

## WHO WE ARE

[Editor's note: The ILAIMH Board has asked Michael to write the cover articles for our Newsletter for 2009. This is the fourth, and last, in the series. Feedback is most heartily welcome, and can be directed to [mtrout@infant-parent.com](mailto:mtrout@infant-parent.com).]

What is it that we infant mental health clinicians have to offer? What is unique about the way we collect and analyze data, about our perspective on both normal and aberrant development? When we sit in on a case consult, or begin an evaluation, what do we bring to bear that is unlike the contribution of anyone else?

### **HISTORY**

We crave the details. We actually think that every shred of the child's history—from pre-conception to the present—and every shred of the parents' histories, is of importance. We hang on the words of those who know this history; we listen with care, and we dignify both the family legends and the seldom-repeated details with our attention and curiosity. We look at people when they talk to us, and we never use forms to collect the exquisite tale. We build our questions as we go, based on the last thing said—or the last interaction noted—and never based on our own format.

### **LABELS**

We're not impressed with them, much. We prefer to *describe*, rather than diagnose. It's not that we fail to find diagnostic nomenclature of interest, and sometimes even of value. It's just that we resist reducing the data to the lowest common denominator, so they can fit the label. Of all things, we actually rejoice when the data confound the classic patterns and the diagnostic parameters. We think it's yet another indicator of the uniqueness of the developmental struggles in which all children engage, complete with their own quite individual defenses and adaptations.

### **PURPOSE**

We are more interested in *understanding* behavior than we are in modifying it—not only as a guide to the next clinical step, but even as a thing-in-itself. If a toddler is hoarding food, getting him to stop is not the first order of business. First, we want to know what makes him so hungry (so to speak). In the process, we would love to evoke curiosity from others, especially his parents, about what makes him so hungry. With amazing regularity, when we have paused to be curious, the source of the child's hunger becomes quite evident; with this new understanding comes the often-obvious solution. We don't have to *make* the baby do anything. He just gets better, now that he is getting “fed”.

This week delivered exhilarating reminders to me about all three of these principles—all three of these unique aspects of Who We Are.

A very poor, rural family with great determination found their way to me from several hundred miles away. They were worried about their seven-year-old, who already wore the overused acronyms of a troubled boy from a poor family: ADHD, ODD, with suspicions of bi-polar disorder, ASD and OCD.

“John” pees on his laundry, smears feces, and is in constant motion. He is extremely demanding, as if everything is urgent. He hoards food, and is always thirsty. He doesn’t have friends, because other children reel back from his controlling and demanding ways.

The parents found me because they wondered if John might have an attachment disorder (they had looked it up on the web), and they had the fantasy that I was an expert in such matters.

We spent four-and-a-half hours together on Monday. (It’s that history thing.) Mom said that John never stopped moving in the womb, as if he were deeply troubled about something. After a most difficult delivery—Mom said he did not want to be born, that he “put out both hands, pressing against my bones, holding himself in”—John emerged. He would not sleep. He nursed “round the clock for weeks; he could never get enough”. He suffered from near-constant gastrointestinal pain. In some ways, Mom says, this has never changed: She still experiences him as ravenous in his needs, and experiences herself as unable to meet them. Immediately upon his birth, she fell in to a serious depression.

But the story doesn’t stop there. (It never does, does it—at least for us? We seem to be the ones who invite the story, and then wait for it. We guard against preoccupation with diagnosis and fixing, lest we collude in stopping the story too early.)

It turns out that Mom comes from a long line (she claims to have counted back seven generations) of little girls who lose their daddies very early in life, gain a stepfather, and are then molested by him. For generations, mothers have evidently been failing to protect their little girls. And now we know why *this* Mom has, against all odds, driven so far to talk to “a baby guy” who might help all of this stop. She wants to be a Mom who protects her child. She wants to do what no other mother in her lineage has been able—or determined enough—to do.

But what’s the matter with John? As we continue to resist the urge to categorize, as we force ourselves to remain open to the data, we learn that Mom’s mom was deeply troubled to be pregnant for Mom. She was only 14. She didn’t want to be “fat”. So she stopped eating, during the pregnancy, and was proud that, on the day she delivered the baby who would grow up to be John’s Mom, she could still snap the same, tight jeans she had worn before she got pregnant.

What sort of uterus can we imagine that one was? What was Mom’s experience of nurturance in that place? And, more to the point, what sort of uterus was she then prepared to offer to her *own* firstborn? It will surprise none of us that Mom became quite obese during her childhood—a perfectly reasonable defense, and a perfectly reasonable organic response by her prenatal liver. But in the year before she came to me, she had lost 100 pounds. She’s in fighting trim, now, ready to take on the ghosts in this nursery.

We start imagining this little boy who hoards food, urinates and defecates all over the place, tries to control people, and whose tummy hurt for the first two years of his life, as a pretty desperate child who had, from the beginning, believed he would not survive. There was not enough for him.

The story keeps rolling in. Mom has a stepbrother—we'll call him "Jim"—who is evidently a psychopath. He has spent most of his life in prison, usually for sexual offenses. Mom is terrified that John will turn out like her brother—that the awful blood of her family of origin runs in her little boy's veins. Naturally, she mixes the names up all the time, using her son's name when referring to her brother. And now we know yet another reason she would drive so far to see someone who might unravel it all, and help her understand and protect her boy.

I think I know how to help this family. I'm going to go to their town to see them—maybe my longest-distance home visit ever—and do a little workshop for practitioners there, in the hope that someone will emerge who can follow up, with my guidance. I won't charge for this; I've been paid quite adequately by the experience of witnessing the emergence of this story, told by deeply damaged but resourceful and determined parents.

We got here because we honor the history, and we won't stop until we've gotten more of it than anyone else. We are cautious with the labeling, worried that a too-early diagnosis might stop our search for the real story. And we stay clear about the purpose. There are plenty of people who can devise interventions for each of John's individual symptoms, and there are medications galore that will address his behavior. But there aren't many who remember that the real point is in *understanding*.

That's our tradition. It was uplifting to be reminded about it this week.

*[Mr. Trout is the Director of the Infant-Parent Institute in Champaign, and the author of Baby Verses: The Narrative Poetry of Infants and Toddlers (2008) and The Jonathon Letters (2005). He was the founding President of both the Michigan Association for Infant Mental Health and the International Association for Infant Mental Health (before it joined with WAIPAD to create the WAIMH). He is a former President of the ILAIMH.]*