to be held because they fear that, if the parent usually gratifies the child's wish to be held, the infant will not want to leave the mother's arms. On a number of occasions young mothers have told us that their own mothers or neighbors have said this to them with much conviction. Experience shows us that this is not so. There is within every child, from the first several months of life on, a strong and quite large inner pressure to want to do things oneself, to be an individual, to want to stand on one's own two feet, so to speak. This strong inner pressure motivates the development of autonomy (of wanting to do things oneself) and of self-reliance. One sees this inner force emerge from about the third month of life on; and this inner pressure to become an autonomous individual has a remarkable upsurge from about 6 months of life on. Indeed, it is often an upsurge which leads to much concern on the part of some parents that the infant is becoming too autonomous, too assertive, too much wanting to do just what he or she wants to do.

Therefore, the fear that, if one reasonably emotionally comforts one's infant when the infant requires it, this will lead to the child's wanting to stay on the mother's lap or in the mother's arms for the rest of his or her life is simply wrong. On the contrary, it is insufficient gratification of the child's emotional dependence needs that tends to make that child become an overly dependent individual. As many parents know, not sufficiently gratifying a child's needs for emotional contact, for comforting, for being held, leads to a persistence of these needs, to their intensification, and soon the child feels

deprived, emotionally starved, which in turn leads to maladaptive developments that handicap the child and interfere with his or her normal growth.

In summary, in the first year of life the infant's dependency needs are at their peak. But even from the middle of the first year of life on, the child's needs to be dependent already begins to be balanced by beginning needs to be autonomous, to do things oneself. Both the need to be held and have things done to and for the baby and the need to do things oneself, are experienced by children from the middle of the first year of life on. From 5 to 6 months of age on, at moments the infant wants to be held; moments later the infant may show clear signs that he or she does not want to be held. It is so that although there are times when parents do not gratify their children's needs to be held enough, there also are times when some parents do not allow their infants to be autonomous enough do not allow them to get off mother's lap or to do things by themselves. The parent who can read the infant's cues best and responds to these cues in a reasonable manner, will help his or her infant most. If the child expresses the need to be held at a time when a parent can do so reasonably, then the parent will best help the child by holding her or him. When the young child does not want the parent to intervene in the child's activities the parent will best help by allowing the child reasonable (safe) autonomy and separateness.

1.3 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.321 HUMAN DEVELOPMENT: The Beginnings Of Intelligence

Jean Piaget, who to date has contributed most to our understanding of the development of human intelligence, emphasized that the development of intelligence occurs inter-dependently with emotional-psychological aspects of the child's development. This has long been ignored by too many parents. The development of intelligence (what Piaget called cognitive development) is influenced by and, in turn, influences the child's emotional development (which Piaget called affective development). The word affective in French is closer in meaning to the English word emotion than it is to the English word affect which means feeling or feeling tone. Piaget's uses of the word affective implies the broader range of human emotional experience.

The point we want to emphasize here is that in order for a child's innate intelligence to develop optimally, the parents need to provide their child with adequate opportunity for healthy emotional development. Our reason for emphasizing this point, is that numerous efforts have been made to help children develop cognitive and intellectual skills, without due attention being given to their emotional needs and the obstacles to their emotional development. As a result, some of us believe, even strong efforts as HeadStart and Get Set programs which do help some have, however, fallen short of their goals. We believe that many children will be insufficiently prepared for school at the age of five years and later, so long as they are emotionally too deprived or abused during their earliest years of life. If we want to prevent the marked educational retardation that occurs in large segments of our society, we will have to be attentive not only to the development of cognitive skills in their young children, but also to their emotional needs, deprivations, and abuses.

Now to the development of intelligence itself. The development of intelligence, or cognitive development, begins in the child's earliest exploratory activities. The infant's earliest explorations are visual, auditory, and tactile, including both the use of their hands as well as their mouths. During the first three months of development, much of the infant's exploratory activity is of short duration, occurring during states of alert wakefulness, especially when the infant is sufficiently comfortable and gratified. The exploratory activities of the earliest weeks tend to be as if accidental, not yet organized into intentional activity. The earliest signs of some built-in cognitive organization may be the newborn's tendency to look at patterns of a face whereas they scan past such a pattern when it is fragmented and scattered. Also, newborns seem to already have learned to recognize their mothers' voices and soon learn to recognize their mothers' odors and typical movements associated with caregiving.

From about the third month of life on, the explorations of the infant begin to become organized in a new way, it becomes directed. By this we mean that now the activity seems to become purposeful, to begin to be intentional, the child tending to explore her or

his own body and the body of those to whom the child is beginning to attach. From about the third to fifth month of life on, the exploratory activity gains more and more momentum. Especially at the middle of the first year of life the degree of directivity in exploration, the integration of movements using the eyes, the hand and the mouth, become further organized and integrated; and the inner pressure to explore, that magnificent inner force to which we have referred, begins to mount sharply. The duration of exploratory periods lengthens, the level of interest on the part of the infant increases, and the span of concentration capability lengthens. In some infants, like in 15 weeks old Jennifer, her exploratory activity could already last more than 20 minutes at a stretch (see Section 1.291 under Non-destructive Aggression).

It is especially during the second half of the first year of life that a marked increase occurs in the development of the skills that pertain to cognitive functioning. Responding to the children's explorations, parents engage in games such as naming parts of the body, a valuable activity we shall talk about in the section on child rearing. Little by little the infant begins to discover that when he or she pushes something it may move, when he or she strikes another child that other child will react in a certain manner which sometimes surprises the striker, and indeed sometimes pleases him or her sufficiently that the child will repeat the striking. To a degree, 11 month old Jennifer's pulling 11 month old Johnny's pacifier from his mouth repeatedly was this kind of discovering activity. She found that indeed it created quite an effect: Johnny got upset, people around were surprised, and her mother got angry and showed much disapproval of this behavior (see Section 1.261 and Section 1.292, under Setting Limits). Here what seems to be at play is the child's learning his or her first principles of physics and social behavior: that when you do something there is a reaction to it. With this discovery of causal effects (causality), comes also the consolidation of intentionality. Intentionality means to do something with a wish to do it; it is a pre-thought act.

Mental Representation:

Each of us becomes who we are by virtue of the actions of experience on our inborn givens, on the temperament and the dispositions with which we are born as these are programmed by our genes. How we record our experiences within our minds (and psyches [souls]) is very puzzling. How our experiences become inscribed in our brains and can be remembered more or less reliably is not fully known. We know that we remember information, events, etc. There would be no learning without remembering. Furthermore, without experiences being somehow inscribed in our brains, we would not become individuals with definite personality characteristics that would basically be the same from day to day, month to month, and year to year. New stages of development bring about evolving changes in each of us, always increasing the complexity of our personalities. So do experiences impact on each of us, some changing us dramatically. These changes nonetheless occur on and modify the core of our self that stabilizes gradually over time.

Mental health professionals and brain researchers propose that our experiences become somehow inscribed in the brain. We speak of these simply as "internal (or

mental) representations." These internal representations make it possible for us to remember things and events. We believe that mental representations become organized in the mind in several basic ways: (1) by certain experiences occurring regularly and frequently which then begin to be expected and even predictable. Thus an infant records an event of mother tending to the infant in some detail. As this type of event is repeated in a similar manner, that recording is repeated. If we assume that the same scene (or "schema" Piaget proposed) is repeated, it will become increasingly stable and predictable by the infant. (2) Events that are sufficiently different from what is expected, by the element of surprise, get particular attention and thereby become registered in the brain. And (3) events that elicit an intense reaction, whether the reaction is pleasurable or unpleasurable (painful), will also become recorded. The element of surprise may also play a part in recording especially intensely unpleasurable experiences.

Either as a second type, or more likely, as a component piece of scenes that are recorded, key pieces or units of experience become recorded which can be retrieved by remembering in varying combinations. For instance, when the 2 month old's social smiling first elicits a loving, cooing, smiling response from the mother, we may assume that the memory of smiling at this person who smiles and coos lovingly is recorded. As this interaction occurs again and again, by 5 months, the representation of this piece of experience will be well engrained in the mind. And it will readily be remembered when the infant sees the face that belongs to this unit (piece) of experience. Similarly, if a 2 month old's social smiling response does not elicit a smiling response but rather elicits a frown or no response at all (say in a disturbed mother, or an indifferent caregiver), this frowning response will feel opposite to the smiling infant's feeling and will dampen or extinguish the infant's smiling response and feeling. So will the non response of the indifferent caregiver. When this experience repeats itself, this is the unit of experience that will be recorded in the mind. So too, smaller pieces of experience will be recorded such as the milk bottle or the breast as a source of gratification.

