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WAIMH Handbook of Infant and Early Childhood Mental Health

Cultural Context, Prevention, Intervention, and Treatment, Volume Two

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Foreword: The Rights of Infants

The *World Association of Infant Mental Health (WAIMH) Handbook of Infant and Early Childhood Mental Health*, Volume 2, provides an overview of the varying cultural contexts of parenting infants and young children. These chapters also describe different perspectives on mental health, assessment, and treatment for infants and young children in their families. The chapters coming from diverse cultural perspectives contribute to and support the growing trans-disciplinary evidence base that informs the protective and long-standing health benefits of early mental health intervention. In addition to the growing psycho-social, biological, and economic evidence base of early intervention, there is also an emerging cross-cutting, global human rights approach to early child development and intervention.

Seeking to integrate a rights approach to the multi-disciplinary research and practice arenas of early intervention, in 2008, WAIMH set out to specify the unique needs of infants that were embedded and assumed within the United Nations Convention on the Rights of the Child (UNCRC) (UN General Assembly, 1989). Furthermore, the UNCRC also recognizes the crucial role and responsibility that parents and families hold for protecting and caring for children. In turn, the UNCRC obliges governments to provide parents with the resources to optimize their capacity to fulfill their children's rights. It is important for all who work with infants and young children to learn about the Infants Rights Declaration developed as a Position Paper by WAIMH leadership and made public in 2014 to be embedded and assumed within the United Nations Convention on the Rights of the Child (UNCRC) (UN General Assembly, 1989).

Infants' Rights Declaration: Its Relevance to Infant Mental Health

In 2012, members of the WAIMH Board worked on the development of a Position Paper on Infants' Rights. WAIMH began to elaborate on General Comment 7, Implementing Rights in Early Childhood (Committee on the Rights of the Child, 2006), which specifically focuses on children aged 0–8 years of age. The general feeling was that General Comment Number 7 did not sufficiently differentiate the needs of infants and toddlers from those of older children, in that infants and toddlers are dependent upon the availability of consistent and responsive care from specific adults for the adequate development of their basic human capacities. There are indeed unique considerations regarding the needs of infants during the first 3 years of life which are highlighted by contemporary knowledge, emphasizing the impact of early experiences on neurobiological and neuroendocrinological development.

The Declaration of Infants' Rights was made public at the 14th World Congress of WAIMH in Edinburgh (2014) and its major points are in the process of being inserted into General Comment 7. It is divided into two parts: (1) The Infant's basic rights, which should be endorsed everywhere, regardless of social and cultural norms; (2) Social and Health Policy Areas to be informed by the basic principles expressed in the Declaration of Infant's Rights, which are more sociocultural context-dependent and take into consideration the fact that in non-Western countries, hunger, diseases, high mortality of mothers and babies, war, infanticide, abandonment, are still common. The seven basic rights are as follows:

1. The Infant by reason of his/her physical and mental immaturity and absolute dependence needs special safeguards and care, including appropriate legal protection.
2. Caregiving relationships that are sensitive and responsive to infant needs are critical to human development and thereby constitute a basic right of infancy. The Infant, therefore, has the right to have his/her most important primary caregiver relationships recognized and understood, with the continuity of attachment valued and protected – especially in circumstances of parental separation and loss. This implies giving attention to unique ways that infants express themselves and educating mothers, fathers, caregivers, and professionals in their recognition of relationship-based attachment behaviors.
3. The infant is to be considered a vital member of his/her/their family, registered as a citizen, and having the right to identity from the moment of birth. Moreover, the infant's status of a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability.
4. The infant has the right to be given nurturance that includes love, physical and emotional safety, adequate nutrition, and sleep, to promote normal development.
5. The infant has the right to be protected from neglect, physical, sexual and emotional abuse, including infant trafficking.
6. The infant has the right to have access to professional help whenever exposed directly or indirectly to traumatic events.
7. Infants with life-limiting conditions need access to palliative services, based on the same standards that stand in society for older children.

The link between these basic rights and the provision of early detection and intervention for infants *and* their parents is therefore obvious. Not only do these basic rights go often unrecognized, but so also does the very existence of mental disorders under the age of 3 years (see also the WAIMH position paper on Infant Rights, 2016).

A paper published by a WAIMH Task Force (Lyons-Ruth et al., 2017) emphasizes the uniqueness of infancy as a time of foundational risks for developing later disorders, the impact of trauma, war, displacement, and violence on the developing brain, and the impact of disrupted attachments and loss of family cohesion. The paper ends with global priorities for addressing early infancy symptoms and disorders to support prevention and intervention measures.

The Rights of Infants in Cultural Contexts, Assessment, and Treatment

WAIMH holds the position that early detection and treatment of mental health problems is part of the infant's human rights. This right is equivalent to the right to receive medical care for biological health conditions which is essential in all phases of the life cycle.

This right underpins many of the dynamic clinical questions that inform the field of infant mental health, such as:

1. How do we identify the need for intervention for infants in a culturally diverse world?
2. How do we detect mental health symptoms and disorders in this early age?
3. How do we design early intervention to prevent disorders, treat symptoms, and reduce the suffering of young children?

We have to approach mental health in a culturally sensitive but not relativistic way. For example, child maltreatment is considered to be one of the most detrimental etiological factors which causes harm to children's psychosomatic development. In this regard, we have to consider that the definition of maltreatment might be different in different cultures. It does not make sense when mental health professionals from Western industrialized countries impose their definitions onto societies from other cultural and historical contexts. On the other hand, physical or emotional violence, sexual abuse, and neglect cause harm to young children no matter in which context.

The younger the child, the more his/her/their mental health is interwoven with relationships with important others: mothers, fathers, siblings, family members, other caretakers, the broader community, etc. We have to describe individual as well as relational symptoms. As early development is characterized by rapid change, disorders barely reach the level of solid categories. There is much debate about whether it might be better to describe psychopathology more dimensionally: for example, it is difficult to define hyperactivity in infancy because activity and body movement are important ways in which infants express emotions, such as joy, anger, frustration, and surprise, as well as their needs for comfort and care.

Furthermore, there is a fluent transition from relational to individual psychopathology. When we look at relationships which are decisive for the infant's development and well-being, we have to take not only mother-child attachment but also father-child attachment as well as triadic relationships and broader relational contexts into account.

Infants as human beings of other ages have the global right to adequate medical care, and mental health care is an essential part of it. Especially for young children, mental health care and interventions should be designed holistically and integrate social support, biological and psychological/psychotherapeutic treatment components. The improvement of the infant's social situation aims at reducing risk factors: poverty, social exclusion, parental disorders, substance abuse, etc. Sufficient and adequate nourishment, fight against infections, vaccination, hygienic care, etc. are all measures to improve the infants' biological situation and contribute as well to mental health.

Psychopharmacological treatments of infants are contraindicated in most cases because of their possible negative impact on the dynamic brain development in the early years. Instead, early psychotherapeutic interventions are known to be very effective, especially when they target caregiver–infant interaction, the child's internal world as well as emotional and behavioral regulation.

Finally, it belongs to the important rights of the infant that all interventions are constantly evaluated. Good clinical research in this field is essential and serves as a foundation for early interventions, provides a solid scientific ground for the interventions, and lays the ground for the development of new and creative processes of change for the benefit of young children.

Volume 2 of the WAIMH Handbook of Infant and Early Childhood Mental Health contributes to the provision of relevant and timely cultural context, assessment, and treatment information that is essential for assuring and improving the conditions within which the rights of infants and those of their caregiving families can be actualized.

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Preface

In August 2021, we decided to approach the WAIMH Executive Committee proposing the initiation of a new two-volume *WAIMH Handbook of Infant and Early Childhood Mental Health*. The first WAIMH Handbook had been published in 2000, more than 20 years earlier which at that time marked the 20th anniversary of the founding of WAIMH. We want to thank the Executive Committee for their support of our proposal. With the initiation of the second *WAIMH Handbook of Infant and Early Childhood Mental Health*, we were marking the 43rd Anniversary of the founding of WAIMH and planning for the 17th World Congress, that, due to the COVID-19 pandemic, was held part in person and part virtual in Brisbane, Australia. As this two-volume WAIMH Handbook goes to press, we have just completed the very successful 18th WAIMH World Congress in Dublin. The four of us – Hiram Fitzgerald, Miri Keren, Kaija Puura, and I – were enthusiastic about collaborating together as developers, contributors, and editors for this important endeavor for WAIMH.

We want to thank many who have helped us during the process of bringing the Handbook together with two volumes that include six sections: Volume 1 – Infant Development, Neurobiological Influences, Parenting and Caregiving; and Volume 2 – Cultural Context of Parenting and Infant Mental Health, Infancy and Early Childhood Mental Health Assessment, Clinical Infant Mental Health. The editors, all of whom have also contributed chapters, have made much effort to include work in the field of infant and early childhood mental health that is being implemented in different settings around the world. As readers will experience, we have intentionally joined scientific and clinical perspectives as well as policy issues.

In expressions of thanks, we start with the support, encouragement, and interest of the WAIMH Board members from around the world. Next, we want to thank Springer Nature Publishers who have been very supportive from the beginning and throughout this endeavor, showing flexibility when needed and consistent support.

It is important to note, when considering the topic of infant and early childhood mental health at this time, that in August 2021, about a year and a half into the COVID-19 pandemic around the world, we had all been working virtually as in-person meetings were cancelled, and lockdowns and social distancing were imposed for all to ensure the best chances for safety from COVID. We knew that this was a very difficult time for all and were very concerned about the growth and development of infants and young children and the stress that families were feeling, especially those with fewer resources.

Inequities were evident including loss of income and food insecurity combined with more serious illness and deaths for families with fewer resources. And for young children, life had been turned “upside down” with their not being able to be with family or friends. For those old enough, virtual schooling was all that was available if families had the resources to help teach children at home. Further, there was much stress and uncertainty as well as many losses of parents and caregivers which for some families was the only person there for the child.

We feel as editors that it is important to recognize that the world for infants, toddlers, their parents, and caregivers has changed a great deal since the publication of the first WAIMH Handbook in some good ways, but also with many challenges especially in the past 3 years during the COVID-19 pandemic. With closed nurseries and childcare centers, parents being stressed, and parents and caregivers becoming sick, and in some cases dying, the indirect effects on small children could last a lifetime. And the impact has been much greater on those with fewer resources in the first place. As was shared by President Campbell Paul following the successful Dublin Congress and other international meetings that he participated in, young children have been experiencing many uncertainties related to co-existing concerns in addition to the pandemic such as exposure to wars, natural disasters, and other traumatic experiences. As he emphasized, attention needs to be given to how to spread resources in different ways in an effort to reach the most vulnerable children and families around the world.

We also recognize that there have been many positive developments with much increased awareness and knowledge about brain development, infant and early childhood mental health that has been gained since the last WAIMH Handbook was published more than 20 years ago. We have had the opportunity both virtually and more recently with the 2023 Dublin Congress to learn and share this new knowledge. We are hopeful that the development and sharing of the new WAIMH Handbook will also contribute to discussion around the world related to new understanding and ways to help and support the growth of the field. As we did in the first WAIMH Handbook, we again join scientific, clinical, and cultural perspectives with a strong emphasis on policy issues that need to be addressed. We worked diligently to represent knowledge and perspectives from around the world to reflect, as President Campbell Paul stated, the 48 countries and regions that were represented at our 2023 18th World Congress,

JDO – As we shared when we did the first WAIMH Handbook, we are hopeful that this publication will provide further education from around the world about the infant and early childhood mental health field that has grown and developed remarkably since 1992 when WAIMH was formed. I thank the WAIMH Executive Committee for encouraging us do this Handbook and for their many contributions for the book. When writing and editing for the World Association for Infant and Early Childhood Mental Health Handbook, I found myself reflecting on how the field of Infant and Early Childhood Mental Health has grown since I started working in this area, developing one of the first training programs, The Harris Center for Infant Mental Health, and learning from the infants, young children, and their parents and caregivers while helping them with their problems. I thank the three excellent editors who worked with me on the WAIMH Handbook always offering helpful ideas and the visions that all of them have provided for the field. And of course, I thank my husband, Howard, who has always encouraged me not only with the development and work on this WAIMH Handbook but also throughout my career to develop and follow my interests and passions. I also thank my three children and my six grandchildren with whom I have experienced personally how very important consistent steady relationships are for positive development. Earlier in my career, I studied "emotional availability," that is not just being there physically but being there emotionally to listen to young children. I learned what is important for infant and early childhood mental health – to "be there" when they were upset, to listen when they were ready and want to share, and to be emotionally present to help when help is needed.

HEF – In 1992, when two organizations met in Chicago, merged, and created WAIMH, little did I know that I was launching a 38-year connection to an organization that would take me to 20 countries, diverse cultures, and to friendships that reflected the essence of WAIMH's emphasis on relationship quality. In my personal life, I've had the extraordinary pleasure of observing and participating directly in the lives of 11 babies (3 children, 11 grandchildren), tracking their life course pathways, observing firsthand changes in their behavior styles, and reflecting on the changes in relationship dynamics that occurred in my wife and I as we moved ever deeper into grandparenthood. One of the side-effects of WAIMH is that one develops relationships that extend beyond academic and clinical work, because those of us who work with infants, toddlers, and their families share our own family stories, perhaps more deeply than may happen in other professional associations. So, I thank not only my three co-editors for work on this book, but for their close friendships. I also thank the hundreds of infant mental health colleagues around the world who stepped up to create 61 Affiliate Associations, with at least 1 on every continent, making WAIMH truly a world organization. I especially thank the anchor of my life, my wife Dolores, who not only endured my absences during my 55-year academic career, but managed to participate in it after her retirement from teaching when she became a key administrative assistant for WAIMH, and a constant traveling companion during my 16 years as WAIMH executive director.

MK – I wish to join Dr. Osofsky's thanks to my three co-editors and to all the authors who have accepted our comments and spent additional time at revising their chapters. The uniqueness of this Handbook is its international nature, with a strong emphasis on cultural differences, justice, and equity issues that are so relevant to research and clinical practice in IMH. More personally, I would like to publicly thank my two Palestinian co-authors in the chapter on Parenting in the Middle East, Dr. Ghassan Abdallah and Mrs. Laila Warwar, as the task of writing a chapter together while being in the midst of an ongoing violent geopolitical conflict was a challenge in itself. For me also, being a grandmother of twin girls and two little boys added an affective dimension to my editorship, as I live these processes we write about in this book…such as intergenerational processes, individual variations in development, resilience, and vulnerability. I thank them for their very existence! Last but not least goes to my husband, who brings to my writings a unique intellectual contribution.

KP – I too wish to warmly thank my three co-editors and all the authors contributing to the Handbook for providing me this unique opportunity to read such a rich collection of chapters from different areas in Infant Mental Health and from different parts of the world. I do hope this Handbook will be of help to researchers, clinicians, and hopefully to policy makers as well. I also wish to thank my co-authors Kevin Nugent and Reija Latva for their contribution – it was a joy to work with you. And finally, I too am thankful of my extended family for all the shared experiences and wonderful moments of playing together with our three grandchildren.

Just as we shared when the first WAIMH Handbook was published, we say again that although we have learned much during the past two decades, these volumes represent steps in our knowledge and not an end to our growth. We hope that the readers will use the Handbook to encourage discussion about the field of infant and early childhood mental health (IECMH). The editors have devoted much of their professional lives to imparting knowledge in this area by establishing training programs so that students and colleagues can learn what is known about IECHM, presenting both within their countries and internationally about IECMH as well as having spent many hours providing clinical services for young children and families. As we shared in our earlier Handbook, we are hopeful that this volume will provoke discussion across disciplines and across national, regional, and cross-cultural boundaries so that we all will understand more about infant and early childhood development, mental health, and ways to support infants, young children, and families. And we are hopeful that this Handbook will provide and expose more of the knowledge that is needed to discuss, share, and hopefully solve some of the difficult issues that infants and young children and families are facing around the world.

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About the Editors

Joy D. Osofsky, PhD, is a clinical and developmental psychologist, and psychoanalyst, Professor of Pediatrics and Psychiatry, Ramsay Chair in Psychiatry, and Lemann Professor of Child Welfare at Louisiana State University Health Sciences Center. She has published widely authoring and editing seven books on the effects of trauma in the lives of children. She is past president of ZERO to THREE and of the World Association for Infant Mental Health and is President-Elect of Division 7 of the American Psychological Association. She serves as Clinical Consultant on the Leadership team for ZERO to THREE Infant Toddler Court Program. She is recipient of the designation "Honorary President" of the World Association of Infant Mental Health. In 2021, she was honored with the ZERO to THREE Lifetime Achievement Award.

Hiram E. Fitzgerald, PhD, IMH-E® IV, is University Distinguished Professor Emeritus in the Department of Psychology at Michigan State University. His major areas of research include the study of infant and family development, risk, resilient and adverse childhood experiences, the impact of fathers on early child development, and the etiology of alcohol use disorders. He is past executive director of WAIMH, and is a Fellow of the American Psychological Association, and the Association of Psychological Science. He is a recipient of the designation "Honorary President" of the World Association of Infant Mental Health, and the ZERO to THREE Dolley Madison Lifetime Achievement Award.

Miri Keren, MD, is Associate Clinical Professor in Child and Adolescent Psychiatry at the Bar Ilan University Azrieli Medical School, and WAIMH Honorary President. Her main research interests are about infant psychopathology and diagnoses, eating disorders in infancy, parental psychopathology and parenting, parent-Infant relationships disorders, and PTSD of infancy. As President of the World Association of Infant Mental Health in the years 2012–2016, she has been very invested in the implementation of a declaration of Infant's Rights. In 2000, she founded the Israeli WAIMH Affiliate and is currently its Honorary President, and she is Chairperson of the World Psychiatric

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Kaija Puura, MD, PhD, is Professor of Child Psychiatry in Tampere University, Finland, and Chief Physician in the Department of Child Psychiatry in Tampere University Hospital. She has authored or co-authored over 90 peer-reviewed articles, chapters, and books on assessment and treatment of young children. She is a child mental health expert and advisor for the national children's TV program "Jyrkin ja Neposen kommervenkkejä," an Associate Editor of the *Infant Mental Health Journal*, Executive Director of the World Association for Infant Mental Health, Vice President of the International Association for Child and Adolescent Psychiatry and Allied Professions, and President of the Finnish Association for Child and Adolescent Psychiatry.

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Part I

Cultural Context of Parenting and Infant Mental Health

1

Cultural Context of Parenting and Infant Mental Health: Overview

Kaija Puura

According to the bioecological model of development (Bronfenbrenner & Morris, 2007), all infants and parents live and develop in a network of relationships in the society in various cultural contexts. Cultural context incorporates values that are learned and attitudes that are shared among groups of people. It includes beliefs, meanings, customs, ideas, language, and norms. Parenting can be defined as the raising of children and all the responsibilities and activities that are involved in it – a process that happens within the cultural context. When parenting is successful, it leads to child well-being when physical, cognitive, and social-emotional-spiritual development is nurtured in developmentally appropriate ways (The Alliance for Child Protection in Humanitarian Action, 2021). However, not only relational, but also spatial contexts affect early development (Zeanah, 2018); in other words, parenting interacts with the concrete environment of children and parents.

Human geography studies how things exist in space, how features of the social world change across spaces and the difference that places make to the nature of human existence (Jones, 2012). Places and spaces where families live can either support parenting and child development or make it harder (Parviainen et al., 2022). Cultural contexts and human geography are particularly important in our time when the number of young children and families forced to leave their own homes and relocate to another place is constantly growing. At the end of 2022, 108.4 million people were displaced worldwide because of some natural disaster or armed conflict; this is the highest number ever (European Civil Protection and Humanitarian Aid Operations, 2023). The chapters in the first section of this handbook highlight different aspects of how cultural contexts affect parenting and child-rearing, both with families living in their own country and culture, and in immigrant families. It also brings up the important questions concerning ethics within infant mental health, which may be even more complex in our constantly changing world.

In Chap. 2, Spicer and colleagues address ethical challenges in infant mental health. In particular, they explore issues that arise in partnering with parents, families, and communities to promote infant development within the diverse sets of values that shape life for infants and their families. The statements they review in their chapter include the Diversity-Informed Tenets for Work with Infants, Children, and Families, the WAIMH Position Paper on the Rights of Infants, and the Code of Ethics now required for Endorsement in Infant and Early Childhood Mental Health by the Michigan Association for Infant Mental Health, which together serve to establish the importance of both justice and care in an ethics of infant

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mental health. In Chap. 3, Joyce Mok and colleagues describe infant mental health policies and practices in different parts of the world. They provide an overview of how parenting practices in Hong Kong changed through generational shifts with the description of the Hong Kong Child Health policy trend and the collaborative effort to promote IMH in the local community. Dawson and colleagues start Chap. 4 by making the point that infant mental health theory is mostly derived from studies in the Western world, while most of the world's children live in other cultural contexts. They argue that effective and evidence-informed infant mental health practice necessitates local research and outline various South African research projects that investigated infant mental health constructs in South Africa. They describe locally developed and locally adapted infant mental health interventions, highlighting the need to integrate Indigenous knowledge and contextualize interventions for their setting.

In Chap. 5, Watanabe describes the loss of traditional of Japanese child-rearing because of rapid postwar industrialization and Westernization. She further describes how Japanese professionals are now called to scrutinize Western approaches more critically and focus on reviving the inner nurturing capacities of families in culturally congruent ways.

In Chap. 6, Puura and Latva go through some of the major changes parenting has experienced during this millennium, like increased involvement of fathers in child-rearing, parents' problems in combining work and family commitments and new potential risks for parenting. They then review studies on infant mental health, current strengths and problems of parenting, and services provided for supporting parents and mental well-being of young children in different parts of Europe. In Chap. 7, Schejtman and colleagues describe the history of the infant mental health field in Argentina and Uruguay and research projects that propose bridges between psychoanalysis, infant research, and infant mental health. The Argentinian program relates maternal reflective function, and the Uruguayan project assesses the emotional state and mothering of women that live with their children in prison.

In Chap. 8, Keren and colleagues review Arabic Palestinian and Israeli parenting beliefs, values, and practices emphasizing the changes that have been evolving along the years in each society and the current situation in the challenging geopolitical context. Rygaard ends the section on the cultural context of parenting describing in his chapter how migration and urbanization can create many conflicts between past and present caregiver mindsets. He also argues that economic inequality, racism, and social disintegration challenge governments, while agreement on health care policies are often paralyzed by antagonistic family policies. Finally, as one of the possible solutions, Rygaard describes virtual designs of parenting educations offering the opportunity of a global outreach to improve infant mental health. He also emphasizes the need for partnering with local NGOs and government agencies worldwide so that their staff are educated to train local caregivers groups in attachment-based daily care.

The opening section of Volume 2 of *WAIMH Handbook of Infant and Early Childhood Mental Health* gives the reader an overview of parenting and infant mental health research in different parts of the world. Importantly, it raises the questions of justice and care within infant mental health into discussion and details specific policy areas to be informed by these principles, including parental leave, provisions for continuity of care and adequate support in alternative care arrangements, education for parents on the needs of infants, emotional support for caregivers, and access to evaluation and treatment for both children and parents. The section describes the wide variety in resources for families with young children between different countries, and the need for constant advocacy for building infant mental health services and support systems for families. The need for further studies on infant and early childhood mental health both within and outside Western culture is of great importance for building culturally sensitive approaches for clinical practice. The section describes some encouraging examples of interventions developed to tackle problems of families with young children in various parts of the world.

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2 Justice and Care in the Ethics of Infant Mental Health

Paul Spicer, Jon Korfmacher, and Michelle Sarche

The field of infant mental health, like bioethics more generally, has increasingly turned its attention to questions of justice, but this engagement has not always been explicitly linked to what is most distinctive about our work. Infant mental health is inherently relational (Emde et al., 2000), which requires a focus on interdependence in a way that may well be unique in professional practice. While there remains much work to be done to understand caregiving in diverse global contexts (e.g., Hrdy, 2011; Lancy, 2022; Rogoff, 2003), in this chapter we argue for an explicit engagement with this core aspect of our work as we build an ethics for our field. Perhaps uniquely among available ethical frameworks, the ethics of care (Held, 2006) centers our attention on relationships, but we find no mention of this framework in contemporary discussions of the ethics of infant mental health. Given the centrality of care work in our practices, for example, nursing, early care and education, psychotherapy, this is doubly unfortunate: We are at once depriving ourselves of an ethical framework that speaks directly to the heart of our work, and we are missing a valuable advocacy opportunity to elevate the importance of care in our broader society (e.g., Mahon & Robinson, 2011). It has, unfortunately, been common to contrast considerations of care and justice (e.g., Gilligan, 1993), but we argue here that a focus on both justice *and* care is not only possible (Tronto, 1994), but required, in thinking about the ethics of infant mental health. We begin, with a brief review of some recent ethical formulations for our work, which highlight the twin themes of justice and care that concern us in this chapter, before turning to consider the ethics of care and an approach to justice, the Capabilities Approach of Martha Nussbaum (2011), that is consistent with this ethics. We close with some of the implications of this approach, in both our research and our practice, especially as we build infant mental health practice for the global majority.

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Justice and Care in the Ethics of Infant Mental Health

Recent years have seen several attempts to articulate approaches to the ethics of infant mental health. As Zeanah et al. (2023) note, these statements lack specific detail on the kinds of ethical dilemmas that often arise in work with infants and caregivers, for example, how to navigate conflicts between the needs of parents and those of children, but each of them is designed to guide advocacy for the needs of diverse children, families, and communities, and all are rooted in emerging knowledge from our field. The statements we review here include (1) the Diversity-Informed Tenets for Work with Infants, Children, and Families, (2) the WAIMH Position Paper on the Rights of Infants, and (3) the Code of Ethics now required for Endorsement in Infant and Early Childhood Mental Health by the Michigan Association for Infant Mental Health. Together, these recent statements serve to establish the importance of both justice *and* care in an ethics of infant mental health.

The Diversity-Informed Tenets were originally published in 2012, with the most recent version available at this writing dated to 2018 (Irving Harris Professional Development Tenets Working Group, 2018). Written with clear awareness of bias in developmental science (e.g., Bruno & Iruka, 2022; Henrich, 2020; Hrdy, 2011; Rogoff, 2003), the central principle for diversity-informed practice is that "self-awareness leads to better services for families," and the tenets begin with the need for explicit reflection on our own cultures in the context of numerous, often intersecting systems of oppression. Additional tenets relate to (1) the stance toward infants, children, and families for diversity-informed practice; (2) principles for diversity-informed resource allocation; and (3) advocacy toward diversity, inclusion, and equity in institutions. Considerations of justice can be found throughout the Tenets, including explicit calls to champion children's rights globally, work to acknowledge privilege and combat discrimination, recognize and respect nondominant bodies of knowledge, honor diverse family structures, allocate resources to systems change, make space and open pathways for historically and currently marginalized individuals and groups, and advance a just and equitable policy agenda for and with families.

A focus on justice is echoed in the WAIMH Position Paper on the Rights of Infants. Originally promulgated at the WAIMH Congress in 2014, and revised in 2016, the Position Paper on the Rights of Infants is designed as a supplement to the UN Convention on the Rights of Children because the Convention "does not sufficiently differentiate the needs of infants and toddlers from those of older children (World Association for Infant Mental Health, 2016)." The Position Paper begins with a recognition of the infant's immaturity and dependence and includes specific reference to rights to sensitive and responsive caregiving, nurturance, and protection from abuse and neglect. Additional specified rights include those to citizenship and identity at birth, access to professional help in the context of trauma, and access to palliative care. The Position Paper separately details specific policy areas to be informed by these principles, including parental leave, provisions for continuity of care and adequate support in alternative care arrangements, education for parents on the needs of infants, emotional support for caregivers, and access to evaluation and treatment for both children and parents. As noted in the preamble and rationale, the Position Paper is an explicit advocacy position, informed by the science of infant mental health.

The final statement of ethics in infant mental health that we review is the one with the most explicit focus on the clinical work of our field, the IECMH Code of Ethics from the Michigan Association for Infant Mental Health (2021). Rooted in the practice of infant mental health, this code begins with the value of relationships, as the "primary instrument for growth and change." This emphasis on relationships includes work to promote, support, restore, and sustain nurturing relationships for all infants, young children, and families, as well as collaborative interprofessional relationships, embedded in an understanding of the impact of past relationships on the present. Like other existing approaches to professional ethics, the code also includes values specifically related to professional practice, including integrity, confidentiality, knowledge and skill building, and, perhaps more uniquely, reflective practice. The IECMH Code of Ethics was revised in 2021 to include greater attention to diversity, equity, and inclusion and includes additional values specifically related to justice: (1) respect for ethnicity, race, culture, individuality, and diversity and (2) a commitment to dismantling inequities through social and racial justice work.

These recent articulations converge around an awareness that work with infants and their families requires a focus on relationships, but also the larger social and historical contexts in which these relationships are embedded, with clear and consistent emphasis on the inequalities that shape the lives of so many children and families and the need to respect diverse family and caregiving arrangements (e.g., Keren et al., 2019). This growing engagement with questions of justice is, of course, not unique to infant mental health, and several recent contributions to the literature in bioethics also center on the need to explore justice more directly. In bioethics, scholars have argued for a focus that extends beyond individual ethical dilemmas, be they between a clinician and a patient or between a researcher and a participant. While explicit consideration of justice in many of these individual interactions is possible, recent perspectives on justice call for a much broader and direct focus on the social and political dynamics that shape these individual interactions. Thus, King and colleagues refer to "lifeboat ethics," where the circumstances leading to the limitations of the lifeboat are bracketed in order to consider the ethical dilemmas of individuals on the lifeboat (King et al., 2022), while Alex London argues that scrutiny on the interactions between a researcher and a participant, as is commonly the case in review by an Institutional Review Board as classically conceived, limit our ability to understand the broader forces that shape research agendas (London, 2022). While the ethics of care is not commonly referenced as a part of these considerations of justice in bioethics, we argue that there is no *good* reason for this, and especially not in the context of infant mental health, where care can and probably should be a central consideration in our growing engagement with social justice.

The Ethics of Care

In her overview of the ethics of care, Virginia Held locates its origin in the work of Carol Gilligan, specifically in her effort to understand the moral development of girls (Held, 2006). Originally motivated by what she perceived as bias in the judgment of girls' moral development in the work of Kohlberg (1984), Gilligan's research has been consistently oriented toward revealing what she characterized as "the different voice" of women and girls—a voice centered more on responsibilities and relationships than on rules and rights, more on the specificity of particular relationships than abstract principles (Gilligan, 1993). These observations were soon picked up in feminist philosophy, which articulated an ethics of care focused on our interconnections.

As Tronto (1994) notes, one of the unfortunate consequences of the way this ethics was articulated has been to make it easy to confine it to the private sphere of specific feminine caregiving relationships, blunting the potential of this framework in the public sphere of politics. Tronto argues for a reconfiguration of what she calls these "moral boundaries" to permit our thinking about care (and our responsibilities to each other) to have a more central place in our debates about politics, and we think the growing engagement of the infant mental health field with policy provides us with an important opportunity to do just this.

From Tronto's perspective, four distinct phases of caring, as a practice, deserve attention: (1) caring about, which she links to the ethical dimension of attention; (2) taking care of, which she links to the ethical element of responsibility; (3) caregiving, which she links to the ethical element of competence; and (4) care-receiving, which she links to the element of responsiveness. The ethics of care, in Tronto's formulation, thus provides us with an explicit way of evaluating our involvement in the relationships that are central to work in infant mental health. These dimensions are of relevance not only to practice—in foregrounding questions of competence and responsiveness—but also to policy—in emphasizing attention and responsibility.

It is one thing, however, to recognize the importance of care. It is quite another to understand the specific issues that can arise in acting on the basis of this value. As Zeanah et al. (2023) note, there remains significant work to do in fleshing out an ethical framework for the challenges that arise in infant mental health practice, but it seems clear that this conceptualization of care, intended to move the construct from the private sphere of home and family to the public sphere of policy and professional practice, can offer important guidance on what we need to attend to in crafting an ethics that fits our understanding of our interconnections and needs for care. And it is specifically in regard to needs for care that we can link, explicitly, to the questions of justice that have become so prominent in our advocacy.

Needs for Care and the Capabilities Approach

Tronto (1994) observes that if we define our needs for care too abstractly we will fail to specify how to meet these needs, but if we define them too concretely, then we might fail to provide broader guidance for social policy. While much work still needs to be done in this area, Tronto (1994) does suggest that the Capabilities Approach (CA) of Nussbaum, originally articulated in the context of international development and its implications for women (Nussbaum, 2000), provides us with a potential way to navigate at least some of these tensions.

In a recent articulation of the Capabilities Approach, Nussbaum (2011) argues that the approach is focused on understanding social orders in terms of what each person, as an end in themselves, is able to do and to become within them. It is, thus, an explicit operationalization of a conception of justice focused on what it takes to be able to pursue one's life projects (or, in the negative, the ways in which this can be denied). Following Sen (1999), this approach focuses on choice or freedom, recognizing that different individuals will have different values, but that they cannot pursue their own projects without certain fundamental capacities.

Nussbaum currently proposes ten areas of capability that she argues deserve universal consideration. While some of these capabilities, including (1) life itself; (2) bodily health; and (3) bodily integrity are probably readily understood, others may benefit from some elaboration here. These include several capabilities most closely connected to the goals of infant mental health intervention, that is, (4) those related to the senses, imagination, and thought, by which she means the ability to imagine, think, and reason, informed and cultivated by an adequate education; (5) those related to the emotions, by which she means the ability to love and grieve, with freedom from excessive fear and anxiety, which depends crucially on the relationships where these emotions can develop; (6) practical reason, by which she means the ability to form and pursue a conception of the good in life; and (7) affiliation, which includes the ability to connect with others and to be free from discrimination. She rounds out her list by including capabilities related to (8) living with other species, (9) play, and (10) having control over one's political and material environments. This conceptualization of capabilities is designed explicitly to serve as a way of judging the justice (or injustice) of different social orders, providing metrics that can be used in evaluating their progress toward cultivating these capabilities in individual citizens.

Originating, as it does, in the context of global debates about human rights and international development, the Capabilities Approach is explicitly designed to be general and relevant across numerous cultural contexts, but continued discussion about the ways in which these capabilities are shaped in specific cultural contexts is important. An international interdisciplinary association, the Human Development and Capability Association, provides a natural venue to continue these discussions and we would suggest, as well, that WAIMH, especially in continuing the discussion that started with the Position Paper on the Rights of Infants, might also take these questions on as a regular feature of its biennial congresses. Indeed, this dialogue has already started to occur (e.g., Gaskins & Keller, 2019; von Klitzing, 2019).

The Capabilities Approach provides us with an important framework for investigating questions of justice that is rooted in an understanding of human development and flourishing, but it does not, by itself, provide us with more general guidance for navigating some of the more complex aspects of our interconnections and responsibilities to each other, even if the capabilities are explicitly connected to human development. As many have noted, understandings of caregiving that are modeled simply on the relationships between mothers and children in nuclear families do not represent global norms (e.g., Hrdy, 2011; Lancy, 2022; Rogoff, 2003), and it would be a mistake to build an ethics (or indeed a practice) for our field with only this relationship in mind. But a broader focus on relationships is quite consonant, indeed more consonant, with global experience than is one based on individual rights.

Toward a More Relational Approach to Ethics

An emphasis on relationships is not, of course, limited to infant mental health practice. It is foundational to the practice of marriage and family therapy, and the so-called relational turn in psychoanalysis makes many of these same points (e.g., Benjamin, 2018; Mitchell & Black, 2016). An emphasis on the importance of relations has long been central to anthropology as well (e.g., Strathern, 2020), and arguably the most frequently drawn contrast between the west and the rest in cross-cultural psychology concerns the uniquely individualistic focus in Europe and North America, which contrasts sharply with the more interconnected vision of self found in the global majority (e.g., Henrich, 2020). While any number of examples bear upon this point, we offer a perspective that has emerged from Critical Indigenous Studies as a particularly clear philosophical articulation of a more relational perspective.

In a recent contribution to the *Oxford Handbook of Critical Indigenous Studies*, the philosopher Kyle Whyte (2021) draws a contrast between what he calls “crisis epistemology,” in which imminent threats like climate change justify a wide range of departures from the requirements of social relationships, and what he calls “epistemologies of coordination,” which characterize the respect, in Indigenous communities, for kinship, connection, and social responsibilities, even in the face of imminent threats. While Whyte’s specific points about epistemology are interesting, it is his point about the ongoing and persistent importance of social relationships and responsibilities in the *ethics* of contemporary Indigenous communities that deserves special attention here: even (perhaps especially) in a time of crisis, interconnection and responsibility remain of paramount importance.

The need for ethical principles that elevate connections between people in Indigenous communities has recently also been explicitly recognized by Bobby Saunkeah et al. (2021). In addition to the well-known principles of respect for autonomy, nonmaleficence, beneficence, and justice (e.g., Beauchamp & Childress, 2019), Saunkeah and colleagues argue that work in Indigenous communities requires considerations of the additional principles of sovereignty and solidarity, to capture important relational and group dynamics in tribal communities. While sovereignty refers to the ability of communities to make their own decisions, asserting the right of self-determination and autonomy for groups, solidarity refers to the duties, within communities, to support the community and its individual members (Saunkeah et al., 2021). As Saunkeah and colleagues note, in the context of work with US Native Nations, “solidarity involves two key aspects: the collective responsibility to defend and promote the conditions for the group to flourish, and the collective responsibility to care for the particular needs of the most vulnerable members of the group (Saunkeah et al., 2021, p. 9).” A related observation characterizes the approach to justice in the posthumously published work of Iris Marion Young, Responsibility for Justice, where she grapples with the interdependent nature of structural inequality and the difficulty of assigning individual blame. She argues, instead, for an approach that is less focused on assigning guilt and more focused on the obligations we have for improving the situations of those oppressed by the structures in which we participate, which she calls the "social connection model of responsibility (Young, 2011)."

There is, then, no shortage of moral discourse for infant mental health to connect to as we articulate the implications of our relational approach, and the prominence of these themes in Indigenous moral discourse underscores the ways in which our practice can connect with a more widely shared view that recognizes that we are not, nor have we ever been, isolated moral agents. In a recent review of Indigenous concepts of wellbeing, Jessica Saniguq Ullrich (2019) argues for what she calls the Indigenous Connectedness Framework, emphasizing the need to embed child wellbeing in the wellbeing of the collective, and five forms of connectedness: spiritual, environmental, community, intergenerational, and family. If we continue work in this vein, we suspect there will be many ways to connect care to human flourishing in ways that, like the Indigenous Connectedness Framework, emphasize the fundamental importance of our connections to each other. We close this chapter by returning specifically to the field of infant mental health and one of the ways this awareness has already informed our advocacy work, by taking up the example of trauma-informed care.