These respective mental representations of interactions with mother and father accumulate and organize into the infant's progressive mental, emotional attachment to his or her caregivers. The first infant (of the paragraph above) is more likely to form a secure emotional attachment. The second is more likely to form a negatively experienced attachment. It is the cumulative factor, the repetition of experience that becomes re-recorded (or re-enforced) in the mind (and brain) that gives to the child's attachment its predominant emotional quality. Research suggests that the infant records experience from birth on. By 5 months or so the infant has developed the capability to record stably enough in his or her mind the representation of his or her primary caregivers so that the infant can distinguish them from other persons.

We believe, as many psychoanalysts and attachment theorists do, that infants are born with the need for form attachments, to become emotionally engaged with reciprocally emotionally engaged caregivers (usually the parents engage to this degree with infants). This need and tendency to attach is powerful. This is why when the mother leaves her 6 month old infant even if for only 1 hour or less, that the infant will experience separation anxiety, the dread that the person to whom the infant is attached will be lost. We believe that what makes the 6 month old feel the dread of loss is, as we shall explain in a moment

(under the development of memory), that the infant cannot yet retrieve from his or her stored memories of mother the mental representation of mother on his or her own.

So too, the 6 month old, who at this time is accumulating and stabilizing, in his or her brain the mental representation of his or her primary caregivers (those to whom he is attaching emotionally) will at times be jarred when he or she looks at someone who is not one of these caregivers. What is jarring, we believe, is the experience of looking at a person, expecting to see the face of mother or father or a well known substitute caregiver, and "recognizing" that this person is not the one expected. That this is not one of the faces expected seems to make the infant feel threatened that the expected one is lost. In this way, the stranger response (a response of anxiety) bears a resemblance to separation anxiety. Also, the stranger response is the infant's social reaction to an unknown face whereas the smiling response is the infant's social response to a known and emotionally invested face. So too positive reunion response is elicited by the re-finding of the mentally represented face which has been temporarily lost. In all of these experiences, the mental representation is a key player. But when can the infant retrieve mental representations? That is, when can the infant begin to remember?

The Beginnings of The Development of Memory:

Piaget and his students have taught us that the beginnings of memory seem to occur in at least two steps. First, to appear is recognitive memory; the second is evocative memory. Recognitive memory, as the word suggests, means that the infant recognizes a person, an object or an event he or she has seen or experienced before. This is most readily observable in relation to the person to whom the child is attached; for example, when that person appears, the 6 or 7 month old will react with a social smiling response, typical of a positive reunion reaction. This smiling response tells us that the infant has in his or her mind, some form of stable memory which includes at least a visual component as well as an emotional component of the mother. On seeing her, or on hearing the mother's voice, the child's specific social smiling response tells us that the child recognizes it is his or her particular mother.

This recognitive reaction should be distinguished from the earlier social smiling responses which are nonspecific, and which, as we described in Section 1.251, are an inborn reactivity to a facial pattern. It should also be distinguished from the even earlier fragmentary smiling responses of the one to three week-old infant to the human voice or to the touch to which the infant has been conditioned. Piaget was able to show that the infant develops recognitive memory by experiments we will not describe here, but which can be discussed and repeated by high school students.

Whereas recognitive memory seems to become evident from about the fifth to sixth month of life on and, of course, continues to consolidate, evocative memory seems to develop gradually from about 14 to 18 months of life on. Studies of some of Piaget's students, however, show that a certain specific type of evocative memory (person permanence, which is remembering a person rather than a "thing" or object) can already begin to appear from about 11 months on. Evocative memory means the ability to retain an image of something which one has seen before and which at the moment of

recollection is not in one visual field. Because of this capability, a child can search for a particular object and can pursue looking for it until he or she finds it, even when that object is not visible at the start of the search. Being able to record in memory the image of something that one has seen before and to retain that image in the mind without having to see it is a highly important development. When we speak of this phenomenon and its further developments during the second year of life, we will use the terms proposed by Piaget which are person permanence and object permanence.

Remembering a past object, a past event, or a past experience that is not visible or in the present is vital to the development of intelligence.

1.322 CHILD REARING: Optimizing the Child's Developing Intelligence

Many parents recognize that they are their child's first teachers. Many parents realize that their less than one year old is developing intelligence: parents often comment about how really smart their 6 month old is, or they worry that their infant is "slow". Nonetheless many parents do not see that the beginnings of true learning do not wait until the child goes to school, but become visible from the first months of life on. Most parents rightly know they can and many wisely enjoy and try to facilitate and promote the development of intelligence in their less than one year old children. Here are some of the major areas where and ways in which they can do so.

The Beginnings of Communication, of the Dialogue Between Child and Parent

The normal infant comes into the world ready to react and even to initiate interaction with his or her caregivers. Even in the first days after birth the infant signals by sounds of complaint and crying that she or he needs to be cared for and reacts according to whether or not the caregiver succeeds in meeting sufficiently the infant's needs. From these earliest days, patterns of communicating and responding to each other begin to be set. The infant can be conditioned (a simple learning process) to the way his or her primary caregiver(s) meet his or her needs, responds to his or her signals, and soon begins to "know" what to expect. Parents can already convey to the infant: "You can count on me (us) to help you meet your needs as best I (we) can, because you are very important to me (us)". Unfortunately, the weeks old infants can also be conditioned to the message: "Are you fussing again! You really are a greedy, bad baby. Don't expect me to come running when you cry, you spoiled brat!" The quality of the dialogue will be very different in these two instances; one will lead to a loving dialogue and the development by 6 months or so of basic trust (see Section 1.271); the other is likely to lead by age 6 months to an emotional dialogue that is heavy with hostile feelings, resentment, and basic mistrust.

All our illustrations come from live children and families with whom we have carried out research or a few come from clinical situations. We have modified some facts to protect their identities. But here we want to use an illustration that comes from a TV

commercial that has been played for several years now which unusually sensitively illustrates the developing emotional dialogue between an infant and parent. A father sitting in a rocking chair in night clothes is holding and bottle feeding his probably 3 month old daughter. He is softly singing a lullaby to her. As he gently sings to her, at one moment, nipple in her mouth, the infant hums too as she is looking into her father's face, for about one second. The moment of togetherness, the communication between father and infant daughter, is tender -- and this becomes part of the dialogue between them.

From these simple but enormously important beginnings, parents can secure the development of an emotional dialogue that will become typical for them. Jennifer and her mother, Diane and her mother and father, Johnny and his parents, Doug and his mother and substitute caregiver, all had quite good, quite positive beginnings to their emotional dialogues. For Bernie and his mother, their emotional dialogue started very well but became abruptly distressed when he began to have his milk allergy. Fortunately for them, mother could ready his feelings pretty well and, we believe, made this problem as minimally disruptive of their interaction as could have been done. This was even further complicated by the unpleasant atmosphere in the home between Bernie's parents who separated when he was 6 months old. For Suzy and her mother and father, their beginning emotional dialogue was very difficult. All mother and father's efforts to help Suzy feel good were defeated by her large difficulty to be calmed and made to feel comfortable. Suzy's mother especially earned her daughter's trust, and our admiration, by her wonderful efforts to make her feel as best as she could. Mother also did well to select and work with Mrs. Sander, Suzy's substitute caregiver when mother went back to work, to insure as positive as possible an emotional dialogue between them. Suzy's emotional dialogue with her father was much more limited because of his lesser involvement with her, but seemed on the whole to improve as time passed. For Ritchie, his emotional dialogue started out very well. Picture of him at 5 months revealed this clearly as his look into the camera showed him to be comfortable, broadly smiling, pleasantly interactive and communicative. This changed dramatically and by 14 months he interacted very poorly. He was then sad, angry, even explosive in interaction and very mistrusting. To regain a better emotional dialogue, his great-aunt and their neighbor had to be patient, try to sympathize (which they did) with his awful pain, and draw out his communications in ways that would make him feel he now was safe again. The recovery of trust was slow and incomplete by the time they stopped coming to work with us.

Victor developed 4 meaningful relationships, with his parents and paternal grandparents. The emotional dialogue with his mother and grandfather was especially tender and trusting. The one with his grandmother was solid and trusting as well but did not have the notable warmth he seemed to experience with his mother and grandfather. With his father there was trust but more distance during the first year, in large part because father's work hours were very long and their contact and communications quite less than with the others.

Again, we emphasize the need for a good-enough emotional interaction and dialogue to optimize the development of communication, of talking, and the ability to interact, to expect help and learn from others. Needless to say, the quality of the emotional dialogue

between child and parent(s) will be part and parcel of the type of attachments the infant makes and therewith, the ways in which experience influences the development of the child's inborn personality dispositions.