Trauma-Informed Care

While the ethics of care is rooted in an understanding of feminine roles in our society, the infant mental health community is well aware that care is far from inevitable. Any number of causes and conditions can shape suboptimal and even destructive patterns in caregiving relationships (e.g., Mate & Mate, 2022; Van Der Kolk, 2014), much of which are rooted in the broader dynamics of inequality that shaped the articulation of the Diversity-Informed Tenets. In the United States, the National Child Traumatic Stress Network (2016) has provided important guidance for those working in child and family services regarding the assessment and treatment of trauma that draws on an awareness of protective and resilience factors and recognizes the impact of intergenerational trauma. Importantly, and consistent as well with the Infant and Early Childhood Mental Health Code of Ethics, this work is also mindful of the need for coordination, that is, relationships, across systems of care and the need to also attend to the impact that working on trauma has on staff.

In the United States, discourse about trauma-informed care draws on a set of principles, articulated by the Substance Abuse and Mental Health Administration (2014), which include the following: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice and choice; and (6) cultural, historical, and gender issues. From the perspective that informs this chapter, it is important to note that each and every one of these principles is rooted in our interconnections and in our responsibilities as caregivers and our hope is that the focus on care and human flourishing that we have argued for here will allow us to extend this important work toward broader social and cultural transformation, addressing trauma at its source (Manchanda, 2013).

The field of infant mental health is rooted in an awareness of the importance of care and the moral implications of our interconnectedness and our responsibility for justice understood in its connections to human flourishing—a perspective closely aligned with what the philosopher Lorraine Code has called "ecological thinking (2006)." Our effort to center this work on care solves some problems, but it most definitely raises others. We highlight two as we close this chapter.

The Way Forward

If we move forward in the direction of an ethics based on care and human development, we will obviously need to carefully grapple with our growing awareness of bias in the knowledge base that informs our interventions (e.g., Morelli et al., 2018). Because our work is global, any effort to articulate ethical principles must rest on careful cross-cultural dialogue about what caregiving should look like and how this is connected to the goals of human development. In this chapter, we pointed specifically to a growing engagement with questions of interdependence in Indigenous communities (e.g., Ulrich, 2019; Whyte, 2021). WAIMH, with its growing global engagement, can and should take a central role in these dialogues, some of which undoubtedly flow from our initial advocacy efforts in the Position Paper on Infants Rights (e.g., Gaskins & Keller, 2019; von Klitzing, 2019), but it is quite clear that a broader participatory approach will be required to truly hear and learn from global experiences.

The second concern we would highlight is the very real danger, already well known in our work, of the costs of caring. We would be loath to think that the ethical framework we have articulated here could be read in any way as a call to deny the needs of our workforce in addressing the profound needs for care that we know exist. Indeed, there would be little value in recommending an ethics of care for others if we did not extend this responsibility to ourselves as well. This need is explicitly recognized in the NCTSN recommendations for trauma-informed systems of care, and we would suggest that our commitment to reflective supervision, explicitly articulated in the Infant and Early Childhood Mental Health Code of Ethics and ensconced in the related system of professional endorsement, needs to be an explicit component of our engagement with our interdependence, even as we recognize the need for greater specificity regarding what reflective supervision is and what it can accomplish (Zeanah et al., 2023). We would be remiss here, as well, if we did not also emphasize the ongoing struggles of the care workforce for adequate compensation and the need for continued advocacy from our field for recognition of the centrality of care work in our society (e.g., Mahon & Robinson, 2011). Indeed, one potentially beneficial consequence of reframing our discussions in terms of care and flourishing might be to focus more attention on these crucial concerns.

Summary and Key Points

In this chapter, we have reviewed recent statements related to the ethics of infant mental health, underscoring their emphasis on justice. We sought to root this concern with justice in what we see as a central concern in infant mental health, that of care, connecting these statements to that evolving literature on the ethics of care (e.g., Held, 2006), and we argued that an approach to justice, rooted in care, can be found in the Capabilities Approach of Martha Nussbaum (2011). There are obvious connections between our approach and the WAIMH Position Paper, which argues for what we believe infants need, but we also recognize that this work requires a more complete engagement with the complexities of caregiving across cultures (e.g., Gaskins & Keller, 2019; von Klitzing, 2019). We closed with the example of trauma-informed care as one way of making a commitment to caring central to policy and practice.

Acknowledgments We dedicate this chapter to our friend and mentor, Dr. Robert N. Emde.

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3

Development of Infant Mental Health in Hong Kong SAR

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The Sociocultural Context of Parenting in Hong Kong SAR

Influence of Traditional Chinese Cultural Values on Parenting

Hong Kong is a Special Administrative Region (SAR) of the People's Republic of China. According to the 2016 Hong Kong Population By-Census, about 92% of Hong Kong population are ethnically Chinese. The traditional Confucius Chinese cultural values exert a strong influence on parenting (Shek & Sun, 2014). Chinese people are well known for their value of harmony in human relationships. As collective interest is always more important than personal will in Chinese society, there are well-defined duties, obligations, and rules which regulate individual behavior. The Chinese family system is highly hierarchical, with a strong emphasis on filial piety. Traditionally, parents have strict control on children and maintain firm discipline among them by exercising physical punishment. Children are required to offer love and respect, if not absolute obedience, to their parents and the elders in the family, such as grandparents or older siblings. As such, children usually have little personal space and are not encouraged to express their feelings, in particular the negative ones. On top of the hierarchical parent-child system, gender roles are also strictly assigned in a Chinese family; Chinese fathers are defined as the family head, who is in charge of matters outside home, whereas mothers oversee domestic ones.

Chinese cultural beliefs and values also have an impact on children's socialization and social relationships. Chinese children are generally perceived as more inhibited, vigilant, and reactive in stressful and challenging situations. Their inhibited behaviors are associated more with parental warmth and accepting attitudes and are more likely to receive positive responses and support. They are expected to have a higher level of self-control and are more likely to maintain compliant behaviors without adult intervention (Chen, 2010).

Generational Shifts in Parenting over the Past Decades

Despite the influence of the Chinese traditional cultural beliefs and values, parenting in Hong Kong has undergone generational shifts in the past decades (Lam et al., 2019a). Before the 1980s, the living standard in Hong Kong was generally poor. Some children in their early teens discontinued their studies to support their families. While busy making ends meet, parents of the

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1970s generally took an intuitive approach to performing parental duties. They believed that the nature of children was innately determined, and they just followed folkways of parenting.

From the 1980s, Hong Kong had an economic takeover, and families were much more well off. In spite of the Asian Financial Crisis in 1997, parents went beyond providing necessities to their children. While western parenting knowledge and practice have become more widely known locally, the millennial parents were more ready to equip themselves with necessary parenting knowledge through training. They inclined to give all their resources to nurture their children.

According to Lam et al. (2019a), as such, parents' belief in child development has been undergoing paradigm shift from nature-determined to nurture-determined during the past decades. Folkways parenting in the 1970s has gradually moved to knowledge-based parenting in the 1990s and then to expert parenting in the 2010s. Many parents nowadays are striving for an "ideal" parent stereotype which could give them additional stress as well as lead them to strive for their child's academic excellence at a very young age. In the past, children before age 6 were thought not to reach the age of understanding yet (Ho, 1989). However, nowadays, some parents want to push this line earlier. According to a telephone survey, 34.8% of the respondents approved the belief in "winning at the starting line" (Hong Kong Institute of Asia-Pacific Studies, 2016). Many Chinese parents are ready to offer unlimited financial support and to sacrifice their own needs for their children's education. They have high expectations and active involvement in children's learning. They put emphasis on their children's diligence and the development of their specific academic skills, usually using didactic methods instead of "fun methods." Underachievement in the child most probably gives rise to anxiety and self-blame in both the parent and the child (Lam et al., 2019a).

The long working hours in the work force in Hong Kong is one of the significant factors affecting parent-child relationship. There was a telephone survey done in 2005 with parents of primary school children concerning the parent's working hours and parent-child relationship (Committee on Home-School Co-operation, 2005). According to the survey results, 43.8% of the respondents said they worked for 41–50 h per week on average, whereas 20.0% said 51–60 h. The average number of hours fathers spent with their youngest primary school age children was 3.42 h per day, whereas for mothers, the figure was 8.37 h. The parent-child activities the respondents spent most of their time on were "doing/checking homework together," followed by "watching TV together." With the long working hours, many dual-earner families rely on foreign domestic helpers to help with childcare. Nowadays, father's involvement in childcare has been found to be increasing, and fathers seek parenting knowledge and skills as much as mothers when compared to fathers of 10 years before (Family Health Service, Department of Health [FHS, DH], 2018). Grandparenting in the family can be a source of support network; however, inconsistency in parenting between parents and grandparents and multi-generational conflicts over parenting/childcare issues are not uncommon. These are the worrying concerns of parent-child relationship.

Infant Mental Health in Hong Kong SAR

History of Mental Health Services for Children from Birth to Age 5

Primary Health Services

In the first half of the 19th century, the majority of the Hong Kong population was Chinese living in poverty. Childbirth risk, infection rate, and infant mortality rate were high. In 1930s, there were more than 300 Chinese infants died out of 1,000 live births (Franco, 2020). The first government-run Child Welfare Center (CWC) was established in 1932 to provide basic support in child hygiene and nutrition including infant bathing, weighing, infant feeding guidance, and nutritional supply of congee. After World War II, the 3 CWCs were renamed Maternal and Child Health Centers (MCHCs) to include health checks for pregnant women. The flooding of refugees from mainland China after the war created problems of overpopulation, and the government subsequently increased public investment in medical and health services (Franco, 2020). The MCHC service then expanded rapidly to include newborns as well as toddlers up to 5 years old. With the control of infectious diseases and a decrease in infant mortality rate from the 1960s to 1970s, there was more emphasis on the wider spectrum of child health. In addition to the scheduled immunization and routine health check, the MCHCs started to screen for vision, hearing, and developmental anomalies in infants and toddlers from the 1970s onward. It was not until the new millennium that there was a major revamp of the child health services in the MCHCs which covered more than 90% of babies born to local mothers. With improvements in socioeconomic conditions and access to quality health care, new health problems such as childhood obesity, behavioral problems, child disadvantage, and maternal mental health problems were targeted in the revamp with a more holistic view. By adopting an evidence-based prevention and intervention model, a parenting program was developed in the MCHCs as one of the components of the integrated child health and development program. The parenting program aims to introduce positive parenting and to decrease child behavior problems early from the antenatal period to preschool age (FHS, DH, 2013).

Secondary and Tertiary Health Services

Other than the primary health services provided by MCHCs, the secondary and tertiary services for infants and preschoolers were late to appear. Crude developmental assessment, if any, had been conducted by pediatric clinics or departments based in hospitals (Lam, 2006). While some rehabilitation services, mainly in the form of physical care and education for the physically and mentally disabled, had been operated by the missionary and welfare organizations since the early colonial era, it was not until the 1970s that the awareness of the importance of rehabilitation and the increasing need for quality services for children with developmental disabilities began (Ku & Tam, 2006; Lam, 2006). In 1976, the first child psychiatric unit was established in a general hospital, providing services to children with psychiatric disorders in Hong Kong (Department of Psychiatry, University of Hong Kong, n.d.). Subsequently, more such units and child day centers were opened in hospitals and outpatient clinics. Preschool children were treated in these psychiatric day centers covering mainly infantile autism, hyperkinetic syndrome, and mental disability while internalized psychological disorders were underdiagnosed. Psychiatric services for children were limited in scope in the 1970s and 1980s (Wong, 1990). Nevertheless, it was not until the psychiatric services had been made more accessible in several ways that parents became more ready to seek help for their children. For example, services were then attached to a general hospital or a primary care setting, and referral sources were made open to school psychologists, child assessment centers, and caregivers. With greater access and availability of services, more internalizing problems were found (Wong, 1990; Ho, 1997). When the Hospital Authority, a statutory body managing all the public hospitals and institutions in Hong Kong, began to operate in 1991, the child and adolescent psychiatric service became more systematically organized in the public hospitals and outpatient clinics (Fang, 2012).

The first Child Assessment Center (CAC) was set up by the then Medical and Health Department (M&HD) in 1977 to provide multi-disciplinary comprehensive assessment and rehabilitation planning for children with developmental problems. The 1977 White Paper on Rehabilitation was the first policy paper which attempted to coordinate the M&HD, Special Education Unit of the Education Department, and Social Welfare Department to provide services for those in need of extra support for their physical and mental difficulties. Planning for training of professionals and staff with expertise in the care for the disabled was included in the White Paper. Other than the launch of the child assessment service, preschool children's needs were acknowledged by expanding screening services, introducing the Comprehensive Observation Scheme in the

MCHCs, and increasing resources and staff training in preschool education and training (Cheng et al., 1998). The second White Paper on Rehabilitation issued in 1995 (Hong Kong Government, 1995) expanded the categories of disability to include non-physical disabilities of autism, mental handicap, speech impairment, maladjustment, and mental illness. The Paper recognized that preschool services had a vital role to play in prevention, rehabilitation, as well as minimizing the medical, educational, and welfare costs in the long run. Preschool services including early education and training centers, integrated child care centers, integrated kindergartens, and special child care centers were planned. Families with disabled children were supported by relevant community services such as social services and parent resource centers.

Despite the development in services for addressing the mental health needs of children, Hong Kong had been criticized to be a well-developed city without a child health policy (The Hong Kong Paediatric Society & The Hong Kong Paediatric Foundation, 2015). With persistent advocacy from the related professionals, the Commission on Children was finally established in 2018 to provide "overall steer on children initiatives; sets policy directions, strategies, and priorities related to the development and advancement of children; and oversees its implementation. The Commission co-ordinates the efforts of various government bureaux and departments, teams up with different sectors and professions in society to safeguard the well-being of children and builds a pro-child and inclusive Hong Kong." (Commission on Children, n.d.)

Current Mental Health Services for Children from Birth to Age 5

The provision of current mental health services for young children adopts a 3-tier stepped care model (Food and Health Bureau [FHB], 2017), with an emphasis on cross-sectoral and multidisciplinary collaboration. Tier 1 refers to a universal prevention and early detection and intervention for the general public offered by the Department of Health (DH) and/or non-government organizations (NGOs). Examples of Tier 1 services are Developmental Surveillance Scheme offered at MCHCs of DH. Tier 2 services are targeted at people functioning at subclinical level or with early indicators of dysfunction. Examples of Tier 2 are Child Assessment Service of DH, Comprehensive Child Development Service, and subvented preschool rehabilitation services. Tier 3 services are tertiary services provided by specialists in psychiatry with support by a multidisciplinary team. These services can be offered via outpatient clinics, day hospitals, inpatient wards, and/or consultation and liaison services. Example of Tier 3 is Child and Adolescent Mental Health Service.

Developmental Surveillance Scheme (DSS)

MCHCs had adopted the Comprehensive Observation Scheme (COS) for developmental screening of infants at 3 months, 9 months, and 3 years since the late 1970s. However, it had the limitations of restricting to clinic-based observations, having low attendance rate and a wide gap between visits. To overcome the limitations, the Family Health Service, Department of Health (FHS, DH, 2003) developed the DSS to replace COS by phases in 2003. The new scheme was in full operation in 2007.

Instead of administering tests with strict passes or fails as in COS, a set of Developmental Surveillance Questionnaires (DSQs) was developed by a team of medical professionals in FHS with good sensitivity and specificity.[1] The DSQs aim to elicit general developmental concerns from carers and gather specific observations to explore main developmental domains including gross and fine motor skills, communication and language, social behavior and play, concept formation, self-care, vision, and hearing. There are

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[1] A double-blind validation study was conducted in 4 MCHCs on 12-, 18-, and 24-month Developmental Surveillance Questionnaires. Validation was done by medical doctors using the Schedule of Growing Skill II as the gold standard. Both sensitivity and specificity were above 80% (S.Yau, personal communication, March 21, 2023).

10 DSQs covering children from birth to age 5. When parents come with their children at the routine 6-month, 12-month, and 18-month visits for vaccination, nurses will conduct an interview with the use of the DSQs to discuss developmental issues and explore any developmental concerns observed by parents. If necessary, follow-up by doctors or nurses will be arranged[2] for close monitoring. Referral to specialists, the Child Assessment Service or social welfare services will be made if needed for further assessment and management.

Through the DSS, parents and knowledgeable professionals work in partnership in observing the child. Teachers can also be involved in the process. Health education materials are provided to parents through leaflets, videos, hotlines, internet, and workshops as anticipatory guidance to promote parenting, facilitate the child's development, and detect possible developmental problems. It is a continuous and flexible process (FHS, DH, 2013; FHB, 2017).

Child Assessment Service (CAS)

Under the Department of Health (DH), the CAS consists of seven centers that serve children from birth to 12 years old with developmental/behavior problems. The professionals making up the assessment team are developmental pediatricians, public health nurses, clinical psychologists, medical social workers, speech therapists, occupational therapists, physiotherapists, optometrists, and audiologists. Upon referral from community physicians, psychologists, or hospital specialists, children and their parents will be seen by nurses to identify the main issues. Then corresponding professionals of the team will evaluate the children's problems, monitor their progress, and provide educational and rehabilitation advice according to their needs. Educational interim support will be offered to parents in the form of videos, leaflets, and talks. In addition, parent workshops and support groups are also available for specific developmental issues/disabilities to facilitate the acquisition of skills in child management and formation of mutual support networks among parents encountering similar challenges (Lam, 2006; CAS, DH, n.d.).

According to the 2004 service statistics, 58% of referred children were aged 0–3 and 17% were aged 4–5 (Lam, 2006). With the launch of the DSS in MCHCs in 2007, the number of referrals of the 0- to 5-year-olds to CAS significantly increased, contributing to a total rise in referral by 45% from 6,809 in 2005 to 9,872 in 2015. In 2015, children diagnosed with autistic spectrum disorder accounted for 20% of total referrals, those with developmental delay were 8%, and those with language and speech disorders were 35%. Over this 10-year period, the number of children with the former two diagnoses was doubled and the latter increased by 40%. There was a rising trend in the identification of preschool children with attention deficit hyperactivity disorder and those at risk of dyslexia, reflecting the concerted effort of the DH and Education Department (currently known as Education Bureau) in promoting the early detection and support to preschool teachers (Lau & Chan, 2016; Chan, 2016).

Besides the function of secondary intervention, the CAS also commits to promoting public education on the awareness of children's developmental problems. Another keen role CAS takes is in the research and development of local assessment tools for children.

Comprehensive Child Development Service (CCDS)

The CCDS was launched in 2005 and implemented in phases. It is a new service model which aims at early identification and provision of timely support and interventions to address the developmental needs of young children from birth to age 5 in Hong Kong. The distinctive feature of this program is its interdisciplinary and cross-sectorial collaboration among the Hospital Authority (HA), the Department of Health (DH), the Social Welfare Department (SWD), and the Education Bureau (EDB). CCDS is an integrated community-based child and family service model with the MCHCs as the platform for alignment of

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[2] The other 7 DSQs covering 2, 4, 9, 24, 36, 48, or 60 months of age may be done when closer monitoring of a child's development is deemed necessary.

the delivery of health, education, and social services. Inter-sectoral collaboration, open communication with mutual respect, responsiveness, and flexibility in service delivery are deemed instrumental in ensuring the families receive the appropriate services (Leung et al., 2007).

Four Components of CCDS

1. *Identification and holistic management of at-risk pregnant women who are (a) suffering from mental illness, (b) illicit drug abusers, and (c) teenagers under 18 years old.* After identification, holistic management plan will be developed by health and social service professionals, and CCDS midwives from HA coordinate the service and monitor the progress of these women in the antenatal period. After delivery, a visiting pediatrician from HA will provide follow-up service for their children in MCHCs and timely intervention is offered via close collaboration of the service partners in the community.
2. *Identification and management of mothers with postnatal depression (PND).* Postnatal mothers will be screened for PND in MCHCs. Counselling service will be provided by the trained MCHC nurses with referral to visiting psychiatric nurses and psychiatrist, and other supporting social services as required.
3. *Identification and management of children and families with psychosocial needs.* There is close collaboration between DH and SWD for assistance to the needy families.
4. *Identification and management of pre-primary children with physical, developmental, and behavioral problems.* A referral and feedback system has been developed to enable pre-primary educators to identify and refer these children to MCHCs for assessment and further management.

Based on the scientific facts that children's brains require stable, caring, interactive relationships with carers for optimal development and that early preventive intervention being more efficient and critical in producing more favorable child outcomes (Center on the Developing Child at Harvard University, 2010a, b), CCDS aims to prevent and ameliorate the possible outcomes related to the early childhood adversities by the joint efforts of different professionals in different sectors. A local study revealed that CCDS midwives could engage the mothers in their pregnancy and improve their mental outcome (Ip et al., 2015) which is essential to improve mother-child interactions. Holistic management of drug-abusing mothers with interdisciplinary collaboration could improve the vaccination rate and identify early the children who were at risk of child abuse for appropriate intervention (Ip et al., 2008; Cheng et al., 2022). It could also improve the developmental outcomes of children born to drug-abusing mothers through integrated CCDS collaboration (Cheng et al., 2022). Their parenting competency could also be enhanced (To et al., 2021) which is crucial for maternal determination of drug detoxification and practice of good-enough parenting to their children.

Subvented Preschool Rehabilitation Services

Subvented preschool rehabilitation services are targeted at children from birth to 6 years old or who have not started primary schooling; these children either have disabilities or are at risk of becoming disabled. The service is provided by a multidisciplinary team involving childcare workers, occupational therapists, physiotherapists, speech therapists, clinical psychologists, and social workers with the objectives of (1) enhancing the physical, psychological, and social development of these children by providing early intervention, (2) improving their opportunities for participating in daily activities and integrating them into mainstream schools, and (3) helping their parents to meet their special needs. There are three types of services based on the level of disabilities of children, and another new model of rehabilitation (On-site Preschool Rehabilitation Services) has been introduced recently to further address the service needs.

Early Education and Training Center (EETC) EETC is designed for children with mild disabilities from birth to the age of 2, offering them weekly center-based early intervention programs with emphasis on the role of the child's family in educating and training the child. Children aged 2 to 6 who have not started primary schooling with mild disabilities can also attend EETC if they are not receiving other preschool rehabilitation services.

Integrated Program (IP) in Kindergarten-cum-Child Care Center IP provides day nursery care together with individual and group training to children with mild disabilities aged 2 to 6 in kindergarten-cum-child care center (KG-cum-CCC).

Special Child Care Center (SCCC) including Residential Special Child Care Center (RSCCC) SCCC is designed to provide developmental assessment, intensive center-based individual and group training, and day care to children with moderate to severe disabilities aged 2 to 6. RSCCC also provides continuous and intensive residential care and therapy for the same age group with severe and complex disabilities.

On-site Pre-school Rehabilitation Services (OPRS) OPRS provides on-site rehabilitation service and training for children under the age of 6 with special needs who are attending kindergartens or KG-cum-CCCs. It has been implemented since 2018 to address the fragmentation of services and to integrate services across different contexts with a multidisciplinary approach (Lam et al., 2019b). With investment from the government in OPRS, it shortens the waiting time for the early rehabilitation service for preschoolers with special educational needs significantly.

The multidisciplinary team of OPRS delivers on-site services for the targeted children which include (a) developmental training as early intervention, (b) support for teachers/childcare workers on knowledge and skills in working with these children, and (c) support for parents/carers on positive attitude and effective skills for raising their children with special needs. Other than interdisciplinary approach, a tripartite approach involving family, school, and community is also adopted into this model. Children can receive school-based training which is delivered by the outreaching professional therapeutic service. With parental support and engagement, complementary training is also provided outside school in different community/welfare facilities (SWD, 2018).

Child and Adolescent Mental Health Service (CAMHS)

There has been no updated epidemiological study in Hong Kong that tells the prevalence rate of mental health problems of children below age 6 except the one done about 30 years ago in 1991 on behavioral problems of the 3-year-old Chinese children (Luk et al., 1991). However, the questionnaire survey done by the Department of Health (DH) in 2014 on the pattern of parenting practices among parents of 4-year-old children in Hong Kong (FHS, DH, 2018) might shed some light on the mental health needs of young children. In the survey, a total of 844 sets of questionnaires were analyzed. It was found that 11.1% of parents fell into the problem range of parenting stress, and 9.6% of children were perceived by their parents to have significant behavior problems, that is, almost 1 out of 10 children was perceived by their parents to have mental health needs. Having said this, not necessarily all require seeking tertiary services in the CAMHS. For the subclinical cases, general parenting support and programs are provided in the community. Only those moderate and severe clinical cases are referred to CAMHS in public hospitals under the management of the Hospital Authority (HA).

The CAMHS is led by specialists in psychiatry with support from a multidisciplinary team, including clinical psychologists, psychiatric nurses, occupational therapists, speech therapists, medical social workers, and hospital school teachers. It serves children and adolescents below age 18. Among a total of 28,800 cases seen at CAMHS for the year 2015–2016, about 10% were young children from birth to age 5 (Food & Health Bureau, 2017). In children of this age range, the major type of mental disorder, which is based on the criteria of the International Statistical Classification of Diseases and Related Health Problems, was autism spectrum disorder (ASD) (60.2%), with the remaining as attention deficit/hyperactivity disorder (AD/HD) (7.0%), behavioral and emotional disorders (1.6%), and others (10.7%) (Food & Health Bureau, 2017).

Multidisciplinary Cooperation for Protecting Children from Maltreatment

Children need to be protected from maltreatment and have the right to develop in the best possible way. They are vulnerable to harm inflicted by people in a position of differential power to them. The adverse outcomes can be severe, particularly on the socio-emotional development of the child, especially when these harms are caused by people who are supposed to be trustworthy and with a duty of care to them. This can result in attachment problems in the infancy period and psychosocial issues in the trajectory of their development (Choi et al., 2020).

In 1978, a 10-year-old girl was severely physically abused in Hong Kong and a concern group composed of multidisciplinary professionals was alarmed. Prior to this incident, the awareness of the existence of child abuse in Hong Kong was very low. A hotline service for child abuse report was then established by an action group, which later became the Against Child Abuse (ACA), an NGO. With the joint effort of ACA, mass media, and university academics, child abuse issue gained more public attention and was recognized as existence in Hong Kong (Against Child Abuse, 2019). A series of actions were taken by the government, including the first introduction of Procedural Guide for Handling Child Abuse ("Procedural Guide") in 1981, and the establishment of hotline service, Child Protection Working Group, Child Protective Services Unit (renamed Family and Child Protective Services Unit [FCPSU] in 2000), and Child Protection Registry during the period from 1982 to 1986 (Against Child Abuse, 2019).

The Procedural Guide has been kept updating, and the latest one is the sixth version that has been in use since April 2020 (Labour and Welfare Bureau [LWB] et al., 2020). It was jointly drawn up by various sectors including government bureaux and departments, relevant NGOs, health services, educational services, and law enforcement units in Hong Kong. The content of the 6th version not only extends on the procedures, matters for attention, and reference materials on child protection but also addresses many societal concerns. As compared with previous versions, this revised version has addressed the pitfalls in the reporting of abuse to a certain extent. Terms like "report," "refer," and "consult" are clearly defined to delineate professional obligation. Besides, it has put more emphasis on the prevention of child maltreatment and its recurrence, in addition to strengthening the content on handling procedures and multidisciplinary cooperation.

Prevention and Early Identification of Child Maltreatment

Hong Kong has been adopting a three-pronged strategy (see Fig. 3.1) on the prevention of child maltreatment and safeguarding the children's safety and welfare (LWB et al., 2018). The three levels are highlighted below:

First Level of Prevention Programs, services, and resources by different sectors on family life education and primary health care are available in Hong Kong, contributing to the prevention of child maltreatment.

SWD has launched district-based programs to raise the public awareness on the importance of family harmony and cohesion, and prevention of domestic violence and child maltreatment. It has also initiated various campaigns with messages to avoid physical punishment, verbal abuse, and neglect on children in recent years. Forums for various disciplines are set up so as to address the problem with a wider community involvement. Committees are set up in districts for liaison with various stakeholders. A non-statutory Child Fatality Review Panel has been set up since 2011 for reviewing fatal cases of children under

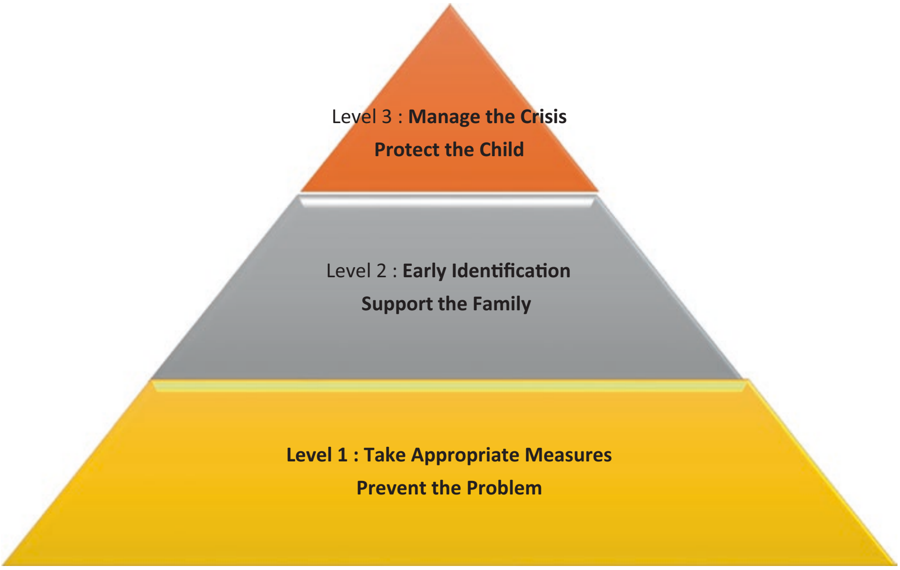

Fig. 3.1 Three-pronged strategy on safeguarding children's safety (Child Protection Guide, 2020)

18 years of age who died of natural and non-natural causes, with the aim to make recommendations for enhancing inter-sectoral collaboration and multidisciplinary cooperation to prevent the occurrence of avoidable child deaths (SWD, 2021).

Second Level of Prevention This level of prevention is to identify those children with higher chance of being maltreated and provide the appropriate support and/or timely interventions to their families, which can ameliorate the serious and long-term impacts on these children.

There are certain characteristics in the parents'/carers' background, life experience, attitudes, and behaviors affecting their parenting capacity. Psychosocial risk factors for child abuse were identified in children with developmental problems assessed at Child Assessment Centers (Lo et al., 2017). The Comprehensive Child Development Service, in addition to a spectrum of services provided by SWD, NGOs, DH, and HA, can offer appropriate support and timely intervention to the children and families. DH, HA, and SWD have developed a Manual of Parenting Capacity Assessment Framework (0–36 months) (DH et al., 2019), which is used as a reference for the social workers to provide good-enough parenting practice and to identify early the family with risks of child maltreatment.

Third Level of Prevention This level of prevention is to prevent the recurrence of child maltreatment through actions taken in handling suspected child maltreatment cases and welfare plan as recommended in the Multidisciplinary Case Conference on child protection. To enhance multidisciplinary cooperation, the Procedural Guide clearly defines the scope of suspected cases, handling procedures, and the specific roles of different professionals. The FCPSU of the SWD, the Child Abuse Investigation Units of the Hong Kong Police Force, and the Medical Coordinators on Child Abuse of the HA are specialized units/personnel involved in handling suspected child abuse cases. Relevant training has been organized to enhance other personnel in different organizations to handle suspected child maltreatment cases.

With the reference of the Signs of Safety approach (Elia International Ltd., 2019), a strength-based and safety-focused approach to child protection developed in Western Australia, the goal of establishing a safety plan among professionals and family members for the best interests of the children can be achieved in our local context. While statutory supervision or out-of-home care is required for those children with higher risk of maltreatment, intensive family-focused therapy under multidisciplinary collaboration is offered to the families so that a permanency plan for these children can be formulated and implemented.

Incidence Rate of Newly Reported Child Abuse Cases in Hong Kong

Despite our concerted effort on prevention, the number of newly reported child abuse cases in the Child Protection Registry has been increasing over the last 27 years (see Fig. 3.2), and the incidence rate of child maltreatment hospitalization has increased annually by 9% between 2001 and 2010 (Ip et al., 2016). However, the suspected cases need to go through a process of different investigations, assessments, and multidisciplinary case conferences before they can be established as cases of child abuse or neglect. The actual number of cases should be higher than the reported cases in the Registry, and many may be hidden in the community.

Mandatory Reporting on Child Abuse

Two incidents in 2018 have exposed the gaps in the child protection systems in Hong Kong: the death of a 5-year-old girl (Siu, 2021) resulted from abuse by her father and stepmother; and a mother starved her 7-year-old daughter to near death (Siu and Lau, 2018). Upon direct investigation, the Ombudsman recommended that the government should explore the feasibility of mandatory reporting of suspected child abuses (Office of the Ombudsman, 2019). Moreover, the recent institutional abuse in Hong Kong (Sun, 2022) further reflects the importance of reviewing the quality of institutional care to young children and the need of mandatory reporting in order to safeguard the vulnerable children's normal physical and psychosocial development. In fact, mandatory reporting on child abuse and necessary follow-up measures to address all forms of violence against children has been recommended

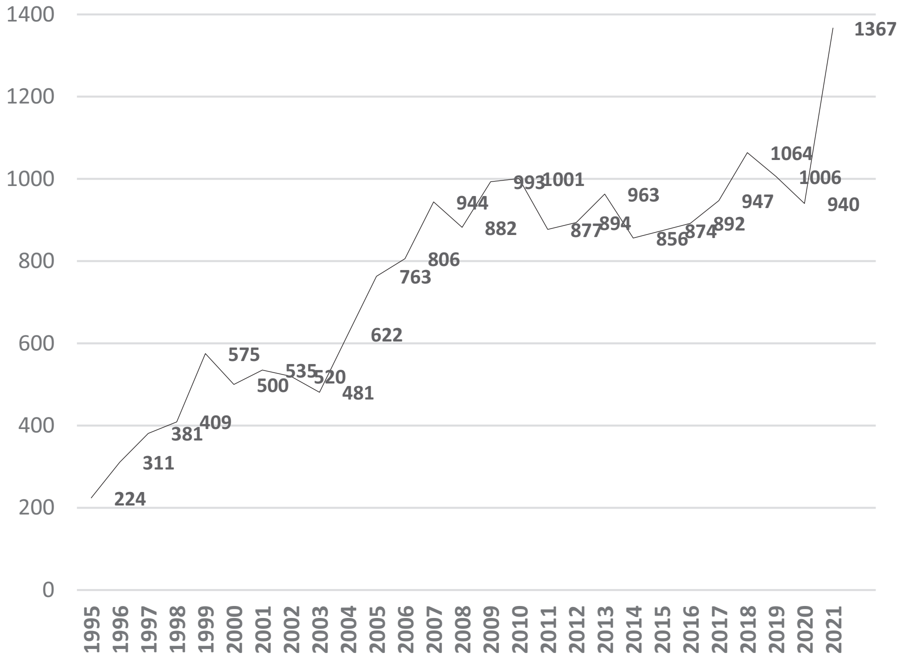

Fig. 3.2 Newly registered child abuse cases in Child Protection Registry – Hong Kong. (Source: Child Protection Registry Statistical Report, Social Welfare Department, HKSAR)

by the Committee of the United Nations Convention on the Rights of the Child (UNCRC, 2013), and Hong Kong has been one of its States parties since 1994. Closely related to the mandatory reporting of suspected child abuse is the proposed "failure to protect" offence in "causing or allowing the death of a child or vulnerable adult" in the consultation paper by the Law Reform Commission in May 2019 (Law Reform Commission of Hong Kong, 2019). The government has targeted to introduce legislation on mandatory reporting in 2023.

What is the reporting behavior of suspected child abuse case among general practitioners in Hong Kong? A local study found that among 171 general practitioners, only 35.8% reported suspected child abuse cases on their encounters. Their professional training predicted their attitude toward mandatory reporting; exposure of reporter identity and reluctance to be involved in the legal system were found to be the two major barriers to mandatory reporting (Leung et al., 2011b). To enhance the mandatory reporters' capacity for handling child abuse cases, interbureau steering group and task force group on mandatory reporting of child abuse have been set up to prepare the relevant training.

Child maltreatment may only be the tip of the iceberg of a family which actually is facing many difficulties underneath. Early identification of possible child maltreatment is very important to enable the children enjoying good physical and mental health. Primary and secondary prevention of child abuse needs higher priority in the system. Following the changes in the family and the societal circumstances, the issue of child maltreatment has been becoming more complicated as compared to previous years in Hong Kong. Child maltreatment has been found to be related to poor mental outcomes of children and psychiatric illness in childhood locally (Wong et al., 2022). Multidisciplinary professionals should work together in protecting the physical and psychological safety of children, in particular those young infants, in safeguarding their best interests, and in ameliorating the adverse consequences of the harm imposed on their physical and mental well-being.

Hong Kong Association for Infant Mental Health Limited (HKAIMH)

The Birth of HKAIMH

A group of practicing professionals initiated the idea of forming a local association to promote infant mental health (IMH) in Hong Kong. Most of us are working with infants, young children, and their families. We share the vision that the social and emotional well-being of very young children, which results from a secure relationship with their primary caregivers, is of paramount significance to a person's development. Our association was started with 17 founders, including clinical/educational psychologists, psychiatrists, pediatricians, psychiatric nurses, and occupational therapists. We relied on the assistance of professional volunteers who shared our passion for IMH to work out the legal procedures of setting up a corporate. This took more than a year to do so. The HKAIMH was established in 2014 and has been approved as a charitable institution in Hong Kong. The directors, the legal advisor, and the company secretary were in post on an honorary basis. It has been really our honor to have Associate Professor Campbell Paul be our Association's advisor till now.

The Work of HKAIMH

As IMH is a new area that has not yet been well acknowledged in Hong Kong, training and promotion of IMH to both professionals and the public become our Association's prime work direction. We aim to facilitate interdisciplinary collaboration among professionals working with young children and their families and to advance the standard of teaching, training, and practice of IMH in Hong Kong.

Organizing relevant IMH training for HK professionals has been our work plan for the first few years. Training programs included Newborn Behavior Observation System, Circle of Security Parenting, Mindful Parenting, MYmind, Parental Reflective Functioning, Reflective Parenting Program, etc. Masters in IMH were invited to deliver the training, like J. Kevin Nugent, Campbell Paul, Bert Powell, Neil W. Boris, Glen Cooper, Susan M. Bögels, Arietta Slade, and Regina Pally. Through these training activities, we have not only learned specific clinical skills and enhanced our appreciation of IMH's significance but also strengthened our connections with local and international working partners.