Exploratory Activity:

From the first weeks of life on, it is easy to see in normal infants who are well-enough cared for, that they begin to explore the environment in which they live by means of their eyes and their ears. When awake and sufficiently fed and rested, from the first weeks of life the infant looks about, responds to sounds, and thus we see that he or she begins to pay attention to, to explore her or his environment. Then by 3 to 4 months, the baby also gradually reaches to touch things and mother's face with his or her hands. As weeks go by one finds that he or she explores not only the external environment, including mother or father's face and things within reach, but also explores the self including especially the hands and feet. By 5 to 6 months when things can be reached and grasped, the infant will bring them to his or her mouth for closer exploration (see Section 1.281).

The infant who is sufficiently fed, nurtured and comfortable during states of wakefulness will have time and the energy available to explore his or her environment and will do so with visible interest and a positive degree of feeling and well-being. The infant whose needs are not tended to in reasonable ways, whether he is hungry or feels neglected -- as we saw in Ritchie -- will be compelled to respond to the internal stresses and pain he or she is experiencing, and will do so with negative feelings and ill-being. This child will not be able to be positively attentive to the external environment and will focus his or her interest and energies in having his or her needs met. The infant who is crying is predominantly attentive to the source of the crying, to the pain and to its stopping. For the child to learn about his or her external environment other than that part of it that cares for his or her needs, and experience this learning in a positive way, it is important that the infant be free enough from the clamor of inner needs for enough of the time. In this of course the parent plays the central part. Here too it is well to remember that the infant has needs not only for food, fluids and to be properly clothed, but also has emotional needs for being held, being interacted with and be comforted.

This early exploratory activity is the first evidence of the infant's being a student of his or her own body and of the world in which the infant lives. The parent who recognizes this tends to automatically assume the function of teacher and help the infant learn about the environment. Very common in the first year of life are the parent's efforts to teach the child names of parts of his or her own body. Games of this kind are virtually classroom games. The important thing is that they are the beginning of learning and it is highly desirable that they occur under conditions of pleasure in the child's interaction with the mother (and father).

The Infant's Level of Interest:

Closely observing parents will also recognize that the infant does not have an equal interest in everything that comes into the child's visual field or to his or her ears. For

instance, the mother's voice seems to get the young infant's attention and interest more readily than others. Sounds of trains passing by, crashing sounds of things falling quickly catch the infant's interest. Sounds that are too sharp can be frightening, though. An environment that is pleasantly colorful may draw an infant's looking activity more than an environment that is drab and dark. Therefore, providing an environment that is reasonably well lit (too much light is also troublesome) and that is pleasantly colorful will probably enhance looking activity and interest. Especially engaging and eliciting of interest, is the parent's interaction with the baby in some of these exploratory activities. Again, the parent's playfully teaching the infant names of parts of the body heightens the infant's interest in himself or herself, in parts of his or her body, and in the very important development of language.

Causal Relationships:

Whether they know it or not, parents can be their children's first teachers of physics and logic. Principles of physics and of logic help human beings organize their thinking, understand better the world in which they live, and adapt more easily. At the very beginning we assume that children do not know that if they push something it will move. One finds that the infant gradually makes this discovery. The parent has ample opportunities to make this discovery easier for the infant, thereby helping the infant learn causal relationships between the child's own actions and the occurrence of the resultant event. For example, when a 10 or 11 month old child begins to toddle, it is well to point out that when the child bumped into a table it was not because the table hit the infant, but rather because the infant walked into the table. We are all acquainted with the distortion and misinformation parents convey to their children when they blame the table for the infant's walking into it. This kind of lesson distorts facts and can confuse children. It is more useful to help a child learn to watch where he or she is going rather than expect that a table will magically move and strike an innocent child. The parent can understand the implications of this lesson for the child's own caretaking functions. When a year or two later the child decides whether or not to cross a street it is important that the child knows that what makes the child cross the street is the child himself, and not the street.

Magical Thinking:

Child developmentalists believe that very early in life children can more easily be made to believe things that are false. It is well known that young children can be made to believe that things can disappear magically or that by wishing it, things can magically happen. Much of this is due to the young child's inability to know what is possible and what is not possible. This function of "testing reality", by which we mean to know what is real and what is not, actually develops fairly slowly over time. Some elementary school age children still show evidence of being uncertain whether or not things can be made to disappear or magically appear. This is why they are so fascinated by "magicians" and why magicians are so entertaining to them. But no one is more unable to test reality well than the less than one year child. This is why we discourage mothers

from sneaking out while their infant is not looking -- because he or she may become anxious and believe that mother has disappeared. Some mothers want to protect their infants from feeling separation anxiety and crying when mother has to go out, and feel they will help their child if they quietly sneak out. Not true. The harm it can cause is far greater than the hurt of separation anxiety. This is because a mother's sneaking out is like a disappearing act and re-enforces the infant's belief that "Poof! mother can disappear." It makes the infant more vigilant, more clinging, more ready to experience separation anxiety and it undermines the child's trust in his or her caregivers and, therewith, in himself or herself. When a mother or father has to leave the infant for a while, tell the baby, make sure the substitute caregiver is ready to help the crying baby, say when you'll be back, kiss the baby, and go.

The Development of Memory:

Of importance here with regard to child rearing is not so much the ways in which parents can help their children's memory develop better, but rather that there is much evidence that the development of memory begins from the first months of life on and that the implications of this finding are of large consequence to the child's development. Contrary to what many people have believed for a long time, infants do record in their memory the quality of experiences they have from the beginnings of life, from the first weeks and months of life. Knowing that children remember from early on in life, will help parents to reasonably protect them against traumatic experiences. It is a serious matter that many parents convince themselves that infants will not understand what occurs around them, and therefore allow for all kinds of traumatizing events to occur in the presence of children, wrongly assuming that these will have no impact on them. Sounds of angry fights, of terrifying noises, handling that is especially pain producing, all of these may have an impact, be recorded in memory by the infant, and remain with the infant to produce pain for many years later.

1.3 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

1.331 HUMAN DEVELOPMENT: The Development of Self and Human Relationships

How one experiences oneself and who one becomes on the one hand, and how we experience and form relationships to others, evolve hand in hand, influencing each other equally. Some people think mistakenly that a person spontaneously becomes an individual and that this is best achieved by being independent from others even from the beginning of life. Many other people, however, including child development specialists, have come to recognize that there is a parallel and reciprocal relation between the development of the self and our relationships to others. Erik Erikson, reflecting this principle of parallel and reciprocal development, said that the development of basic trust means the development not only of one's trust in others but equally of trust in oneself. We have all heard one time or another the statement that respect for others starts with respect for oneself. In short, the development of a healthy self goes hand in hand with the development of our relatedness to others and ultimately concern for and consideration for others.

Because mental health professionals have found the development of a healthy emotional life to be dependent on the child's (and adult's) relationships to those closest to him or her, mental health researchers have explored the interplay of the child's own development and the character of his or her developing relationships. Nearly fifty years of collective work by a number of child development specialists have culminated in several theories of human development during the early years of life. Among the most useful and fully developed of these to date is the theory formulated by Dr. Margaret S. Mahler which she called Separation-Individuation Theory.

Before giving an overview of the theory, let us forewarn that this is only a working model; it is not a complete theory. Furthermore, this model makes the important but limited assumption that the biological and/or psychological mother is the prime relationship of the young child. Most child development specialists in the U.S. agree on this point, although we do not exclude reasonable variations of this assumption. Let us remember that there are families and living conditions where this assumption may not be sufficient to explain how a child is reared. The assumption that the mother is the prime relationship for the young child is not a false assumption; quite the contrary; but it is a limited one. Now, then, to an overview of Mahler's theory of separation-individuation.

The Theory of Separation-Individuation of Dr. Margaret S. Mahler:

Separation-individuation theory holds that over the course of the first three years of life, the infant progresses from experiencing the self and the mother as one unit, as a twosome (dyad) enclosed as if in a unifying membrane, to experiencing the self and the mother as two separate distinguishable human beings related to each other in a deeply

meaningful emotional relationship. Of course, we cannot know for sure what infants experience because they cannot tell us what they experience or think. But many years of infant observations leads us to infer and assert that Mahler's theory represents well how the infant experiences himself or herself in states of need and in the relationships to prime caregivers. This process of going from feeling one with mother, to recognizing self and mother as two separate individuals, can be subdivided into several phases and subphases.

The first of these is the phase of one-ness with the mother, which Dr. Mahler labeled that of symbiosis. The second is that phase during which the one-ness with the mother becomes transformed into an emotional relationship that binds the self with the mother but as two separate, individual beings. This second Mahler has labeled the separation-individuation phase. The phase of symbiosis begins during the second month and spans about the first ten or so months of life. By symbiosis Mahler does not mean, as the biological term implies, that the mother and child are mutually and beneficially dependent upon one another; rather, Mahler means that the infant seems to experience the mother and self existing as one entity, as if enveloped in an emotional membrane.