In addition to the above short training programs, it was our privilege to have the full 18-month training in Child-Parent Psychotherapy (CPP) with Joy D. Osofsky held in Hong Kong in 2018. This was the first CPP training to be done with an exclusively Asian orientation and population. The training included 3 + 2 + 2 days of in-person training and biweekly online consultation calls for case presentation and discussion. Through the training process, we became more aware of the cultural issues, such as our role expectations of women as primary caregivers in Chinese families, the involvement of intergenerational parenting, and the inconsistency of parenting across generations. It was a great learning opportunity for bringing an excellent psychotherapy model for treating very young children with trauma to Hong Kong.

While widening our IMH knowledge base, we have been actively participating in local seminars/conferences/symposiums at the same time to disseminate IMH knowledge to various professional disciplines, such as pediatricians, pediatric nurses, psychiatrists, psychiatric nurses, psychologists, physiotherapists, early childhood educators, and nursery teachers. Similar work has been done to promote IMH among the public. We have taken part in public education activities to reach parents and parents-to-be in the community to enhance their awareness of infant socioemotional well-being.

With the establishment of our Association, we are in a favorable position to connect with both local professionals and overseas professional bodies. Internally, we are better informed of the interests/needs of our members and bring in each of their expertise, like arranging reading groups for peer sharing. Externally, we serve as an advocacy group to stand for the rights of young children. For example, we submitted our response to the 2017 Mental Health Review Report to the Advisory Committee on Mental Health, Hong Kong. Furthermore, we also act as a contact point to liaise with international bodies, like WAIMH. We were so honored to be invited to share our local IMH issues in the Asian Institute at the WAIMH Congress.

Highlights of IMH Practices and/or Research in Hong Kong

Effort has been made to adapt relevant programs developed in Western countries to local practices. Some have been applied to the clinical population (such as babies with prematurity, very young children with developmental disorders), whereas some to the community population (such as parents at MCHCs and NGOs). Outcome research is also conducted whenever appropriate to demonstrate the effectiveness of clinical practices. Below are some highlights about IMH practices and research in Hong Kong.

Applications to the Clinical Population

Babies with Prematurity

The estimated pooled preterm birth rate in Hong Kong, Macau, and Taiwan was found to be 6.13% from 1990 to 2016 (Jing et al., 2020). The preterm babies and their parents not only face challenges from possible medical complications and/or neurodevelopmental impairment, but their early mother-infant interaction might also be compromised. As preterm babies are more likely to become aroused and distressed, it is harder for their parents to console them, leading to parental disappointment and additional stressors (Bozzette, 2007).

Mother-infant interactions are indeed transactional. A local study investigating the effectiveness of a modified version of the Mother-Infant Transaction Program in enhancing Hong Kong Chinese mothers' sensitivity to their premature infants' physiological and social cues was conducted by Yu and her team (Yu et al., 2022).

A four-session maternal sensitivity training was delivered to these mothers during their babies' hospitalization in the neonatal intensive care unit. Results were positive, which demonstrated that mothers who had received the training showed higher maternal sensitivity and better mother-infant interaction quality, and they reported less parenting stress and postnatal depression after the training than those who had not received it. The gains in maternal psychological well-being were found to persist at 3-month, 6-month, 9-month, and 12-month after the training, and the training significantly predicted better weight gain and developmental outcomes in infants, mediated by maternal well-being and interaction quality.

The study of Yu et al. (2022) provides excellent support for very early intervention to mothers of premature infants for enhancing maternal sensitivity as well as reducing maternal intrusiveness. This is in line with the current evidence that mothers' attachment and maternal interaction behaviors are at greater risk than the infant's behaviors during the first 6 months after birth (Korja et al., 2012).

Very Young Children with Neurodevelopmental Disorders

Young children with neurodevelopmental disorders, such as ASD and ADHD, constitute over 60% of the age 0 to 5 cases seen in CAMHS in 2015/2016 (FHB, 2017). With current advances in early detection science, ASD features can be identified during a child's toddlerhood. Timely access to training and intervention has to be matched with the unique characteristics of this young age group of children to optimize the gains. Given children's very young age and their close contact with caregivers during their waking time, a caregiver-mediated play-based intervention is particularly appropriate. DIRFloortime is an evidence-based approach (International Council on Development and Learning, n.d.) which emphasizes caregivers' involvement in a child's training and usually takes place in a natural social environment. It is deemed the most suitable training for very young children with ASD features. DIR is the acronym for Developmental, Individual-Difference, Relationship-Based model, which was developed by Stanley I. Greenspan (Greenspan & Wieder, 2009). The goal is to promote a child's functional emotional developmental capacities through coregulated positive affective interactions with his/her caregiver(s).

In Hong Kong, the DIRFloortime model has been well implemented in the regional hospital where the first author is working (Mok & Chung, 2014). Caregivers of very young children with ASD are invited to participate in parent training, and they have been coached DIRFloortime techniques, like following their child's lead and engaging them, joining in their repetitive play, and always interacting with them purposefully. Caregivers begin to learn ways to promote appropriate child-caregiver interaction to support their children to develop higher functional emotional developmental capacities. Given the significance of caregiver's commitment and involvement in a child's training, parents' mental health and their availability to deliver adequate intervention dosage become two major concerns. Nevertheless, in view of its developmental approach and play-based nature, DIRFloortime is a promising intervention approach for this very young age group of children with ASD.

Applications to the Community Population

Universal and Preventive Parenting Programs at MCHCs

The first local community survey conducted by DH on patterns of parenting practices among 942 Chinese parents of 4-year-old children showed that 10.5% of children could be classified as being in the clinical range for behavior problems (FHS, 2004). The survey results also indicated that child behavior problems were associated with parenting stress, which was related to social support and economic status. Systematic reviews of randomized controlled trials (RCTs) had shown that parent training programs were effective in improving child behavior problems and reducing maternal anxiety and stress (Webster-Stratton & Taylor, 2001; Barlow & Coren, 2001).

Supported by research evidence, the parenting program has been established as a component of the revamped integrated child health and development program in MCHCs since 2002. The aim was to equip parents with the necessary knowledge, attitude, and skills to bring up healthy and well-adjusted children. The program covers parents in the antenatal stage to those having children from 0 to 5 years old. It consists of the universal and the intensive components.

The Universal Component It was developed by in-house professionals. It includes information leaflets, videos, e-newsletters, online resources, a series of "Happy Parenting!" workshops, as well as individual counselling by nurses to give anticipatory guidance on childcare, development, and parenting specific to the age of children. An evaluation found that parents had knowledge gained after attending the "Happy Parenting!" workshops (FHS, DH, 2013), and ongoing evaluation showed positive feedback from parents. When comparing the users and non-users of the MCHC educational resources, there were more parents in the latter group showing higher parental distress and problematic parent-child interaction (FHS, DH, 2018).

The Intensive Component When early signs of child behavior problem are detected or parents encounter parenting difficulty, they may enroll in the intensive component in the form of a structured group program – Positive Parenting Program (Triple P). Triple P has robust evidence of efficacy in different countries (Sanders et al., 2003; Matsumoto et al., 2010). The effectiveness of Triple P on local parents was established in an RCT with 69 parents of 3- to 7-year-old children. After the intervention, there was a significant decrease in child behavior problems and dysfunctional parenting practices. There was also an increase in parenting competence and improvement in marital relationships (Leung et al., 2003). Ongoing evaluation indicated improvement in child behavior, parenting competence, and parenting stress from families attending Triple P. Although more new immigrants and families of low income did not complete the Triple P, it was found that when they did complete it, they gained greater improvement (Leung et al., 2006).

Anticipatory Guidance to At-Risk Parents at MCHCs

Being a platform of alignment of Comprehensive Child Development Service (CCDS), MCHCs have a role to identify parents who are at higher risk of parent-child psychopathology transmission such as (1) teenage mothers, mothers with (2) history of drug addiction, (3) mental or mood disorder, and (4) psychosocial needs. Newborn Behavior Observation (NBO) has been incorporated by the CCDS Pediatrician into routine physical and developmental assessment at the infant's 2-month visit in MCHCs since August 2016. The infant's behaviors are used as means to communicate with their parents during assessment, enabling parents to understand more about the physical and behavioral aspects of their infants in order to provide related good-enough parenting skills. Up to July 2017, there were 236 infants having NBO applied in which all parents were eager to learn about these behaviors and the process also strengthened the parent-infant bonding.

Community Parenting Programs for Disadvantaged Families with Preschool Children (NGO- and Home-Based)

The attendance to MCHCs becomes less regular after the completion of immunization program at 18 months of age and there is limited service provision for children aged between 18 months and 3 years. Social security fee assistance is limited to families with social needs. In view of these service gaps, Leung and her colleagues had developed a series of local parenting programs for disadvantaged families based on the National Institute for Health and Clinical Excellence (NICE) guidelines (2013). These programs cover such families with young toddlers under 2 (Fun to Learn for the Young [FLY] Program) and aged 2 (Parent and Child Enhancement [PACE] program), new immigrant families with children aged 2 to 3 (Hands-On Parent Empowerment

[HOPE-20] program) and 3 to 5 (HOPE), and home visiting program for preschool children (Healthy Start program). The duration of these programs ranges from 20 to 60 sessions. The content varies with programs, covering play and behavior management skills, skills in enriching children with school readiness and learning, as well as healthy lifestyle. All were supported with RCTs with promising evidence and have been implemented in the community through NGOs (Leung et al., 2011a, 2015a, b, 2017a, b).

Integrated Community Support for Low-Income Families with Preschool Children

Poverty is a risk factor for child mental health and behavioral concerns. It has been found that children living in low-income households were significantly more likely to have psychiatric conditions and inferior mental health (Jakovljevic et al., 2016). Despite their high need for mental health service, they have less access to high-quality mental health care (Hodgkinson et al., 2017). In view of such disparities, the KeySteps@JC Project (KeySteps@JC, n.d.) was launched in Hong Kong in 2017. It is a five-year project with the aim to build a stronger foundation for improving the physical, cognitive, emotional, and social development and enhancing school readiness of children aged 3 to 6 from low-income families.

The Project adopts the medical-welfare-education model, which bridges the gap between schools, families, and the community. Its objectives are (1) to provide holistic support for the children on their health, social skills, emotional, and cognitive and language development to build stronger foundations for better life outcomes, (2) to enhance parent-child attachment and promote parent/grandparent/caregiver well-being to strengthen family functioning based on evidence-based program, and (3) to enhance capacity building in schools and enrich learning environment and school curriculum to create quality learning environment. Community hubs are set up to act as the platforms to connect school with the families. Facilities in the hubs are designed to provide age-appropriate and multi-dimensional learning experiences to the children. There are different zones for enhancing gross and fine motor development, scientific thinking processes, and reading experiences. Multicomponent parenting intervention programs are also designed and provided by NGOs. The programs include the parent-empowerment program with emphasis on emotional coaching and child-led play, and the parent-child interactive component via didactic reading.

The Project has rolled out to 32 local kindergartens in two pilot low-income districts covering around 6,000 children and their families, and the participating kindergarten teachers. Effectiveness of the intervention programs in the community hubs has been evaluated through an RCT. The result showed statistically significant improvement in the children's behaviors as well as parents' use of emotional-coaching strategies and involvement in child reading with implications that the children were more socially and emotionally ready for schooling (Leung et al., 2022).

Hub-Based Programs for Parents with 0- to 3-Year-Old Vulnerable Children Most of the vulnerable families are difficult to be engaged in the routine service. Their children are at high risk of experiencing adverse childhood experiences which are traumatic events that occur in childhood, like child abuse or neglect, witnessing violence in the home, and having a parent suffering from mental illness or being an active substance abuser. Children's safety and bonding with carers are severely affected as there is a lack of nurturing environment for them to grow (Felitti et al., 1998; National Child Traumatic Stress Network, 2019). Hub-based program can achieve easier accessibility to the targeted intervention and retainment of these families in the service.

1. *Pilot Program*

During the period from 2019 to 2021, the hub-based program (KeySteps@JC Project (KeySteps@JC, n.d.)) was further extended downward to younger children from birth to 3 years old whose mothers are illicit drug users (with not more than 4 times per month), teenagers, or having mood disorder under regular treatment. The recruited mother-infant pairs were under the care of the CCDS teams, and mother was the main caregiver of the child. There was regular communication on the dyad progress between CCDS teams of HA and the NGOs. On initial recruitment, home visitation was done to assess the quality of stimulation in the home environment, and during the home visits, age-appropriate toys were given, and anticipatory guidance to facilitate child development was also recommended to the parents. The Circle of Security Parenting™ (COSP™) program (Powell et al., 2013) was then offered to the participating mothers. Preliminary results showed improvements in children's development profile, parental sense of competence and reduced parenting stress after the COSP™. The mothers reported to be satisfied with the support by the program. Besides, they also considered the community hub as a means of a social network to connect with one another, creating a supportive environment for nurturing their children.

2. *"The Amazing Start" program*

With these rewarding results, "The Amazing Start," another collaborative hub-based program between the CCDS team in one of the HA clusters and an NGO, started in 2021. The program aims to enhance responsive parenting capacity, secure child attachment, and age-appropriate child development. It includes home visitation for recruitment, parent-child infant massage for babies below age 1, parent-child playgroups (12–16 sessions) for toddlers aged 1 to 3, and COSP™ coaching (4–8 sessions). Outcome evaluation results in children's developmental progress, parenting competency, and parental stress will be expected in 2023–2024.

Current Service Gaps and Challenges

Inadequate Recognition of Mental Health Problems at Infancy and Early Childhood

Current services in Hong Kong for children under age 6 tend to focus more on training and rehabilitation for children with neurodevelopmental disorders than prevention and early intervention for children at risk for mental health problems. Evidence does show that the risk factors during the perinatal period and early infancy, like parental depression and anxiety, early trauma experiences, and disruption of attachment relationships, lead to vulnerabilities to later mental health difficulties (Izett et al., 2021). Thus, enhancing the awareness of parents and professionals to mental health concerns at infancy and early childhood is deemed necessary. Possible indicators include (1) psychosomatic concerns, such as feeding problems, sleep difficulties, and failure to thrive, (2) emotional and behavioral concerns, such as excessive crying, temper tantrums, and anxiety, and (3) attachment concerns, such as over-clinginess and social withdrawal. Early recognition of the precursors of mental health problems facilitates timely referrals to appropriate mental health services (Phillips & Best, 2007).

Parents' Readiness to Seek Help for Young Children's Socioemotional Problems

Having said this, though some young children do exhibit behavior problems, their parents may not seek help because of their concern about stigma (Dempster et al., 2013). Cultural factors do play a role. Lau and Takeuchi (2001) found that Chinese-American parents of elementary school aged children who had more traditional Chinese values responded with more feelings of shame to child behavior problems and, in turn, reported lower intentions to seek help. To reduce the impact of stigmatization on help-seeking, it is worthy for policy makers and service providers to take careful consideration of the service platform in the community that is easily accessible and stigma-free.

Intergenerational Significance in Local Childcare Practices

As there is a Chinese traditional belief that mothers are responsible for domestic matters, mothers in Hong Kong are usually assumed to be the primary caregivers regardless of having a good career, having emotional problems, or coming from a traumatic background with inadequate parenting skills (Osofsky, 2021). The stresses of these mothers may affect their children's behavior and emotions. When grandparents from the paternal and/or the maternal side are involved in childcare too, the cross-generation dynamics and inconsistency in parenting could complicate the stresses on the parents and children (Osofsky, 2021). A local study on children of 6 to 48 months showed that about 30% of the children lived with their grandparents for at least 5 days a week, including those in the extended family context, and the grandparent was the main caregiver in 25% of the families in the study (Leung et al., 2012). However, parental stress was found to be higher when grandparents were involved in childcare comparing with childcare carried out by domestic helpers (FHS, DH, 2004). A recent local trend analysis found that respondents who were parents tended to have more positive attitudes toward grandparent involvement in family issues than non-parents. Involving support from grandparents is likely to be need-driven rather than value-driven from an economic perspective (Chen et al., 2022). In view of the potential intergenerational conflicts in values and childcare practice, both parents and grandparents may need support in knowledge and skills in child management as well as intergenerational communication. The Grandparenting Triple P developed in Australia (Kirby & Sanders, 2014) covering these elements was trialed out in Hong Kong (Leung et al., 2014). The results showed some initial efficacy in reducing child problems and enhancing grandparenting confidence, though no significant change in communication skills was found. While the working parents are still waiting for more and better childcare provision, the asset of grandparent support is not to be overlooked and more local studies on grandparenting are needed.

Recommendations

To Make Infant Mental Health Services More Accessible to Families

The provision of community hubs provides a platform to engage families for parenting programs and connect them with mutual networking and support. It will be a good model to be established in every district with disadvantaged young children. Involvement of families in the service planning can be considered as the users should know their needs better. There is an imminent need to coordinate different stakeholders in the community to design interventions with easy accessibility and to build up the professional capacity in managing children coming from families with complex needs. There are successful programs run by NGOs with CCDS like the integrated program for children born to substance-abusing mothers (Cheng et al., 2022) or have been trialed out in the community with satisfactory results in studies, such as the "Healthy Start" program. Home visitation programs are found to be effective in engaging the hard-to-reach families to provide intervention. The Nurse-Family Partnership home visitation program in the United States (Olds, 2006) targeting low-income first-time mothers from pregnancy till the children reached age 2 is well recognized to have good long-term outcomes including better parental care as reflected in less child abuse and neglect, better infant emotional and language development, and an improvement of maternal life course. More funding and resources from the government will surely help to bring such robust program for use on our disadvantaged families as well as to sustain the running of meaningful programs in the community.

To Strengthen Public Education on Infant Mental Health

Currently, most resources in IMH have been directed to the early detection and intervention work, and there is much less attention to promote infant mental health in the prevention of infants' well-being both physically and psychosocially. Public education on the importance of providing a nurturing environment to raise a child should be promoted to the parents, teachers, social workers, police, and general public. Positive discipline with no physical punishment should be promoted and the importance of the socioemotional development in children in the society should be reinforced. Relevant training related to infant mental health should be provided to the involved professionals. The policy makers and service providers should make use of every opportunity to emphasize the importance of socioemotional development of young children to the public.

To Further Enhance the Multidisciplinary and Interdisciplinary Collaboration

Comprehensive Child Development Service (CCDS) in Hong Kong demonstrates a cross-sectorial collaboration among hospital, health, social welfare, and education services to offer IMH services to children at or under age 5 and their families. Continuous review of the service territory-wide and data collection from the various collaborating sectors are required to further improve this child-focused, family-centered, and community-based service in Hong Kong. Despite the fact that the CCDS in Hong Kong has been established since 2005, there is still much room for enhancing its resources in manpower and training. By doing so, CCDS services targeting the dysfunctional or disorganized families (e.g., parents who are active substance abusers or parents suffering from mental disorders or teenage parents with poor social support) could be sustained to safeguard the mental well-being of the children at risk.

Interdisciplinary collaboration and support with cross-specialty training are essential to tackle childhood neurodevelopmental/mental problem. A shared care model of CAMHS cases by pediatricians and child psychiatrists should be considered to be implemented to shorten the long waiting time and improve child mental outcomes. Resources should also be allocated for clinical psychology service which offers targeted mother-child interaction problems, attachment issues occurring in patients who are managed by the general pediatricians, CCDS pediatricians, and child psychiatrists.

Not only effective communication is required for the multidisciplinary and interdisciplinary collaboration, but there is also a need for setting up a central database to collect data from various disciplines in different sectors involved in providing mental health service to the children so as to analyze the associated factors for satisfactory mental health outcomes.

To Introduce Infant Mental Health as a Pluralistic Subspecialty Across Disciplines

Infant mental health is a newly developing area of study in Hong Kong. Though there have been more IMH training opportunities available for local practitioners during the last decade, the training programs are mostly topic-specific delivered by overseas expert trainers. To the best knowledge of the authors, there are not yet any structured IMH training modules/courses offered by local universities/tertiary educational institutions. Practitioners who are interested in IMH either go overseas or attend online postgraduate study. In view of the complex, inter-related nature of infant and early childhood development, IMH involves close collaboration of different disciplines, such as pediatrics, psychiatry, psychology/psychotherapy, nursing, allied health, and early childhood education. Introducing IMH in each of these respective training curriculums is deemed worthwhile. This not only enhances the knowledge base of each professional discipline but also stimulates related local research and validation of local observation/assessment tools.

To Conduct a Surveillance on Mental Health of Young Children

As Hong Kong does not have a large-scale epidemiological study on young children's mental health other than the one done in 1991 on the behavior problem of the 3-year-olds, it may be time to have one such that the services for the young children population can be better planned. This could be conducted in relation to post-COVID evaluation and surveillance for understanding the impact of the pandemic on the mental health of families (Venta et al., 2021) such that timely prevention and intervention could be planned ahead for future community crises.

To Advocate for a Child Health Policy

Hong Kong still lacks wide recognition of the importance of infant and early childhood mental health and has limited accessibility of such services. While related professionals are working hard to raise public awareness on the issue, and policy makers have joined hands to work on the mandatory reporting of child abuse, we are still yearning for a comprehensive child health policy, in particular a child mental health policy, to coordinate the different government bureaux and departments. The comprehensive child health policy should be child-centered and family-focused, covering medical, social, educational, legal, and economic aspects. The On-site Pre-school Rehabilitation Services led by the former Chief Secretary for Administration was regarded by the Hong Kong Paediatric Society and the Hong Kong Paediatric Foundation (2017) as a good example of how the role of a Children's Commissioner should be. We hope the Commission on Children of HKSAR will better coordinate the relevant bureaux and departments in the best interest of our children to (1) set a clear timeframe and roadmap with guidelines and action strategies for implementation, (2) coordinate resources, and (3) monitor closely the progress and effectiveness.

Summary and Key Points

- Hong Kong has come a long way to raise the awareness on infant and early childhood mental health among the related professionals and the public notwithstanding the deep-rooted Chinese traditional values. The emphasis on health services has been extended from mainly physical to include mental well-being.
- Advocates have persisted to influence policy makers to meet the children's physical, psychosocial, and developmental needs. In response, the government has set up developmental screening and assessment, child welfare, medical, educational, and rehabilitation services for children. These needs of children are even more imminent in times of hardship such as during the COVID pandemic. Giving support to parents makes an impact on their parental efficacy as shown in Lau & Li (2021) on the preparedness of their children's readiness for primary school.
- The self-initiated effort from non-government organizations plays a significant role in promoting IMH among the professionals and the public and in supporting families with young vulnerable children in the community.
- Nevertheless, we perceive the local field of infant and early childhood mental health is just budding with gaps and challenges ahead. We look forward to making the IMH services more accessible to the families and to further enhancing the interdisciplinary collaboration and professional training on infant mental health across related disciplines.

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4

Developing Culturally Sound Infant Mental Health Practice for the South African Context

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Introduction

Awareness of infant mental health as a distinct field of study only emerged in South Africa after the democratic election in 1994. The first infant mental health conference was organized at the University of Cape Town during the following year. The emphasis on the early years in child development was mirrored by the hope of a new and fairer society coming into being. This synchrony may have been one of the reasons why this conference marked the beginning of an ever-growing local interest in the field.

While important research did take place during this early period (Cooper et al., 1999), the focus for many clinicians at the time was to support the mother–infant relationship. Two projects were initiated during this time – they are mentioned here as it is out of the clinical experiences gathered there that the research reported in this Chapter is based.

The University of Cape Town Infant Mental Health (UCT IMH) Service was initiated in 1995. It stood on 2 pillars and communities that were different on economic, ethnic, and language levels. While the centrally situated service mainly attracted middle-class, English-speaking, economically advantaged patients, the pillar located in an informal settlement on the outskirts of the city served a population that was economically and educationally disadvantaged – the result of the previous political system. The clinical experience of the UCT IMH Service has been documented in several papers (Berg, 2010; Berg et al., 1997).

In 2006 a parent–infant reading group was started in Johannesburg. This was the beginning of Parent-Infant Psychotherapy training at Ububele, a community centre situated on the border of two very different suburbs in Johannesburg. It was soon followed by the creation of the Ububele Umdelzane Parent-Infant Project (Dugmore, 2011) and the Baby Mat Project (Frost, 2012). Over the years several papers have emerged from these interventions (Bain et al., 2017; Bain & Baradon, 2018; Baradon & Bain, 2016).

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Most of the evidence-based IMH interventions available at the time originated in Europe or the USA. To have implemented these without having adapted the interventions to the local context, would not have made sense nor would they have been acceptable to the mothers who brought their babies to us. It was thus vital to develop interventions and approaches that were attuned to the needs and customs of the communities we served.

The peoples of Africa have lived and thrived before the Europeans entered their shores. Anthropological papers describe the rhythm and order of growing up in traditional society (van der Vliet, 1974). The physical closeness between the mother and her infant, the immediate attention to distress, the involvement of the neighbors and extended family in caring for the child; all of these are, even in modern times, ways of being with babies and toddlers that are protective of the child and fostering of relationships within a broader community life. However, these positive influences existed alongside harsh realities such as economic and health challenges, interpersonal and family strife, educational disadvantage;– the ongoing legacies of colonialism and Apartheid. Parenting practices worldwide are influenced by cultural, social, and economic contexts, which differ from region to region (1986) (Ainsworth et al., 1978). Economics determines the divide that exists globally with names such as Western vs non-Western, High-Income vs Low Middle-Income (LMIC) or WEIRD vs non-WEIRD countries (Western Educated Industrialized Rich and Democratic) (Henrich et al., 2010). However, most children live in LMIC or non-WEIRD countries, in contexts that are very different to those of the Western world from which IMH theory was developed and from whence most publications come (Tomlinson et al., 2014). Thus, for evidence-based practice in South Africa to develop we need local research into infant mental health constructs. Without local research and evidence, we run the risk of perpetuating the colonial mindset.

We acknowledge that the research projects presented here do not include fathers. This is partly due to local customs where it is traditionally the mother or female relative's role to care for the infant during the first 2 years. However, the importance of the fathers' presence in their young children's life is gaining increasing attention and traction in South Africa, such as their involvement in pre-natal screening (Slemming et al., 2021). There have, however to date been no research projects in South Africa that specifically examine father-infant interactions.

Three research themes will be offered here. They revolve around what it means to be a 'good mother' and how this could be assessed in the local context. The many psychosocial burdens that our mothers deal with impacts on their mentalizing ability and thus their relationship with their infants follows. The question of whether positive engagement between mothers and infants could ameliorate the effects of limited resources is addressed in the last section.

The research questions posed in the above projects flow from the clinical engagement in our community settings and in turn the findings will shape the interventions – the aim is to find "African answers" to "African questions" This is in line with the aspiration of repair that has always been part of the infant mental health field in South Africa, not only between caregiver and infant but also within our complex and diverse society.

Sensitive Responsiveness in the South African Context

The construct of sensitive responsiveness (originally "maternal sensitivity") is widely used to refer to parenting behaviors that promote secure attachment (Ainsworth et al., 1978). Rather than a defined set of behaviors, sensitive responsiveness refers to a parental behavioral response to both overt and subtle infant signals and communications, which is prompt, appropriate, and contingent upon the infant signal. Sensitive responsiveness is well documented, across several WEIRD countries, to play a central role in attachment security (de Wolff & van Ijzendoorn, 1997; Pederson et al., 2014) and optimal child outcomes (Baumwell et al., 1997; Callahan et al., 2011). Repeated experiences of consistent sensitive responsiveness are understood to provide infants with a secure base experience and organizing system (Pederson & Moran, 1995). Conversely, inconsistency or dismissiveness in response to signals is understood to lead to the development of insecure attachment (Ainsworth et al., 1971).

In recent years, a debate has emerged regarding the universality of the construct of sensitive responsiveness. Attachment researchers (Ainsworth & Marvin, 1994; Mesman et al., 2012, 2016a, b, 2018; Posada, 2013) have asserted that sensitive responsiveness is a universally relevant construct. Notably, unlike the majority of pervasive child developmental theories, research that contributed to the development of the concept of sensitive responsiveness included the study of African, specifically Ugandan, mother–infant dyads (Ainsworth, 1967). This is used as a central argument for the universality of the construct. Further, sensitivity has been observed in a variety of non-WEIRD contexts (Mesman et al., 2018), and studies in South America, Africa, and Asia have replicated the finding of a predictive relationship between sensitive responsiveness, attachment, and social competence (Mesman et al., 2012; Miyake et al., 1985; Posada et al., 2004; True et al., 2001; Valenzuela, 1997). These studies are also used to support the argument for universality. A 2016 study further supported claims of universality when it found consensus on the beliefs about ideal parenting behaviors across 26 different cultural groups, and alignment with Ainsworth's definition (Mesman et al., 2016a, b).

On the other hand, the universality of the construct has also been strongly contested. Arguments have been asserted that attachment theory is linked to individualistic cultural values embedded in Western constructions of parenting, including autonomy, curiosity, and independence, which diverge greatly from the values and social constructions in other cultures (Keller, 2018; Keller et al., 2018). For those arguing against universality, sensitive responsiveness is seen as a means of socializing infants to promote autonomy and independence, and supporting optimal development for Western schooling systems and workplaces (Feldman, 1998; Rothbaum et al., 2000), while behaviors often considered as insensitive are seen to socialize children from non-WEIRD contexts to survive threatening environments, adhere to group outcomes and manage with unavoidable separations (Crittenden, 1999; Keller, 2018). In a context such as South Africa, where there is both great cultural diversity and variance from Western cultural norms, but also large pockets of high social stress and trauma which has been shown to impact negatively on sensitivity (Mesman et al., 2012; Mesman et al., 2016a, b), local research becomes imperative when looking to provide culturally sound and contextually relevant infant mental health interventions.

Research Findings into Sensitive Responsiveness in South Africa

In search of culturally and contextually relevant IMH practice for the South African context, the construct of sensitive responsiveness has been under local investigation in recent years. While only a small number of studies measuring sensitive responsiveness in the South African context exist, reported sensitivity scores are low (Dawson et al., 2021; Dowdall et al., 2021; Timmers, 2021) and intrusiveness scores are high (Cooper et al., 2009; Tomlinson et al., 2005).

Pervasive low sensitivity scores for South African mothers on predominantly Western-developed sensitivity measures, in contrast to the scores of their counterparts from WEIRD contexts, could be seen to indicate a problem with contextual and cultural fit of the measures or construct of sensitivity for South Africa. However, the participants in the South African studies all came from low socio-economic backgrounds and high-stress environments. As previously indicated, studies from WEIRD contexts have reported a link between socioeconomic status and sensitivity (Mesman et al., 2012). Thus, pervasive low sensitivity scores alone fail to outline to what degree socioeconomic stressors versus cultural bias, and even power differences, are contributing factors to low sensitivity scores found in the context.

In the pursuit of locally informed understandings of caregiver–infant interactions in South Africa, Dawson et al. (2021) made use of the sensitivity data to provide a profile of maternal behavior in a sample of 50 South African mothers from the township setting. The coding provided data on behaviors found to be relatively common and relatively absent from the sample; a starting point for understanding maternal behavior in the context.

The study identified several behaviors that were found across the sample of 50 mothers, regardless of their individual sensitivity score (Dawson et al., 2021). These included behaviors such as (1) "provide the baby with [little or no] opportunity to contribute" to the interaction (2) setting the "content and pace" of the interaction and (3) not "build[ing] on the focus of the baby. That is to say, interactions in the context were largely mother-led and directive – behaviors considered as insensitive and intrusive in WEIRD contexts. These were in line with findings of high levels of intrusiveness in other South African studies (Cooper et al., 2009; Tomlinson et al., 2005), with assertions by Keller and colleagues (Keller et al., 2018) that such behaviors are more common in non-WEIRD settings as well as with assertions by Mesman et al. (2012) that they are more common in contexts of socioeconomic disadvantage.

In the same study, several behaviors included in the Maternal Behavior Q-Sort mini (MBQS-mini; Pederson, Moran & Bento, 2011) were also found to be relatively absent from the entire sample, regardless of sensitivity score (Dawson et al., 2021). Specifically, the study found an absence of (1) social games, (2) verbally based teaching (3) responsiveness during divided attention, (4) overt expressions of positive affect, and (5) praise. While some of the items listed above are not heavily weighted on the MBQS-mini, indicating that they are not considered as central contributors to sensitivity, many of these behaviors have been put forward by Western researchers more broadly as indicative of sensitive responsiveness (Dawson, 2018a) bringing the relevance of some applications and interpretations of the construct for the South African context into question.

Another related qualitative South Africa study provides an emic lens of the relevance of the construct of sensitive responsiveness for the context of South Africa (Dawson, 2018b, 2022b). In this study, eight South African mothers watched local videos of mother-infant interactions and were asked to comment on the appropriateness of the maternal behavior. The comments of the mothers indicated general agreement with Ainsworth's idea that a "good mother" is attentive and promptly responsive to infant distress and non-distress signals. The participants considered moments of missed signals and nonresponsiveness to be negative, while they regarded mothers who promptly responded to both stress and non-distress signals positively.

Importantly, three key contextual factors that were felt to influence maternal behavior were highlighted during the interviews (Dawson, 2018b, 2022b). First, mothers expressed concerns about the impact of the context on the health and safety of their infants. Second, maternal behavior appeared to be heavily influenced by socioeconomic stressors. Lastly, levels of loss and trauma were notably high in the interview cohort. As noted above, the participants came from a context with high levels of violent crime (Crime Statistics South Africa, 2019) and poverty (Statistics South Africa, 2020). Shared personal narratives by the participants highlighted ways in which these contextual stressors resulted in more parent-led interactions and greater instances of maternal control, as parents sought to ensure that their infants did not become sick or hurt (Dawson, 2022b). Considered together, the two studies outlined above appear to support ideas that directive, parent-led interactions are common in non-WEIRD and socioeconomically stressed settings. The prevalence of these behaviors appears to have both evolutionary and protective benefits (Dawson, 2022a; Keller, 2018) and possible developmental consequences (Dawson, 2022a; Mesman et al., 2012) and highlight the need for systemic interventions in this context. Further, the studies support arguments that aspects of current conceptualizations of the construct of sensitive responsiveness may contain cultural biases, not applicable to the context of South Africa.

Implications for Intervention in South Africa: The Ububele Home Visiting Programmes

The Ububele Home Visiting Programme (UHVP) is a South African–developed IMH intervention, aimed at promoting sensitive responsiveness, parental mentalization, and knowledge about infant sentience (Frost et al., 2018). The program was inspired by the Thula Sana Home Visiting Programme, also developed for the South African context and shown through a randomized control trial to improve attachment security (Cooper et al., 2009).

Both the UHVP and Thula Sana make use of lay counselors as practitioners (Cooper et al., 2009; Frost et al., 2018). Carefully selected, trained, and supported lay counselors provide a solution to the country's local shortage of culturally and language-diverse IMH professionals, and a shortage of mental health professionals in the public health care system more broadly. Lay counselors are drawn from the local community, ensuring that the range of cultural groups and first language speakers found in the community is represented by the lay counseling team (Frost et al., 2018), factors known to improve receptivity and adherence to interventions (Woolfolk & Unger, 2009). Through intensive reflective supervision offerings, lay counselors are provided with opportunities to reflect on, process, and share the impact of the work and the personal experiences it evokes (Frost et al., 2018).

The UHVP has undergone various adaptations since its beginnings in 2012, strongly informed by local research. Randomized control trials (Bain et al., 2017; Timmers, 2021) have provided useful information about the efficacy, but also highlighted issues with goodness-of-fit and acceptability of the program and has encouraged emic and explorative studies (Bain & Baradon, 2018; Bain & Richards, 2016; Dawson, 2018b, 2022a, b). Feedback from beneficiaries and the lay counselors themselves also serve as a central source of information to guide adaptation, and the lay counselor team actively participates in the adaptation of the program manuals, information sheets, and psychoeducational videos.

Guided by feedback from beneficiaries and the lay counseling team, program materials have been translated into an increasing number of local African languages (including isiZulu, sePedi, and Tsonga) to improve accessibility. Local buy-in has been improved through the replacement of freely available video and graphic psychoeducational materials, with locally produced videos and graphic materials, containing images of families who resemble and are representative of the program beneficiaries and lay counselor input on the wording and phrasing of IMH information. The program, with a solely mental health focus, has also increasingly partnered with organizations that can provide financial support (i.e., food parcels, food vouchers, baby care packages, and support to access social grants) to provide relief from financial stress where possible.

The UHVP has, from the outset, attempted to respect local cultural values and ideas. Beneficiaries are supported as they draw on ancestral wisdom, and advice from their elders, while considering Ububele messaging and making their own decisions about how to proceed in parenting. The local research into sensitive responsiveness outlined above has also resulted in the careful removal of potentially culturally biased ideas from program material. However, in an increasingly acculturating South Africa, and against the backdrop of local family investment in school success, programs that promote the facilitation of learning and development have been made available to parents who are interested, including the International Child Development Program (ICDP) (Skar et al., 2015) and the Booksharing Programme (Dowdall et al., 2021).

Within this context of respectful cultural engagement, concerns remain regarding the high levels of gender-based violence, child abuse, and use of corporal punishment in the context, and the links between these and intrusive parenting and negative child outcomes Gustafsson et al., 2012; Levendosky et al., 2006). Thus, targeting the reduction of highly physically intrusive parenting, reducing corporal punishment, and increasing positive parenting practices have become a central focus of the UHVP and the basket of services that support it. To this end, additional adaptations have included the integration of the Newborn Behavioral Observation System (Nugent et al., 2007) into the UHVP in an effort to promote physically nonintrusive parenting and the offering of the ICDP positive parenting course (Skar et al., 2015) to UHVP beneficiaries.

The notion of sensitive parenting comes from observing the behavior between caregiver and infant. The mental processes that are underlying this behavior are addressed in the following section.

Parental Mentalizing as Focus of Study in SA

Mentalizing involves the "capacity to perceive and interpret behavior in terms of intentional mental states, to imagine what others are thinking and feeling" (Busch, 2008, p. xv). Parental mentalizing capacity has been proposed as the mechanism by which the parent–child relationship facilitates attachment security and supports the child's socio-cognitive development (Sharp & Fonagy, 2008). Fonagy and Target (2005) suggested that the mother's mentalizing capacity enables her to create a psychological and physical environment wherein she may represent a secure base for her child, thereby facilitating the development of secure attachment. Mentalizing capacity appears to facilitate the recognition, understanding, and managing of strong emotions (Greenberg et al., 2017). This emotion regulation function inherent in parental mentalizing capacity has been the focus of several intervention studies that have shown promise in supporting parents who are vulnerable to emotion dysregulation due to substance use (Suchman et al., 2010) or mental illness (Suchman et al., 2016).