The phase of separation-individuation begins around the middle of the first year. It thus emerges at the height of the symbiotic phase. The separation-individuation phase then spans from the latter part of the first year of life and the second and third years, to about 30 to 36 months. None of these figures are absolutes, since each child has his or her own schedule of development; these are given as an average.

The Phase of Symbiosis:

Dr. Mahler proposes that during the first two months or so, before the phase of symbiosis begins, the infant in essence tends to experience all events as emanating from and about herself or himself. We assume that the infant cannot yet form ideas about his or her experiences and perhaps cannot yet distinguish what is inside and what is outside the self. Nor does the infant distinguish what is the self and what is the other person who responds to him or her at times of hunger, and from time to time cuddles, holds and warmly communicates with her or him. In a simplified way of putting it, it is as if the self and the world around were all part of the self. The 2 month-old infant does not have in his or her mind a clearly representative image of the self at all. Many child development specialists assume that during the first 3 months of life, the infant begins to organize and register in the brain not images of the self but only some representation of inner experiencing, especially of feelings.

From about the middle of the second or so month on through about the tenth month is the actual phase of the symbiosis. The way Mahler uses the term symbiosis, meaning that the child experiences the self and mother as if the two were in one unifying membrane, we could propose that the major mental representation of the self and of the mother (or other regular caregiver) at this time would consist of a unified "self - other" or "me - mother". During the course of these first ten months an extremely important development occurs which we have already talked about in Section 1,251 but which we now would like to bring into the context of the child's development of the child's emerging sense of self and of relationships. That is the phenomenon of emotional

attachment on which so much of the child's personality development depends.

A number of researchers have worked arduously and contributed significantly to our understanding of how during these first ten months the infant comes to feel emotionally connected to and establishes the all important relationship with his or her mother. Of these we shall refer especially to the work of

Dr. Rene Spitz and Dr. John Bowlby. Their research, but especially that of Spitz, led to ideas and concepts that fall very well in line with those of Dr. Mahler. Focusing on how the child establishes a emotional relationship with the mother during the first eight months of life, Spitz proposes three phases in the development of this process. First, during the first two months or so, the infant experiences everything as coming from an undefined and all-life-encompassing sense of self. During the second phase the infant begins to respond to the external environment in a highly specific manner, which is signaled by the emergence of the nonspecific social smiling response which we described before (see Section 1.251). This response emerges from about the middle of the second month of life in some children to about the 4th month of life in others. This second phase which gives evidence of beginning attachment, goes until about the 6th month or so, each child varying to some degree from others, until the time when the infant clearly now identifies the mother as a specific person and shows evidence of preferring her over other persons.

This point is signaled by the specific social smiling response which tells us to whom the child responds most intensely and meaningfully. For example, in Section 1.251 we described how studying 6 month old Jennifer's social smiling responses, we graded her social smiling response for her mother to be a +6, a +4 to +3 for siblings and several individuals well known to her and 0 smiling response for persons Jennifer did not know. Thus over the period from about five to eight or so months of age, she showed evidence of having sorted out from the experiences in the environment, a face, a mosaic of smells, feelings, and modes of handling of that one person to whom she became most strongly attached, with whom Jennifer had begun to make that vital emotional attachment. Similarly we later found her to also have a unique attachment with her father, and a well stabilizing attachment with her siblings and others frequently experienced by her.

In Section 1.251, we detailed those valuable indices which help us know how the process of attachment is taking place. We have just mentioned the social smiling responses, especially as it progresses from being nonspecific to becoming specific and selective. Let us add again that the stranger responses help us sort these things out too. A stranger response in essence tells us "this is a person I do not know at all, in fact a person who causes me distress."

The two other important indices that help us sort out and affirm the establishment of attachment to the prime person, are the separation and the reunion reactions. As we have explained before, the separation reaction might be said to mean, "I don't want you to leave me now, your leaving me scares me". The positive reunion reaction could mean "I'm so glad to see you, its wonderful seeing you"; whereas the negative reunion reaction could be said to mean "Where have you been, I needed you; I am very angry with you for having left me". All of these indices help us determine when the child has formed that very special, strong, emotional relationship with a specific person.

At this juncture in the child's development, at about six to eight months of age, the child is still experiencing that very special relationship with mother, a symbiotic emotional relationship Mahler proposed, as if self and mother are part of a dyad that is bound by a common membrane.

While the infant is developing this emotional relationship, other factors essential to his or her development are maturing, including the ability to recognize that even though mother and self are experienced by the child as if in a common membrane, mother and self are separable individuals who do from time to time move apart from one another. And one can see this in an infant who is comfortably fed and rested and is then content to be by himself or herself, busily looking around exploring his or her surroundings. The infant's growing intelligence also begins to help him or her sort out that certain experiences and feelings comes from within the self, from inside, and others come from outside the self. This development especially helps the infant begin to sort out the universe around him or her. Of course, the development of the ability to assess what is actual reality takes a number of years; at this point it is beginning.

The Beginnings of Separation-Individuation:

From just before the middle of the first year, at the height of the symbiotic phase, the infant begins to push away from the mother from time to time in several ways. First, by crawling away from where the mother may be located. Second, at times now, when the mother is holding the infant, he or she seems to be pushing away from the mother's body as if placing distance between and separating from her body. The molding seen earlier still occurs, but occurs less frequently. Mahler proposes that the infant now is actively differentiating herself or himself from the mother, and she labels this period the Differentiation Subphase.

Then in parallel with this differentiation subphase, from about seven or so months of age on, depending on the particular child's maturation schedule, the infant begins to move away physically from the mother in a rather consistent and more or less vigorous manner. This is done at first by crawling and soon by walking. This subphase of the separation-individuation phase is a highly exciting period for the infant; this is when the infant becomes a magnificent explorer of the universe about him or her. Mahler calls this period the Practicing Subphase. This is because during these periods of exploration, the infant is exercising newly developing sensory and motor skills, exercising physical and psychological systems that serve adaptation, and deriving much pleasure from their being exercised. (See Section 1.261 on Exploratory and Locomotor Activity.) As we described in Section 1.261 close observation of the infant also shows that this activity is pressured, strong, and seems obligatory, which is much suggested in the child's facial expression and total bodily efforts. In our discussions of explorations (Section 1.261) and of aggression (Section 1.291) we proposed that the tremendous inner pressure that causes this kind of activity is one which makes the child as much the victim of that inner pressure as the mother, and commonly leads to battles of wills between them and makes it necessary for mother to set limits on that activity.

But we must emphasize here that, although the young explorer looks as if he or she

has now totally separated from the mother, and seems to now be a totally independent young creature, individuation (becoming a separate individual) is not as complete as it appears. Because of the children's reactions to the absence of the mother, the crying during separations, stranger responses, and reunion reactions, we know that the work of individuation (feeling stably secure on one's own) is only beginning. The less than one year old infant at moments very sorely needs to feel the presence of the mother. It is quite true, that there are moments during the child's exploratory activities, when the less than one year old gives the impression of being totally self sufficient and of needing no one in the universe. As we shall describe further when we talk about the second year of life, this apparent individuation, apparent independence, is not yet a true one. We say this at this point because some mothers become alarmed when during the middle of the second year, due to normal developmental processes, the child needs to cling to the mother again somewhat as the child may have during the third, fourth and fifth months of life, behavior which, after months of seeming independence, many mothers find disconcerting. These mothers seem to experience and indeed say, "But she or he looked so independent six months ago and now she or he is a little baby again.

" We shall describe and discuss the reasons for this seemingly regressive activity when we talk about it during the second year of life.

Hierarchy of the Child's Earliest Relationships:

How important each member of a family is to the less than one year old child varies. We have assumed in the above paragraphs that in usual circumstances, in a family that consists of a mother, father, and one or more siblings, that we find the mother to be usually most valued by the child during the first year of life, then the father, then the siblings and individuals with whom the infant is quite familiar. As we indicated earlier, the model that we are using makes the assumption that the mother is the individual most emotionally and physically available to the young child. But there are variations. In fact, the experiences of each child vary, perhaps even widely, depending on a number of factors including the degree of emotional valuing and involvement on the part of the mother, the father, siblings, etc., as well as personality factors in each of the parents. There are instances where a father may be more nurturing than the mother resulting from their respective individual earlier life experiences. Also relevant, is the emotional and actual physical availability of the parents, as when the father cannot find a job or prefers to not have a job outside the home and stays home to care for the children. In such instances the father would be more available to the infant than the mother and this will variously impact on the earlier child-parent relationships. Also, conditions surrounding the birth of a child, as various types of traumas, may interfere with a secure child-mother attachment.