Although there have been studies of maternal caregiving among South African populations where high rates of common perinatal conditions have been reported, few studies have focused on both maternal mentalizing and caregiving within a clinical population. Two such studies will be briefly described.

Parental Mentalizing in Clinical Populations

In the first South African study to examine maternal mentalizing and caregiving among a group of 40 women who experienced psychotic symptoms during and after pregnancy, Voges (2020) found that the majority of mothers exhibited a prementalizing level of parental reflectiveness. However, a third of the sample did not demonstrate impairment in mentalizing capacity, which may support Muzik et al.'s (2015) finding that mothers whose psychiatric symptoms are adequately treated display an increased ability to self-reflect and attend to their children's emotional needs. Moreover, all but one of the participants displayed the potential for adequate to complex mentalizing ability, which suggested that the reflective capacity of mothers who experienced psychosis during and after pregnancy could improve with targeted interventions. Psychosocial factors such as being single and having a primary level of education, were associated with lower levels of maternal mentalizing. Factors such as psychosis during pregnancy, postpartum psychiatric admissions, and maternal diagnosis were not associated with maternal mentalizing capacity. The majority of dyads displayed a moderate to low overall quality of interaction, with similar findings for maternal sensitivity and infant engagement. Psychosocial factors such as level of education, unemployment, and prenatal substance use impacted the quality of interaction. This study highlighted the combined burden that mothers experience in the context of severe mental illness and psychosocial vulnerability. The need for integrated maternal mental healthcare, which could assist mothers in recovering from their experience of psychosis, while also addressing psychosocial risk factors, was suggested. The potential mitigating impact of early interventions that promote maternal mentalizing and support the developing relationship between mothers and their infants was also highlighted.

The moderating effect of maternal mentalizing on the effects of trauma was examined by Adams (2020) in a sample of 72 women with a history of substance abuse and trauma exposure. The study sample was divided into two groups – mothers diagnosed with Posttraumatic stress disorder (PTSD) and those who did not meet the criteria for the disorder.

High rates of substance use during pregnancy were reported by the mothers in the study. The majority of mothers in the study displayed pre-mentalizing levels of mentalizing, a finding that corresponds with other studies of substance-abusing mothers (Pajulo et al., 2006; Suchman et al., 2017). Mothers with PTSD and those without exhibited similar levels of mentalizing capacity and caregiving sensitivity. Surprisingly, infants of mothers without PTSD displayed greater withdrawal than those of mothers with PTSD. Adams (2020) hypothesized that the clinical distinction between the two groups may be smaller than anticipated and suggested that mothers without PTSD still presented with a significant level of pathology. Similar to previous findings (Schechter et al., 2008), maternal mentalizing did not appear to moderate the effects of PTSD on caregiving sensitivity. This study emphasized the need for substance and trauma interventions during pregnancy and beyond in order to support mothers who have a history of substance abuse and trauma exposure. In addition, the value of attachment-based interventions that promote the bond between mothers and their young children was highlighted.

Both studies reported on maternal mentalizing and the quality of mother–infant interaction in clinical samples and suggested the need for interventions that focus on maternal mentalizing and mother–infant interaction. In the following section, two such interventions will be discussed.

MIO Implementation in SA

Mothering from the inside out (MIO), a time-limited, evidence-based parenting intervention, was adapted and implemented in a multi-site pilot study in the Western Cape (Suchman et al., 2020). This intervention was developed to enhance parental reflective functioning (RF) and improve mother–child interactions of mothers with substance use and mental health concerns and has shown efficacy in two randomized controlled trials in the USA (Ordway et al., 2017; Suchman et al., 2016, 2017). In its original format, MIO was delivered as a 12-session individual therapy in addition to medical and/or psychiatric treatment. The intervention supports mothers who may be vulnerable to psychosocial stressors and emotional dysregulation in developing their capacity to regulate their own emotions, as well as to support their children's development of emotion regulation skills. By encouraging the mother to mentalize, she is better able to understand and control thoughts and emotions that interfere with her capacity to respond sensitively and accurately to her child's emotional needs (Suchman et al., 2020). The essential features of the MIO intervention, as identified through two separate investigations of the mechanisms of change, were the therapist's mentalizing stance, the mother's mentalizing for herself and mentalizing for the child (Suchman et al., 2012, 2018).

A community-based participatory research (CBPR) approach was utilized in adapting and implementing MIO across six hospital unit settings in the Western Cape. The CBPR methodology recognizes the different strengths that each partner brings to the research collaboration and utilizes an equitable approach that emphasizes co-learning, and capacity-building within a mutually beneficial relationship that should have a long-term focus (Wallerstein & Duran, 2006). The therapeutic approach of the MIO intervention aligned itself closely to that of the UCT Parent-Infant Mental Health Service of the early years (Berg, 2010).

After an initial 4-day workshop held by Prof. Nancy Suchman in Cape Town, a 2-year process of planning, training, and adaptation of the assessment and intervention approaches followed. In the end, MIO was piloted at six clinical sites with the following populations: mothers of premature infants receiving Kangaroo-mother care (KMC), mothers of children who had suffered burn injuries, mothers whose children were receiving treatment for intellectual disability, mothers receiving treatment for mental illness, and mothers receiving treatment for substance addiction (Suchman et al., 2020). Three pilot sites adapted the MIO model as a group intervention (KMC, burn injuries, and mental illness), and three sites utilized the MIO intervention in an individual setting (intellectual disability, mental illness, and substance addiction). Overall, MIO was found to be a highly acceptable and feasible intervention for both the recipients and providers. Qualitative examination of the treatment providers' experience of the pilot implementation highlighted the importance of adopting a flexible approach when adapting an intervention to a setting with a distinctly different cultural demographic (Suchman et al., 2020). Although sample sizes were small, quantitative results suggest improvements in maternal mentalizing and mother-infant interaction quality post-treatment, compared to pretreatment. This successful collaboration highlights the importance of flexible partnerships in adapting and implementing evidence-based interventions to clinical settings with diverse cultures.

Improving Reflective Functioning in Community Settings

The majority of health services available to mothers and young children in South Africa are located within urban settings, with fewer services and medical professionals in rural settings (Rural Health Advocacy Project, 2015). Community health workers (CHWs) are paraprofessional lay counselors employed by nongovernment organizations (NGOs) or primary healthcare clinics to extend services beyond facilities. Their focus has primarily been on the provision of health and nutritional information (Nsibande et al., 2013). Home visitation services by CHWs assist in expanding health systems to community settings and have been shown to improve maternal and child health outcomes (Stansert Katzen et al., 2020; Tomlinson et al., 2016).

Ibhayi Lengane (meaning "baby's blanket") is a relationship-based intervention for CHWs that was developed to complement existing early childhood development (ECD) home visitation programs. The goal was to develop a scalable tool that could be implemented within resource-constrained areas using a task-shifting approach, targeted to be implemented with high-risk mothers for whom health and social welfare services were less accessible (Rochat et al., 2018). The content of the intervention incorporates concepts from the World Health Organization's (WHO) Nurturing Care Framework, focusing on the importance of sensitive and responsive caregiving in the first 1000 days (World Health Organization et al., 2018). The intervention aims to support the development of parental skills, improve maternal mental health, and increase familial support among women at high risk, while promoting their capacity for responsive caregiving of their children (Rochat et al., 2018). Three structured home visits take place over four time periods: pregnancy, birth to 6 months, 6 to 12 months and 12 to 24 months. For each of the time periods, two home visits take place with mother and infant and one with the family. Each visit has specific relationship-based goals around the caregiver-mother relationship; the mother-baby relationship and the mother-family relationships. Through developing a supportive relationship with the mother, the CHW aims to support the mother's well-being and models a relationship-based approach to healthy behaviors, sensitive and responsive caregiving, while also focusing on strengthening family relationships and support (Rozentals-Thresher, 2015). The central premise of Ibhayi Lengane is that a mother's ability to provide responsive caregiving is influenced by her own emotional well-being, skills, confidence, and support from those close to her. As part of the intervention, each mother is provided with a blanket, which serves as a culturally acceptable physical metaphor, the presence and use of which represents a golden thread that runs throughout the intervention. The blanket represents a physical manifestation of the support embodied in the presence of CHWs , the support that the mother provides her baby, and the family's support of the mother. Home visits include activities, many of which utilize the blanket, which create opportunities for creativity, psychoeducation of the mother, and conflict resolution within the family. A preliminary feasibility study in rural KwaZulu-Natal found that the intervention was feasible and highly acceptable to stakeholders within the health sector, to HCWs delivering the intervention, as well as to mothers and families who received the intervention (Rochat et al., 2018). Results from the feasibility study indicate that the intervention has the potential to improve maternal mental health, parental skills, and family support and recommend a wider implementation thereof to determine its efficacy.

Parental sensitivity and mentalizing could be said to find expression when sharing positive emotions. These will be discussed in the last section.

Positive Engagement and Screening of Mothers and Infants in a Limited Resource Setting

Common perinatal mental health disorders, such as depression and anxiety, are highly prevalent in women living in high-risk environments and may compromise the parent-infant relationship (Brittain et al., 2015). Many studies from LMICs have highlighted the importance of the early parent-infant relationship as one of the key contributors to socio-emotional development of the growing child (Richter et al., 2017; Wachs et al., 2009). For example, children of depressed mothers are considered at risk for physical health and developmental and behavioral problems (Matijasevich et al., 2015; Wachs et al., 2009). Maternal depression, specifically, has been shown to interfere with parents' capacity to provide adequate responsiveness and stimulation, which are critical to support early child emotional and cognitive development (Stein et al., 2008). The infant also plays an important role in this relationship. It has been suggested that the infant of a depressed mother might become exceedingly sensitive to the mother's emotional state in order to read her better and to better regulate the interaction (Weinberg & Tronick, 1998). In such situations, an infant may persistently attempt to engage with a depressed mother by smiling and striving for eye contact.

This reciprocal adaptation of behavior between interactive partners (in this case the mother and the infant) is referred to as "synchrony" (Leclère et al., 2014). Synchronized behaviors (such as mutual gaze and gaze following) between mothers and their infants are thought to create the foundation of early social connectedness and regulation (Brooks & Meltzoff, 2013). Positive emotions shared in meaningful relationships build social, intellectual, and psychological resources for the infant throughout their life span (Ramsey & Gentzler, 2015). Sharing positive affect, specifically in the parent–infant interaction, fuels the organization of early infant experiences of socialization (Feldman, 2007). Demonstrations of affection are important for parents to be able to empathize with an infant's experiences, to manage their own responses to their baby's dependence and to model regulatory behaviors. Santamaria et al. (2020) reported that mothers' influence on and connectedness to their infants was consistently higher during positive emotional interactions. This connectedness also showed stronger integrations of neural processes between dyads during positive maternal demonstrations of emotions.

Shared Pleasure Moments

Puura and colleagues hypothesized that the sharing of a smile together with direct eye contact between a mother and an infant is a marker of high-intensity positive affect and named this paradigm "Shared Pleasure" (SP) (Puura et al., 2002, 2005). They hypothesized that direct eye contact between a mother and her infant while sharing a positive affect could mean a stronger emotional experience for both. Their follow-up studies showed that infants with a longer mean duration of SP with their mothers showed fewer problematic behaviors 2 years later and that this buffered the influence of parental psychopathology on child development (Mäntymaa et al., 2015). In addition, dyads were more likely to experience an SP where mothers and infants were best able to read and respond to each other's positive cues (Puura et al., 2019).

An original study on SP in South Africa also focused on mothers with maternal mental illness and showed an overall low (20%) occurrence of SP moments, although significantly more SP moments ($p = 0.02$) were recorded in mothers with no mental illnesses (Lachman et al., 2019).

One of the significant findings in this study was that SP was significantly more commonly experienced in Black African mothers ($p = 0.033$), married mothers ($p = 0.016$), and those who had no current mental illnesses. When infants were screened for withdrawal behaviors as measured by a validated tool (the Alarm distress baby scale) (Guedeney, 2007), there was a significant correlation between low occurrence of SP and higher rates of Infant withdrawal ($p = 0.0002$). Interestingly, in this sample of high-risk infants, those who experienced Shared Pleasure moments with their mothers at 6 months, showed an improvement in cognitive ($p = 0.052$) and motor ($p = 0.007$) scores at 18 months. While overall cognitive improvements were noted across the sample, further regression modeling showed stronger associations for the presence of SP moments. Additionally, having an SP moment resulted in a smaller decrease in later motor scores compared with those without an SP moment (Lachman, et al., 2021).

The WHO's Nurturing Care Framework reminds us that the presence of bidirectional communication and enjoyable stimulating care is core to the provision of responsive care within a healthy mother–child relationship (WHO et al., 2018). Specifically positive caregiver–child interaction helps to develop the social and emotional development of the infant. Shared pleasure requires a synchronous and joyful engagement which enhances the shared experience and thereby creates an opportunity for learning which may ultimately support infant cognitive development. While mothers in this sample were receiving mental health treatment, this study offers some preliminary evidence that the mother-infant dyad may not be as protected simply by treating the maternal mental illness. Evidence suggests that while treating a mother's symptoms of mental illness per se may improve her mental health, this does not necessarily extend to an improvement in the interaction between herself and her baby. The finding of significance in the occurrence of SP in Black African mothers compared to mothers from different ethnic groups highlights an important consideration when exploring mother-infant interactions in culturally diverse settings. Culturally specific features in mother–infant interactions have been shown to predict socio-emotional development; however, research is lacking on what the specific processes are. There is limited research in South Africa that specifically addresses experiences of mothers and their interactions with their infants. In the 1990s, Richter (1995) documented interactions and communication styles between Black African mothers and their infants and reported that they were more verbally expressive and responsive to the communicative offerings from their infants when compared to their Scottish counterparts. The limitation in this finding is the assumption that Africa is a continent of uniform cultures.

As other studies have proposed, a significant positive quality of the mother–infant relationship and parenting capacity has potential to contribute to favorable child development attachment, and SP, in this case, may likely be one of those protective contributors. The potential for SP to serve a protective role in a vulnerable setting of high-risk social adversity, is further supported by results from a community-based study of SP in a well-baby clinic, which showed up to an 82% occurrence of SP (Lachman et al., 2022). There were no associations with SP and any risk factors including on screens of substance use, intimate partner violence, or postpartum depression. The high frequency of SP in a sample of high exposure to risk factors may suggest that SP reciprocal interactions may only be disrupted in extreme cases (such as severe mental illness) and so may serve as an early red flag for screening if absent early in the interaction.

Screening of Positive Interactions

While the abovementioned studies are small and exploratory in nature, they potentially open up the possibility for a more deliberate focus of research that investigates supporting positive relationships between mothers and their infants. How best to assess the positive quality of interactions between mothers and infants that are culturally sensitive or that do not rely on sophisticated ideals of caregiving (Keller et al., 2018) remains a challenge, especially in LMICs. There are very few opportunities and tools available to appropriately assess infant and maternal mental health in vulnerable populations.

An example of a simple screening tool that is currently recommended to be implemented as part of everyday well-baby screening at a primary healthcare level is the Basic Infant Mental Health Screen (BIMHS) developed in 2018 by Drs Puura, Berg and Malek (Puura et al., 2018). This five-item tool consists of two questions to the primary caregiver/mother that are considered to predict real-world problems well (Borg et al., 2014; Mäntymaa et al., 2015), one about the growth parameter of the infant that is considered a good marker for associated nutrition and stress, and two further questions related to infant observation. The BIMHS questions include the following:

1. *Are you worried about your infant/child?*
2. *How have you been feeling?*
3. *Is the growth achieving a positive trend (weight and height)?*
4. *Is there shared pleasure between the infant and caregiver (specifically eye contact)?*
5. *Is there a sense of the infant being connected with you (the health care worker)?*

If there is any concern raised about any of these items, the caregiver is asked to return sooner for a follow-up appointment to review if the concern persists. If similar concerns are flagged up again, the dyad is referred to a more specialized service or IMH clinic. The BIMHS then serves to "flag" concerning interactions rather than diagnosing any disorder, and reliably can then direct to earlier interventions where necessary.

The reality is that most studies have focused on identifying problematic or negative infant interactions with their caregivers (Christodoulou et al., 2019; Cooper et al., 2002; Murray et al., 1996). If the focus is on identifying the "fault or the negative" parenting interaction, this may serve to further stigmatize vulnerable caregivers or to reinforce the false belief that good-quality interactions are not possible in vulnerable parents or those at risk of mental health disorders or adversity. Furthermore, there is vigorous debate around the cultural applicability and suitability of existing screening tools originating in Euro-centric contexts and its sensitivity to diverse models of child rearing in African contexts. As LMICS are faced with escalating resource limitations in both human resources and facilities, screening may need to also consider the identification of good parental interactional practices that require less input on correcting impairment and more on the support or enhancement of existing positive practices.

Summary and Key Points

Developing culturally sound infant mental health practices in South Africa is an ongoing endeavor. Redressing the imbalance that exists between HIC and LMICs, where the majority of infants live, is an important task. Local African voices need to be heard and it is hoped that the knowledge systems generated in LMICs will contribute to more equitable partnerships between the global divides. In this chapter, we describe three aspects of mother–infant interaction in the local context that have been researched and have contributed to shaping current interventions.

The reported low sensitivity scores of previous studies raised the question of whether these were in fact 'insensitive' mothers, or whether cultural bias and socioeconomic status played a role in the scoring of the mother-infant interactions. For example, directive, parent-led interactions were common in the local non-Western setting, while there was an absence of other items such as caregiver–infant play, verbal responsiveness, and intentional teaching which are more frequently seen in Western contexts. The investigation points to the fact that the definition of what constitutes a "good mother" may have to be tailored according to the cultural and socioeconomic context in which the caregiver–infant dyad is embedded.

Following on from the above and given the economic struggles of the majority of parents in an LMIC, such as South Africa, it is not surprising that this would have an impact on the mental health and well-being of mothers in the perinatal period. Socioeconomic hardships, trauma, and substance abuse are ongoing stressors that affect the mentalizing capacity and caregiving sensitivity. The present local study found that while the majority of mothers with severe mental illness exhibited low levels of mentalizing capacity, a third of the sample did not show impairment. It is suggested that the capacity for complex mentalizing can be retrieved, given adequate integrated maternal mental health care.

Similar findings came from the study and substance use during pregnancy and its association with PTSD, reflective functioning, and caregiving sensitivity. The high rates of substance abuse impacted the mentalizing levels and caregiving sensitivity of the mothers irrespective of whether they displayed symptoms of PTSD or not. The pervasiveness of trauma in this group is of concern and emphasizes the need for substance and trauma interventions during pregnancy and the perinatal period.

Despite the complexity of South African society with its culturally diverse communities and its traumatic political past, there is also an impetus to "make things better" and to enhance what is positive. Infants are by their very nature wired to engage with the other, looking for connectedness. The sharing of a smile together with direct eye contact is an inherent expectation to which most parents respond. These natural "Shared Pleasure" moments were explored in a local setting with mothers who were suffering from mental illness. Black African mothers, married mothers, and those without current mental illness showed significantly more SP moments than mothers from different race groups. Furthermore, there was a significant correlation between low occurrence of SP and higher rates of infant withdrawal. At 18 months of age, the infants who had experienced SP moments at 6 months showed an improvement in their cognitive and motor developmental scores. These findings highlight the importance of considering cultural factors when exploring mother-infant interactions. They also point to the importance of noting and facilitating SP moments.