However, on the average, during the first year of life, the biological unity of the child and mother, plus basic psychological and continuing biological factors in the mother, give priority to the mother-child relationship over other relationships during the first year of life. In addition, as we said before, a relationship is also established between the infant and father, depending especially on the father's degree of involvement with the baby,

especially the degree of his emotional involvement. Relationships to siblings also begin, depending on the degree to which siblings become involved emotionally with the infant. While it is essential that the infant form a deep attachment with at least one constant person in his or her environment, deep attachments with several other persons does not detract, does not weaken, and may, in fact, enhance the development of deeply meaningful relationships. Our observations to date suggests, however, that a higher priority emotional attachment with one individual, most usually the mother, seems typical for the child under one year.

In fact, the relationship to the mother is commonly so important to infants, that even when a father and older siblings are present, unless they become significantly involved in the care of the infant, the mother will most impact on the infant. Here is an instance of a child attaching to her depressed mother and how this attachment evolved during her first year.

When Vicki was about 6 month old we began to see that her mood tended to be subdued. She had been quite adequately reactive to events and responsive to interactions with much evidence of being a healthy, normal infant. Her own mother, a quite responsible woman with 4 other children, was overburdened and did at times look depressed. At times over-stressed, she would be impatient with Vicki's average expression of needs and tended to give her a milk bottle whenever Vicki expressed any need. There were times when mother was overly impatient and detached in her handling of her baby. Vicki accepted her mother's handling quietly, never complaining. But we noticed that she smiled less often than expected in interactions with her mother, her siblings and peers. From 7 months of age on Vicki's subdued mood began to concern us. At moments she looked sad and she seemed less involved in peer interactions and even with her mother she seemed to initiate contact less frequently than before, and quite less frequently than the other children around her. By 8 months she appeared to be depressed. Her face looked sad and stiff, her cheeks were flat, her mouth drooped at the corners. She had a vacant look and moved slowly, sluggishly, and minimally.

Because she presented the picture of a depressed infant we began a course of psychotherapy with the infant and her mother. Mother had been unaware of the fact that her daughter was depressed -- what we call an "anaclitic depression." In part it may have been due to the fact that mother herself was depressed. In twice a week treatment, both infant and mother improved gradually and good recovery of both occurred by the time Vicki was 3 years of age.

During year one, Vicki's affect had gradually become less cheerful and smiling, and more and more subdued, then sad and eventually depressed. Her mood was depressed; her well-being painfully poor.

Vicki's attachment to her was quite age-adequately developed and stable even though the quality of this attachment to mother was sad and poor. Vicki's trust in mother and in herself seemed poor. Her lack of demandingness, her passive acceptance of what mother gave her, led to us to feel that she did not expect to be reasonably gratified and lovingly taken care of because these just did not happen.

The consequences of being brought up without a mother or parents, as occurs in institutionalized upbringing or in socialist type of group upbringing, are not yet fully

clear. Studies going back to the 1960's, of infants in institutions such as orphanages have long shown strongly negative consequences of not forming an emotional attachment to one specific caregiving person; the absence of such a singular and emotionally meaningful attachment is seriously detrimental to the development of a number of aspects of personality which can have a life long influence. More study is required of those forms of group upbringing as occurs in a number of countries including Russia and other countries that once formed the Soviet Union, China, Israel, and others where children are reared in small groups and in nurseries.

The effects of daycare in the U.S. and in Europe on children one year old or less have been studied for years. Because many factors influence the outcome of daycare experience on very young children, the results are difficult to evaluate and much controversy exists. Major concerns lie in (1) the number of hours per week children less than one year old spend in daycare -- 20 hours per week seems a common cut off point thought by some researchers to produce detrimental effects; (2) the quality of care in daycare; and (3) the quality of the parent-child relationship(s). In general, the findings, which are still uncertain, suggest that infants between 3-12 months should be in daycare less than 20 hours per week; the better the care in the daycare center, the more favorable the outcome; and the better the attachment and the relationship between the child and his or her parents the less the likelihood that daycare will cause the infant harm. Much more work needs to be done to truly evaluate this complex issue.

In speaking of the hierarchy of the earliest human relations, having now commented on that hierarchy for the first year of life, let us briefly comment on later relationships. During the second, and even more so, during the third, fourth, and fifth years, where the father is present in a family, the father can take on a meaning equivalent in importance and in value for the child to that of the mother. It is especially from the second year of life on that the father begins to be enormously valued by the infant and can serve to enrich the child's early development side by side with the continuing important part played by the mother. During the third, fourth and fifth years siblings also begin to take on a notably important part as co-players, peers and models for the younger child; their playing together and their relationship can be quite enriching for the individual child.

We might emphasize at this point, that the prime tasks of human emotional-psychological development during the first 5 years of life occur within the family. Under average expectable conditions, it is in the home, in working on the principal tasks of the first 5 years of development which we are addressing in this curriculum, that the largest emotional and psychological growth takes place. It is the psychological adaptive work required of children by experiences in these early relationships that most contribute to personality development in the child. It is for this reason that the current trend toward getting children into schools at earlier and earlier ages (even less than 3 years of age), and the use of day care centers for infants even less than one year old brings some concern among many mental health professionals. The issues are complex and the challenge of doing justice to children and parents alike continues to need our attention. For now, we must recognize that the prime tasks of human emotional and psychological development occur in the context of family relationships. If this is disregarded, it may deprive children of the opportunities they need to master the basic tasks of emotional development.

1.332 CHILD REARING: What Can the Parent Do That Is Growth-Promoting Regarding the Child's Development of Self and Human Relations?

We have attempted to impress on the student that the development of the self is intimately and directly influenced by the quality of the child's human relationships. In this, it is important that parents secure and protect two parallel developments: that of the self, of the child as an entity with her or his own needs, feelings, thoughts, and boundaries; and that of the child's relationships to the parents--which will pave the way for later relationships to others. Let's first talk about the parents' helping the child begin to become a self during the first year of life, and then about the parents' helping the child secure growth-promoting and gratifying relationships.

A good sense of self can be fostered in simple common sense ways. Reasonably prompt and warm responses to the child's signals for help convey to the child a sense that he or she is valued. Playing with the infant, using his or her name when speaking to him or her will help build a sense of identity. Helping the infant in her or his struggles to do something on her or his own (reach for a toy, stand on her or his feet) will help the child see himself or herself as someone who can do and accomplish things. Siblings as well as parents can invent many ways to help the infant discover who he or she is and what he or she can do.

Let us now turn to how the parents can help the child's developing human relations. In speaking about attachment we have talked about how parents can help by dealing and responding to the child's social smiling responses, stranger responses, separation and reunion reactions. The parent can use these indices of attachment to sort out to what degree the infant is forming a sufficient relationship with the parents. We repeat that separation anxiety and stranger anxiety in the 5 - 6 month old child is not only a normal development, but a desirable one, because it indicates a meaningful degree of attachment to the specific mother and father. If there is no social smiling response in a six month old child, as we have indicated before, it should alert the parent to some problem which needs to be professionally evaluated. We urge that parents ask questions of qualified mental health professionals if they have doubts about their child's attachment reactions, since deep attachment is essential to healthy development.

The quality and the quantity of relating to the child are both important in the formation of good relationships. With regard to how much time parents need to spend with a less than one year old, we often hear that quantity of time spent with one's child is not enough, that the quality of interacting with one's child is critically important. That statement is absolutely right; the quality of the child-parent interaction is extremely important to the character of attachment and to all those developments which are influenced by it. But we must also add that a minimum quantity of such good quality time is needed too. In other words then, a sufficient amount of time has to be spent by the parent in the relationship with the child, and good quality, although extremely important, is not enough in and of itself. The parents' time, affection, and interest in their

own child are more valued and needed by children than gifts of toys, candy, entertainment, etc. Very important issues come up when one considers the quality and quantity of time spent by parents in the relationship with their children. It is better to spend less time with the child if that time is mutually gratifying to the parents and child, than it is to spend more time together with resentment or the parents' feeling constantly trapped, deprived and frustrated in needs the parents have in other areas of their lives. In the section on parenting for the first year of life (following this section) we will take up this point and describe some of its details more extensively.

We want to look here at what the parents of the children we have talked about in this Unit did that, generally speaking, was growth-promoting on the one hand, and was growth-disturbing on the other, during their child's first year. Specifically, what did they do to optimize or trouble their child's developing sense of self and of relating to others.

Jennifer at 12 months was doing very well with respect to both of these developments. Mother, whose input we knew better than father's, -- as was the case with all the children we saw in our project --, was quite comfortable with her role as a mother. Jennifer was her 4th child. Mother clearly took pleasure in her daughter's inborn spunk, interest in the world around her, and determination. Mother had much of this in herself too. We thought her liking this in her child most likely facilitated Jennifer's experiencing of these feelings which clearly contribute to one's sense of self. Mother had a nice way of being able to be firm with spunky Jennifer without becoming hostile; she could be firm without putting her daughter down or being otherwise destructive. She could comfortably get annoyed and angry with Jennifer perhaps because it seemed to never get out of hand. Actually, even though Jennifer seemed to have a mind of her own from very early on, she did cooperate well enough with her mother and seemed to know, to learn, when her mother would not back down. Probably the strongest factor that made their interactional challenges work out well is that their emotional dialogue was so positive. It was clear that mother loved Jennifer, took her seriously, responded warmly and well to her needs, often cuddled her warmly and enjoyed Jennifer. Mother also responded well to our explanation of her child's behaviors and had a very good feel for what to do with her daughter once she understood what Jennifer's behavior might be about. By the end of year one, Jennifer's mood, her activities and interactions suggested good basic trust and a secure feeling about her sense of self. And Jennifer's relationships were good. This, we learned, also included her relationship with her father even though he was not as involved with her care as some of the other fathers. Her first year was very good.

Much of the same can be said for Diane and her parents, but there are some differences. Mother who had been depressed (for several reasons including her own mother's death at mid-pregnancy) was really thrilled at having a daughter to add to her two sons. So was father who had been in the delivery room during Diane's birth. He too was thrilled about having a daughter. Diane was a well put together baby who, like Jennifer, ate well and was quite emotionally responsive. But she was not as active during the first 6 months as Jennifer was. She explored more by looking than by getting her hands and mouth onto things. She was a calm, moderately active infant in fact up to about 6 months. Attachment to mother was really very warm and secure. This, in spite of the fact that mother was still moderately depressed during the first several months of

Diane's life. But mother was nonetheless well engaged with her children, indeed very positively with Diane. We saw that this was so with father as well on the several occasions when he too came to the project. Interestingly, Diane all at once became a much more active child from about 6-7 months on, and like Bernie, gave the impression that her motor was suddenly switched on. By contrast Jennifer had gradually, progressively become more active. With this the need for limit setting began and battles of wills became more intense than we had predicted when she was 3 months old, we felt, because the aggression motor that got turned on drove her into activity with force and persistence, and it would be a matter of months and many battles of wills before Diane would get her inner pressure under some control. In fact this did not occur until into her second year and we shall describe this in Unit 2. Two major factors at least prevented the battles of wills between Diane and Mom from leading to significant problems for Diane: (1) The emotional relationship between them was visibly very loving and with this, Diane's attachment to her mother seemed very secure and basic trust was stabilizing; and (2) unlike 10 months old Diane who was by now a very assertive, vibrant and determined child, mother was a stable, gentle, soft and quietly deliberate woman who held her ground pretty well when she needed to. Like most of the mothers in our project, Diane's Mom (and father too) grasped very well our explanations for Diane's behavior that needed limits to protect Diane, and rather than getting into hostile limit setting, she did a very good job of explaining, holding the line, and helping Diane pull herself together, all in a non hostile reactivity to these difficult interactions. We shall describe what she did in Unit 2 (Section 2.242, Handling Aggression in Growth-Promoting Ways). Given her good inborn disposition, it was especially due to the quality of parents' efforts, that Diane's attachment and basic trust were good, her hefty aggression satisfactorily handled, that by the end of year one, although tension was mounting between Diane and her mother, we evaluated her sense of self as stabilizing well and her primary relationship to be of very good quality.

Johnny was also a well endowed healthy infant, born to a 36 year old woman and 38 year old man, both of whom immediately "fell in love" with Johnny. He felt like a gentle baby from the beginning. Although mother had been worried that she wouldn't know how to take good care of her baby, she and father were very responsible, patient, and loving with him which laid the foundation for Johnny's easily developing a very good attachment to both of them. Johnny responded quite nicely to the two substitute caregivers he had during year one, and seemed to not have been very pained by mother's withdrawing into her "office" at home to do her work for a few hours a day since Johnny was about 3 months old. We assume that the separation between Johnny and his mother was made less intense because she did not leave home to "go to work", she went into one of their rooms and shut the door. When Janet, the college student who took care of Johnny from 3 to 10 months, left, Johnny did have a loss reaction which showed itself in his seeming to look for her and some adjustment had to be made by him when Mrs. Clark (and her 2 kids) became his substitute caregiver. Johnny had a stranger response to Mrs. Clark which was nicely worked through with Johnny's mother's explaining that Janet went out of town, that Mommy would work in her office until 4, that Mrs. Clark would be nice to him, and she would get Mommy if it was necessary. Johnny seemed to be a

readily accepting baby. As we saw when Jennifer pulled his pacifier from his mouth, rather than letting her know she can't do this to him, he just let her do so. He was gentle and seemed a bit soft and passive (something mother and father would need to help him with during year two [see Section 2.242]). Nonetheless, although he was not able to stand up for himself as readily as is optimal, Johnny seemed to have a pretty good sense of himself and seemed to have very good relationships with his mother and father. He also had good relationships with his 2 substitute caregivers.

We have not said much about Doug in this Unit. He will appear more in later Units. For now we can say that he was a healthy newborn who was very much wanted by his 24 year old parents. He attached well to his mother (and his father). He was nicely disposed infant with a moderate level of activity and healthy aggression. Mom went back to work when he was 6 months old, 4 hours a day, for 5 days a week in her uncle's business (an office manager). Doug had a fair amount of separation anxiety which was handled well by mother, a very good, warmly responsive caregiver. It seemed to have produced no lasting problem for them. Doug's reunion reaction during year one were quite positive. All in all, Doug was developing well and by end of year one seemed to feel pretty good about himself and his relationships seemed quite good as well.

At birth Bernie was a healthy infant, was nicely reactive to his 30 year old mother and 36 year old father. He was much wanted by his mother, even though her relationship with Bernie's father was difficult, with much discord and fights between them. She had been worried during her pregnancy because she already felt she wanted to separate from his father. Father was pleased with Bernie but did not become very engaged with his care. Mother turned much attention to Bernie's care and did very well. At 2 weeks then, Bernie developed a milk allergy which caused Bernie and mother a good deal of difficulty until about the 4th week by which time the problem has been diagnosed by Bernie's pediatrician and a milk substitute eliminated his distress. Although mother initially felt it was all her fault, and got little encouragement to think otherwise from Bernie's father, the pediatrician's diagnosis, Bernie's favorable response to the mild substitute, and our finding that she was responding very well and lovingly to her baby given the stresses of her relationship with her mate and Bernie's reaction of pain and distress, all seemed to give her more confidence that she could care well for her baby. She could read his feelings well and she was superb at interacting with him in play activities as he got into the 5th month of life. Mother also dealt with Bernie's upsurge of activity and aggression which occurred at about 7 months. There was a feeling of strain in both mother and Bernie which we felt came more from the difficult relationship between mother and father, and mother's eventually demanding that 6 month old Bernie's father leave the home. His father did so after quite a scene which mother told us really upset Bernie. By the end of the year one, Bernie was developing quite well, was a busy explorer, seemed to have a good sense of himself, had a very good relationship with his mother and his trust in her was solid. We could not be certain of his relatedness with his father, although later life events told us that his father was quite important to him.

Suzy started life at a disadvantage because from birth on she was irritable, difficult to calm and showed strong evidence of some immaturity and dysfunction of her central nervous system. Her 31 year-old parents were understandably very upset but wanted

very much to be good parents. The hardship, the disappointment in the degree of difficulty encountered in caring for her, in feeding her, in getting her to sleep, created a strain between mother and father. When father lost his temper on several occasions he blamed mother for Suzy's difficulties. This unfortunately added to mother's feelings that she was being a bad mother. We welcomed being involved with them from the time Suzy was 3 weeks old. It did not take long to see that Suzy's problems did not arise from mother's being a "bad mother" at all. It was truly rewarding to see the good efforts made by mother especially, but also by father, in trying to calm her, feed her, diaper her, respond to her smiling (which was like a large ray of sunshine in between storms), and to gradually learn, as Suzy gradually became more and more responsive to their efforts, the ways that most reliably worked for her. This difficult beginning was complicated some when mother felt (by the time Suzy was 6 months) that she would have to go back to work, at least part time, and did so when Suzy was 8 months old. Fortunately mother really valued being a lawyer, found gratification in this work, had missed it, and decided that she would just work as hard as she could both there and at home with Suzy. She interviewed 2 women to take care of Suzy and liked Mrs. Sander who proved to be very good with difficult Suzy. Mrs. Sander's entry into her care was managed well; mother reacted pretty well to Suzy's rage reaction and following our recommendations, detailed for Mrs. Sander how to deal with them as we had done with Suzy's mother and father. Despite these large difficulties, we felt that by the end of year one, Suzy's relationships with her mother and father were really of good quality. Most important we came to realize how persistent her parents were in caring for her as well as they could. She could count on their being there, intent on helping her, -- and Mrs. Sander did a good job of substituting lovingly when mother was at work -- which led to her developing good basic trust. We were less certain of how positive Suzy's sense of self was at the end of year one. She experienced much pain and distress from her own body. She experienced rage reactions. These would become part of her sense of self and take away from whatever good feelings of being valued, loved, cared with love, understanding, and respect by her parents and Mrs. Sander. Fortunately, she was developing pretty well, her irritability was much less, being able to be calmed was much easier from about 9 months of age on, and she was just beginning life. With good experiences she could grow well and even overcome these difficult beginnings.

We have said much about Richie in this Unit. The severe traumas he experienced at the hands of his troubled teenage Mother during the second half of his first year had enormous consequence to his sense of self and his relationships to others. From a very healthy, cheerful, even joyful baby, who was well on the way to forming loving and secure attachments, good basic trust, at 6 months of age, by 12 (or 14 months when we saw him), he was a depressed, enraged, profoundly hurt child who seemed to have stopped growing and developing. By 14 months it was painfully clear that he mistrusted everyone, had a very poor ability to relate, seemed to not feel related positively to anyone. We assumed that he must have felt unloved, unvalued, a discarded and abused baby, and that his sense of self must have been very poor. His good beginnings seemed to be severely damaged, almost altogether destroyed.

Vicki, the last child we shall comment on here was healthy at birth. Her mother had

again had a painful and upsetting delivery (as she felt all of her 4 to have been) but seemed pleased with her baby and started caring for her well. Vicki's first two months seemed good; mother seemed nicely responsive to her. But then, gradually, mother's care became less and less tender, gentle and loving. Mother seemed irritable, terribly burdened and becoming more and more depressed, and she had less and less to give to her infant. By 6 months, mother's handling of Vicki was brusque, at times painful (she would almost smash Vicki's face when she wiped her nose, and would handle her baby roughly when changing her diapers), and disengaged from her, as if there was no contact between them. By 9 months Vicki, somewhat like her mother though more severely so, was depressed. Her relationship with her mother existed, there was an emotional investment between them, and mother never stopped attending to her physical needs. It seemed clear that mother was valued by Vicki but that there was much pain in that attachment, pain especially coming from mother's brusque handling but also, pain coming from not being cuddled, talked to with tenderness, comforted when hurting. We knew nothing of her relationship with her father. When treatment of mother and Vicki began, Vicki was a very passive and depressed infant. She began slowly to warm up to her therapist who handled her clinically very well, modeling holding and interaction for mother. Mother was, of course, also treated and she too improved very nicely in time. But by the end of year one, Vicki's relationships, focused on her mother, was stabilizing but seriously lacking the expectation of love, warm care, joy and closeness. (Fortunately, their treatment eventually changed all this as we shall detail in Unit 2). We assumed her sense of self at this time to be that of a self who does not expect to be loved, cared for with tender affection, pleasure and joy. This has to be a poor sense of self.

Hierarchy of Relationships:

Regarding the hierarchy of relationships which we discussed in the previous section, what of the emotional attachment that can develop between a less than one year old child and father? We find that where the father is included in the relationship to the child from the start, from the labor and delivery rooms, from feeding and diapering, etc., important attachments are made by children and the fathers in a mutuality that is not only useful, but is, indeed, enormously gratifying to both. Where possible, it is important to include father in the parenting of the very young infant, in fact, from before the birth of the child.

Next in line in the hierarchy of relationships made during the first year of life, are the infant's siblings. Siblings can become important and helpful to an infant from quite early on. We have seen meaningful attachments on the part of 10 month olds and 12 month olds to an older sibling as well as to a twin. Reports indicate that a 12 month old infant can miss, will search for and show signs of sadness because a sibling is no longer available to him or her (a sibling who died) to whom the infant was more attached than was realized.

As is well known, a good caregiver, a good substitute for a parent who must absent herself from the baby during the day, also can become a source of positive attachment. Varying factors play a part in how significant an attachment the infant makes to such, other than parent caregivers. For example, caregivers know, many without being aware

of it, that a particular child is in their care for only a certain number of hours during the day, that they will leave the child at the end of the day. These caregivers understandably withhold the level and degree of emotional investment that a parent makes in a baby that (comes from her own uterus and) is part of the family. We shall discuss this point further under the section on parenthood.

A question that is often addressed to us is "From how early on should the infant have playmates?" During the first year having playmates is a very minor consideration. The critical developments that occur during the first year of life, in fact during the first five year of life, occur most in the context of the child's relationship to his or her primary caregivers, foremost to the parenting figures. Indeed it is in the best interest of the child that this is where most early basic personality developments take place, since, under optimal conditions, no one has the child's best interests so much at heart and in mind as that child's parents.

1.333 PARENTHOOD ASPECT OF: Furthering The Development Of Self and Human Relationships On Optimizing The Parent-Child Relationship

As we said in the section above, the value to the infant's development of making the nuclear family relationships as mutually gratifying to child and parent as possible is of cardinal importance. This should be the central goal of parenting. The way this is achieved has been a topic of interest, concern, and discussion for centuries. Current cultural trends fortunately make us more aware than before that mothers have economic needs and/or professional, or emotional, intellectual, or social needs which are equally important to their well-being as is their need to be mothers. A complementary statement can be made regarding fathers; that fathers to too large a degree have been excluded from or seem not to have been considered sufficiently important to the child's healthy emotional development. Without taking up the complex issues that have led our culture to its attitudes regarding the roles and the functions of fathers and mothers, we are now aware that certain considerations pertinent to this issue are also pertinent to the best interest of the child's optimal development.

We propose that in order to optimize the mother-child relationship as well as the father-child relationship, the needs of each and all persons in a family must be recognized and taken sufficiently into account. In order to take into account the needs of each member of the mother-father-child triad, it is important to know what the mother's needs are. We are speaking of all kinds of needs that human beings experience, including especially emotional needs. In the section on human development pertaining to dependence, we have talked about the character of the less than one-year-old infant's needs. Let's look briefly first at the character of the needs of the mother and then at those of the father.

For most women, if not indeed all women who become mothers, whether the pregnancy was a planned one or not, having a baby is a very important emotional experience in and of itself and also has very large consequence for her own life. Our own

research and current, updated understanding of human development leads us to hypothesize that, generally, women think of, have fantasies of, and plan to have a baby from the time they are about 2 and 3 years of age. We find that the wish to have a baby is an experience that can be generalized to occur in girls during the period from 2 1/2 to 6 years of age and beyond. Because this wish produces a conflict in the child at this age, it usually becomes repressed and is then out of the child's awareness. (We will talk about this further in the Units that follow.) Nonetheless, even while repressed and made unconscious (put out of awareness), this wish to have a baby becomes an important motivator of her behavior and goals, and an important determinant of the personality of the girl and subsequently the woman.

But side by side with that wish to have a baby, to become a mother, are other components that make up the girl's evolving self-image and personality. Some of these include seeing herself grown up perhaps as a teacher, a writer, a doctor, a nurse, etc. In other words, the self-image of some day being a mother is not the only one important to the girl's psyche and personality. When a person becomes a mother, the fulfillment of that old long existing wish and component self-image is a large source of gratification. But that does not eliminate the need to also gratify these other component self images, depending on the extent to which those self images are valued by the person and have achieved importance in her experiencing of herself. In other words, a woman physician who has just become a mother may not at all stop wanting to be a physician, nor stop actively practicing medicine. If by pressures from outside or from within herself, this woman totally denies her need to be a physician because of her current very large need to be and the gratification she feels in being a mother, she may at the same time feel frustration, resentment, and anger. Because her own baby is the agent causing these frustrations, the resentment and anger that the frustrated professional woman may feel will become directed toward the baby she loves deeply. Such feelings of resentment toward the baby, because the baby is highly valued by the mother, will precipitate a conflict within her which can make her life very difficult, may hamper and interfere with her parenting and with the smooth evolving of a positively affectionate and unconflicted parent-child relationship. This conflict, therefore, will work against the development of an optimal relationship between the mother and her child.

Furthermore, when she makes valiant efforts at being both a mother and a doctor, she may experience much distress at leaving her baby, while at the hospital or office will often think of and worry about the baby, which in turn hampers her being the very good doctor she may be. It is a serious dilemma for the woman -- who has the good fortune of having two major goals of her self-image gratified but because of the demands of each cannot gratify both fully. Of course, the situation becomes even more difficult for the mother who must work outside the home not because she needs to fulfill an idealized self-image of being a factory worker or a saleslady, but because she needs to earn living money. This may be due to her being a single mother or, as is prevalent today, because the cost of living comfortably enough is so high that 2 salaries are needed by the family. In this woman, leaving her baby may be even more difficult because the reason for leaving the baby daily does not come from the gratification of an important component of her idealized self-image. This statement does require the following clarification.

Working to make a living in itself does gratify a component of our idealized self-image. We would say, in most if not in all of us. That is, in that it gratifies seeing ourselves as capable as well as responsible, caring and reliable individuals toward those we value most, our mates and children (as well as aging parents), to that degree working to make a living is emotionally rewarding. What robs it of greater pleasure and gratification than for the woman who does the work she has seen herself doing even when she was a kid, "Being a teacher like Aunt Jane", or "Being a doctor like Uncle Ben, or Mom", is that the work itself is not idealized. This makes it more difficult to work and to leave the baby.

With these thoughts in mind, we believe that it is important for each mother to develop a formula for herself which will account for and integrate the needs within herself, the needs of her child, and the needs of her mate. In this, it is best if the mother and her mate work together on developing this prescription (or formula), and if the young father can judiciously give due weight to the needs of his wife as well as his baby. From the standpoint of optimizing her relationships, the young mother must consider the needs of all three partners and give due weight to each. It is only when a mother duly gives consideration to her own inner needs and pays reasonable attention to them, that she and her mate will be able to develop a formula for the family that is more likely to optimize her own relationship with her own baby and her mate. Babies do not always need to come first nor to have all their needs always met in order to develop well, to feel deeply loved, appreciated and respected. It is so far the parents as well.

Let us comment about the needs of the father. Again, without going into the possible causes for it, we are all aware of the fact that many fathers see their primary functions as being that of breadwinner and disciplinarian in the family. Like mothers, many fathers have wanted to be fathers from the time they were two-and-a-half to three years of age. Again, child development research and clinical work teaches us these assumptions. When there is a tendency in a mother-child relationship to exclude the father from that relationship, a situation that occurs more often than seems recognized, a potentially good father feels deprived of deep wishes to be meaningful to the baby as well as to his mate. For example, we find that when fathers are permitted to be in the delivery room to witness and share in the process of the delivery, some say with excitement, some with awe, that they feel part of the process of the woman's giving birth to their baby.

Diane's father asked and was allowed to be in the delivery room when she was born. Even though this was their third child, father just "could not believe it" (as the expression goes) when he saw the baby come out of the birth canal (as we say in medicine). He just could not believe it. And he nearly fainted -- which did not surprise the nurses nor the doctor. Although he had gone to Lamaze classes with his wife, he clearly indicated by his words and feelings how drawn he felt into his wife's experience and how he suddenly, at the moment Diane came into the world outside mother's womb, he felt bonded to her. This feeling visibly continued in this father as we saw him from time to time.

Johnny's father did not go into the delivery room although he was at the hospital in the 3 day live-in arrangement this hospital had. For some time, Johnny's father was worried about how having a baby would take time away from his very meaningful work, given that his wife a newspaper writer wanted very much to have a baby but also continue with her career, and this meant he would have to pitch-in with the baby's care.

Besides, they would need mother's income since his income would continue to be quite limited for sometime to come. Despite these worries, he did feel drawn in when he felt the baby's movements while still in his wife's enlarging abdomen and he attended Lamaze classes with her. But when soon after the delivery he was called into the delivery room, he saw his drained but broadly smiling wife holding their baby, then -- half scared and half in awe -- he took the baby in his arms, he said, and he "just fell in love" with the baby. He sounded as if he had heard what pediatrician Dr. Berry Brazelton likes to say, that parents ought to "fall in love" with their babies. Although some of us prefer to reserve the phrase "falling in love" for mates, we believe that all concerned are winners when fathers feel this marvelous surge of love for their babies, which powerfully draws them into meaningful relatedness with their babies.

Unfortunately for the baby, the mother and the father, many a father feels excluded from direct relatedness with the baby, especially during the first year of life. This is the result of several factors. First is the exclusion of the father (by his own or his mate's doing) from the evolving pregnancy and the birth process itself, and then from the very intimate two-some relatedness (dyad) that naturally and normally exists between a mother and her newborn infant. This tendency in a father to exclude himself or accept being excluded is, of course, enhanced by the fact that the mother-infant twosome is biological and powerfully physically and instinctually intimate.

There are issues about which we have no definitive proof to date. One of these is that there seem to be instinctual factors for parenting that play a much larger part in the human female than in the male. It seems that mothers are equipped biologically and psychologically for nurturing infants in a way that fathers are not, and that some of this comes from biological and instinctual factors. To some these assumptions are obvious; to others, they seem insufficiently proven. It may be that it is this kind of factor that accounts for the common and natural tendency on the part of infants to develop a more important relationship with their mothers than their fathers during their first year of life, indeed perhaps during the first five years and, perhaps for the rest of life.

We have found fathers to feel pushed away exactly by this factor, that when infants are upset and in need of care, they tend to prefer their mothers during the first year of life. For example, it is common that an 8-month old child will accept father's caregiving and interactions and enjoy these. As the infant tires, however, we find as the father tries to comfort the infant, his efforts fail and the infant begins to demand that the mother comfort the child. This is a common experience, and one which causes many a father to feel rejected, to feel not important to the baby. The mother, on average, seems psycho-biologically better equipped and capable in this function, and by her baby's eighth month she has become the prime comforter. There are, of course, individual variations in that some children prefer to be held by their ably soothing fathers calming and comforting than by their tense and/or stressed out mothers, both being the way they are due to temperament and emotional factors in these parents. The more usual finding tends to be that the mother seems preferred by the young infant for nurturing and comforting whereas the father seems preferred for playful activity and rough-housing. These different forms of attachment to the father serve useful purposes that will become clearer as we talk about the child and parenting in subsequent Units. The point that we want to

emphasize here is that the father can be brought into the parent-child relationship earlier than has been characteristic for our culture, and this can be advantageous to the infant, the mother, and the father.

This discussion brings our attention briefly again to the question of the hierarchy of relationships that the infant normally develops during the first year. Although the child's earliest attachment to the mother in general tends to be greater than to the father, we must encourage fathers not to back off or withdraw from their emerging and evolving relationship to their babies.

Fathers ought to be encouraged to enhance the formation of the relationship with their baby, and can gain comfort from knowing that from the second year of life on, observations show that fathers begin to play a unique, special part which enlarges enormously the quality and the character of the child's experiences in human relations. During the second year of life, as we shall detail in the next Unit, where fathers are involved with their children in a meaningful, loving and respecting way, they begin to have a large importance for their children, an importance equaling that of the mother. Obviously the child is most fortunate where both these relationships are gratifying, loving and respecting of the child.

A Note on Primary Relationships in Contrast to Secondary Relationships:

In speaking of the hierarchy of relationships we have touched on the importance to the infant of not only a mother and where possible, a father, but also the usefulness of siblings, the relationships to caregivers and the question of playmates. In talking about the attachments of the infant to the caregiver, we made the point that there is a critical difference in the quality of the attachment the infant makes to a caregiver in contrast to the person or persons who are the child's parents. Let us clarify this here.

In the course of our work with parents and their young children, one mother expressed feelings that stated well the point we want to make: she recognized that when she takes care of one of her neighbor's children or one of her nieces or nephews, she cannot invest emotionally in those children as she does in her own. She wondered why and came to the realization that it is because, without having previously been aware of it, she felt and recognized that if she invests emotionally in these children as in her own, when it comes time for the children to go home to their own families, she would experience too much pain on separating from them.

How right she was! It is exactly this more complete emotional investment that parents make in their own children which accounts for the very important difference between the kind of emotional relations parents make in contrast to the kind of emotional investments and relationships very committed and devoted teachers, doctors, substitute caregivers, etc., make in the children for whom they are transiently and limitedly responsible. It is this large differential of emotional investment parents make in their own children that reciprocally leads to the child's forming relationships of an equivalent emotional degree with them which makes for primary relationships. In contrast, with teachers, substitute caregivers, and the like, infants form relationships of a more limited or secondary degree of emotional investment which makes for secondary relationships.

We cannot overstate the importance of the qualitative difference between primary relationships and secondary relationships.

To clarify the point further, let us add the following. In a conference of teachers, a number of kindergarten and elementary school teachers expressed much distress in being baffled and at a loss to know what to do when some of the more emotionally deprived young children in their classes turn to them for nurturing, when the teachers challenge and responsibility are to teach. These children make demands for a primary relationship in a secondary relationship setting, creating an enormous conflict and burden for the teacher. Teachers are often challenged by such children who, because of deprivations in their family relationships turn to teachers for more than the kind of relationship most students look for in teachers and their teachers are trained and set to give. Teachers will have to address this issue more and more, if things continue on the way that they are currently heading.