The above three research topics have had implications for practice by shaping IMH interventions in South Africa. The UHVP has relied on feedback from its beneficiaries and lay counselors in order to shape the intervention in line with local customs and culture. It is understood and respected that a "good mother" will ensure her child's physical safety which would of necessity lead to instances of maternal control. At the same time, the high levels of domestic violence are addressed and the negative effects of intrusive parenting, such as corporal punishment, are discouraged and positive parenting skills introduced. In addition, interventions such as the NBO have been adopted and integrated into the Home Visiting Programme.

Enhancing parental reflective functioning in mothers with substance use and mental health concerns was implemented in the Western Cape by Nancy Suchman and her team. The adaptation to the culturally non-Western setting was enabled through a community-based participatory research approach that respected local practitioners' knowledge and experience. MIO was found to be a highly acceptable and feasible intervention to both local providers and recipients.

While the two abovementioned interventions were implemented in urban settings, a third intervention was developed to complement existing, rural early childhood development home visitation programs. *Ibhayi Lengane* is a relationship-based intervention that aims to support and promote responsive caregiving with the aid of a blanket which represents support for the mother and baby. The use of the blanket provides a culturally synchronous approach that stands for continuity of nurturing care.

The findings on the long-term impact on the development of early shared pleasure have been encouraging. This is a specific, natural, and universal interaction that can readily be observed by community health workers. Its absence needs to be noted, as it could provide a "red flag" for identifying infant–mother dyads at risk. As such it has been incorporated as part of a simple screening tool that is being used by the Department of Health of the Western Cape.

Infant mental health practice in South Africa started 27 years ago. From its initial exploratory beginnings, it has now become an academic discipline with research being central. The aim to find "African answers" to "African questions" is being realized. It is hoped that this will contribute to "different ways of knowing" (Eichbaum et al., 2021), which includes what it means to be a "good mother" and, with future research, what it means to be a "good father" in the African context.

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5

Reviving the Inner Nurturing Capacities of Families in the Unpredictable World: A Japanese Perspective on Infant Mental Health

Hisako Watanabe

The goal of the chapter is to offer a Japanese perspective on infant mental health (IMH), including Japan's unique socio-cultural contexts, challenges facing the IMH field with which to prepare for survival and adaptation in the unpredictable challenges ahead. The chapter will illustrate the supporting activities over the past years and discuss the unique realities and needs facing the field of IMH in Japan.

Historical/Socio-cultural Contexts in Japan

Japan is a country with a deep-rooted culture of life existing in harmony with nature. Before she opened her doors to the world and put an end to the enclosed era of Edo in 1868, Japan was a matriarchal society, where children were cared for with caution and affection at home and in the neighborhood. People shared a simple life of toiling and raising children together, with family life revolving around mother–child relationship in closely knit unity around rituals and symbols of agricultural community passed down the generations. Westerners who traveled in Japan were impressed to see children cherished by community adults, vibrant and content (Bird, 1911; Benedict, 1946). Community members were inter-connected with each having a unique role in the whole milieu. Infants and children were bearers of joy and prime time of *Kairos*.

Geographically, Japan is a long and narrow archipelago sitting on the meeting points of four tectonic plates. Constant earthquakes, volcanic eruptions, and tsunamis combined with seasonal typhoons, torrential rains, and storms are parts of daily life. Intricately attuned to the flow and rhythm of nature, the Japanese exist with awareness of the frailty and fleetingness of life, and thus cherishing the lived moments in the here and now in community and in connection with the earth. Deep down in their hearts is the belief that the souls exist in all living beings, in rocks, rivers, trees, and mountains, and the dead are invisible but reside in proximity, observing and protecting us (Yanagida, 1945).

There exists in Japan a word – *amae*, which is a vernacular implying a unique cultural mode of interdependence (Doi, 1971). *Amae* was an ethos of tacit collective survival and adaptation for centuries but has been eroding fast with the rapid postwar industrialization and Westernization. The ethos of *amae* is depicted in Kenji Miyazawa's writings. Born around the same time as R. Spitz and D.W. Winnicott, Miyazawa wrote poems and children's stories in communion with nature and the universe with his passion for

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geology and astronomy. His poem *Rain Won't* represents the inherent moral of community rushing to help a suffering person. His lines say, "(i)f a child were to fall ill in the east, I'd run there to help with the nursing" and "(i)f a mother were to overwork herself in the west, I'd be there to carry the heavy bundles of rice" (Miyazawa, 2013). These denote an architype of indigenous Japanese infant mental health embedded in humanity, interconnected ways of being, and environmental ethics.

A*mae*, a Japanese mentality of expectation of warmth and kindness from the other, is ubiquitous and pervasive in Japan, belonging to the realm of intersubjectivity, which is immersed with motives and vitality affects inherent in human experience. Doi's concept of *amae* needs to be further studied with a broader perspective. *Amae* also refers to the innate Japanese capacity to perceive the other's feelings to survive together, cultivated over centuries to become the collective mentality to survive in the throes of natural and manmade disasters. The Japanese language often refers to visceral experiences at gut level, denoting embodied experiences. Japanese ancestors, without any medical knowledge of the sympathetic nervous system, shared an intuitive gut feeling of the basic assumption that body and soul were inherently one, and emotions were generated from organs of the body. From ancient times various organs were denoted to describe vivid emotions of lived moments. For example, *haragatatsu* (guts are erected), *haraga niekurikaeru* (guts are boiling), and *hara fukukuru omoi* (feelings of guts swelling up) express outrage.

Within less than two decades from Miyazawa's poem, however, an unprecedented event turned Japan upside down. The Second World War, which ended with atomic bombs on Hiroshima and Nagasaki, which led to the subsequent total surrender, shattered the collective and individual identities of the Japanese people. In the existential crisis of unbelievable defeat, people were led to employ a coping mechanism of massive collective denial and toiled untiringly to rapidly industrialize and Westernize the nation at the cost of their inner life. Only after having achieved the so-called miraculous economic rise, as evidenced by the fastest bullet trains, Tokyo Olympics, and world-class electronic devices, could they expunge their shame and survivor guilt. But as Santayana warns, history repeats itself without reflection (Santayana, 1905). Japan continues to mourn the massive loss of their countrymen in the undertone as depicted in the poem of Kiyoko Nagase: "Snow falls on this country of sorrow" (Nagase, 1979).

When this author started her child psychiatry practice in the late 1970s, Western ways of examination, diagnosis, and treatment did not seem to strike a chord with Japanese children and parents. Although they sought the best expert treatment for a swift cure, Western intervention seemed intrusive and frightening for many patients. Instead, patients responded with relief and willingness when this author welcomed them into the office with a nonjudgmental stance, first appreciating them for coming and assuring them that things would be all right if we could work well together. A nonintrusive approach seemed to fit with the ways of being of the Japanese, such as the provider deeply listening and sympathizing with the enormity of stress they were experiencing and recommending rest first and foremost with *amae*. This simple and ordinary kind of approach that did not rely on Western clinical treatment intervention allowed the Japanese patients to regain confidence in themselves. Such open and humble stance of practitioners wishing to be informed and educated by the patients' subjective stories led to de-Westernizing and undid the internalized perceptions of Japanese parents that had been exposed to the Western values. To promote authentic communication, it has been important to strive to create *in-between spaces* where everyone could be themselves. The stance of not knowing and being genuinely curious about the lived realities of the other with whom one is sitting, without any assumptions, aligned with the deep-rooted Japanese sensibilities of quietly listening for what is yet to be named. Thus, I applied what Bruch would call the "Constructive use of ignorance" (Bruch, 1975). It worked not only for the treatment of anorexia nervosa but for any social-emotional problems for Japanese children. Through attuning to their need, emanating from their whole body and movements, this author realized the enormity of stress many children were carrying, while living in such a fast-paced, competitive society. In treatment rooms, this author's suggestion that the child patient opt for more *amae* with the mother was often met with relief and a smile. *Amae* became the common thread of trusting therapeutic relationship. It became a key word to revive sense of self in Japanese children. Parenting, which is inherently intuitive, has over time become so commercialized and shaped by Western ideas of logical reasoning and perfectionism that it has lost mutuality and empathy, leading to problems in children. With *amae,* it is possible to reverse the vicious cycle of parental mental health struggles further aggravating quality of parenting. For example, an only child in a household often tended to be exposed to tacit pressure for academic performance from a very young age, while they were seldom hugged in *amae* out of parental fear of spoiling the precious only child. Such pervasive family problems are not made visible to the public eye due to shame, keeping the struggling families isolated. Instead of Westernized assessment processes via checklists and quick fixes, continuous dialogues between patient families and practitioners facilitated a deeper understanding of human experiences. Pediatricians in various regions of Japan were using similar kinds of approaches as this author.

The Postwar Improvement and Paradox in Infant and Child Health

In the immediate aftermath of the Second World War, pediatricians, neonatologists and other medical professionals strove to improve maternal and child health and wellbeing, and the birth rate soared (Nishida 2015). In 1947, the infant mortality rate (IMR) was 76.0, and it kept steadily decreasing over the years, with the IMR in 2021 at 1.7, marking the lowest in G7 countries. A high cultural value was placed on childrearing, with the great roles played by the maternal child health (MCH) handbook and population-based screening and health check-ups being major contributing factors (Kiel et al., 1999). Every baby received free national systematic check-ups covering the perinatal period to preschool years.

This wellness check-up has a national average attendance rate of almost 99%. The MCH handbook is given to every mother on registration of pregnancy. With its coverage maintained at almost 100% since 1947, it ensures the quality of life of mothers and children. The MCH documentation includes all the records of prenatal visits to obstetric examinations attendance at prenatal classes, delivery and child development and healthcare, and routine vaccinations. The MCH continues to be revised and improved, while its reach has expanded to more than 20 developing and developed countries. However, in spite of such national care systems and government-led initiatives as the Angel Plan in 1994 and the Healthy Child for Future in 2000, the birth rate is plummeting. The Japanese government has set a paternity leave of up to more than 1 year, which is implemented only around 17% in 2022. The male-oriented society tacitly hampers young fathers from benefitting from the federal support structures for young parents for fear of causing inconveniences in the workplace with due consequences.

The desperate race for post-war economic improvements led to environmental decline in Japan. Natural landscapes in Japan in Miyazawa's era disappeared rapidly due to massive deforestation and construction of new towns. Dumping harmful chemical waste from factories into intoxicated rivers and seas, led to serious pollution, such as Minamata Disease, impacting more than 70 infants with lifelong severe fetal anomalies. These postwar changes in Japanese environments coincide with the start of the Anthropocene Epoch, a unit of geologic time, with plutonium traces detected in geological layers, denoting human activity impacting the planet's ecosystem and climate. The government's prolonged denial of the tragedy of Hiroshima and Nagasaki added another layer of denial of nationwide pollution and destruction of the natural environment. It was the people of the victimized communities, who stood up to fight against the powerful companies and government that continued to push forward a capitalistic agenda. The nuclear energy policy with a myth of safety is another governmental flaw. Now, in every portion of soil measured are detected minute yet indelible radioactive and chemical materials across the country.

Under the façade of an economically vibrant country, the family life is insidiously impoverished with prolonged absent fathers. As the bedrock of Japanese family and community resiliency silently dissolved, children's social-emotional problems increased. Around the time of the oil shock in the mid-1970s, social-emotional problems of children started to emerge and continue to increase until today. Blinded by materialistic prosperity, the decay in the quality of childrearing went unheeded. This generated a wide population of adults with emotionally and relationally deprived infancy. When they later became parents, how could they manage to love and care for their children when they had not had their own secure attachment?

A Super-Aging Society with Declining Birth Rate

In 2023, Japan is a fast-aging country with a world record of 29.1% of population over 65 years of age, one in 10 people being over 80. A life expectancy of 85.03 years marks the world's highest longevity. With the total population being 124.56 million, only 1.49 million (12% of the population) is under 15 years of age (Statistics Bureau of Ministry of Internal Affairs and Communications, 2022). More than 80% of the total households are nuclear families.

At the same time, the infant birth rate (IBR) has continued its steady decline. In 1990, it marked 1.57 and shocked the nation, but in 2022, the birth rate plummeted further to 1.26, accelerated by the COVID-19 pandemic and worldwide economic turmoil. Warnings of a decreasing nation due to joyless childrearing and lonely mothers had been long coming (Jolivet, 1993). Increasingly in Japan, young men and women report lack of interest in marriage and one in every three marriages end up in divorce. After divorce, 48.8% of mothers fall below the poverty line. One in every seven children belongs to a household below the poverty line. Japan faces a threatening reality of diminishing population. Experts are analyzing the factors of the plummeting birth rate. For example, the postwar baby boomers were born through a natural birth at home, aided by trusted community midwives. This practice allowed babies to bask in mothers' breasts in the secure warmth of three-generation families with grandparents, siblings, relatives, and people in the community, where everybody took responsibility to protect the mother and baby. When hospital births began to prevail in the 1970s, mothers' sense of agency as the master of childbirth was deprived. This diminished the joy of childbirth and childrearing. During the recent COVID-19 pandemic, mothers who went into hospitals to give birth had to endure manifold alienation being left alone to look after themselves without the usual care from the medical staff and their family.

More concerning is the increasing unhappiness of average children, as manifested in the high suicidal rate of teenagers. In the UNICEF Innocenti Report Card 16, Japan ranked 20th in child well-being outcomes among 38 countries. Further, the content of well-being shows that while in physical health Japan ranked 1st, in academic and social skills she ranked 27th, and in mental well-being she ranked 37th. (UNICEF, 2020). An average child in Japan today has no sibling and only a few peers to play with in the community, compounded by having less unscheduled time of joyful freedom. General unhappiness creeps in from infancy, making pediatricians concerned about so-called silent babies, who lack vitality to cry out when left alone in distress (Horiuchi, 1991). An increasing number of mothers work outside the homes, leaving their infants in the care of daycare nursery before the age of one. Children from an early age lead busy lives with schedules for swimming, piano classes, extra tutoring lessons, etc. out of parents' fear of their children lagging in the competition to enter prestigious universities many years later. While

Japan has a homicide rate of 0.3%, one of the lowest crime rates in the world, cases of child abuse rose to 280,000 in 2022, with a high proportion of infant death continuing (Ministry of Health, Labor, and Welfare, 2022). The number of children showing school refusal reached 245,000 in 2022. Intra-familial violence of children against parents, anorexia nervosa, child abuse, intimate partner violence, sexual abuse, suicides, and *hikikomoris* continue to rise. Emerging with industrialization, *hikikomori* is defined as a prolonged severe social phobia in children confining themselves at home. Between the ages of 14 and 60, the prevalence of *hikikomori* has risen to an estimated 1.46 million, creating a social issue (Ministry of Labor, Health and Welfare, 2022). Under the façade of economic prosperity, Japan created lost generations of *hikikomori*, who are outwardly polite and sensitive but who suffer from an irretrievable sense of internal void. From early life, their genuine affection towards caring adults had been responded to with rejection, reprimand, and pressures to achieve outward successes and performances (Zieleginger, 2006). *Hikikomoris* are but the tip of an iceberg of children suffering from the stress of a competitive society.

Birth of the Infant and Early Childhood Mental Health Field in Japan

The Japanese people were led insidiously to distance themselves from their culturally adaptive form of intuitive parenting (Papousek & Papousek, 1987) and from their community of shared nurturing practices. Fathers worked long hours outside the home while mothers became isolated in the nuclear home, managing housekeeping and childrearing on her own. A deluge of information puts pressure on parents to bring up competent children in the eyes of the success-oriented, capitalistic society. People have long felt pressured to incorporate Western ways of thinking and performing in their day-to-day lives, but they are now having to face a grim reality that this way of living and parenting is not working, as unprecedented variety and complexity of problems in children keep emerging.

Endeavors to Retrieve Intuitive Parenting Leading Children to Spontaneously *amae*

In exploring ways to help infant and child psychiatry practitioners address emerging social-emotional problems in Japan, this author attended the 3rd WAIPAD Congress in Stockholm in 1986, presenting a paper on the stressful early life observed in the cities of postwar rapid industrialization. There, T. B. Brazelton directed the author's attention to a genuine cultural Japanese infant care in the Goto Islands, off the coast of Nagasaki, where he had been studying (Kawasaki, 1994). There, he had witnessed a baby-centered family and community life, where affective communication prevailed, and babies were far calmer and more content than babies in Western cities. Also presenting at the congress were R. Emde, B. Cramer, and D. Stern, sharing their wisdom and microanalysis of video-recorded infant–parent psychotherapy work (Emde, 1988; Fraiberg, 1983). The exposure to their work inspired this author to widen her scope of understanding peoples' lives around Japan and to fathom how *amae* as a crucial nonverbal affective communication originating in infancy was in Japan.

Already in Japan, this author had shared similar approaches with pediatricians like Kei Sawada, who focused on reviving Japanese intuitive parenting in Japanese families. He listened intently with utmost respect to mothers, who complained to him about their children's problems. In his practice, Sawada extensively used the word *amae*. He understands *amae* to be an affect and behavior emerging from the child's initiative, which is not necessarily conscious. For example, he asked the mother, "Couldn't your eldest boy want to have *amae* time with you? Could he be feeling a bit left out now that a baby sister is born?" To this gentle inquiry, the small boy started to cling to his mother like a baby, as soon as he perceived his mother's reflection and renewed sympathy towards him. The mother's *amae* as such was the norm of traditional childrearing and needed to be revived through gentle guidance. In an orphanage where Sawada regularly supervised, the caregiving staff bathed with toddlers in the same Japanese bathtub as any parents would do with their toddlers in a traditional Japanese practice. In this way, intuitive caregiving capacities were enhanced to the benefit of the young children in the orphanage. In the late 1970s and early 1980s, a video of separation-individuation process studied by M. Mahler and her team was available in Japan. This author witnessed how a deep sincere commitment of the mother who could provide again a quality *amae* experience led a child showing prepsychotic symptoms of pan-neurosis, such as dissociation, mutism, cataplexy, and withdrawal, could be transformed going through the rapprochement phase again. Sawada and Watanabe called this approach, *amae* therapy, where the child is supported through regression into infancy (Watanabe, 1992. 1987).

While the concept of *amae* was introduced to Western psychoanalysis in English (Doi, 1971, 2005) (Okonogi, 1992), only a few experts, a philosopher, and infant psychiatrists (Wisdom, 1987; Emde, 1992, 2011) responded. Half a century has passed since then, and *amae* has become a crucial focus of practice in IMH. Emde has discussed the need to study *amae* as it denoted a sphere of "*we*-go" (vs. ego), or interrelatedness of human development.

Infant–Parent Psychotherapy Reveals Family Secrets and Trauma in Japan

This author extensively videorecorded and carried out micro-analysis on her infant-parent psychotherapy (IPP) cases in Japan. IPP revealed the infant's symptoms to derive from mostly unresolved family wartime and post-war trauma. As poet Nagase described in her poem, "Snow falls on the country of sorrow" (Nagase, 1979), the grief of massive wartime and post-war loss had not been mourned. Returnee soldiers remained reticent with unspeakable trauma and sensitive infants perceived them and manifested symptoms. Thus, IPP revealed manifold unresolved family trauma, conflicts, and family secrets. IPP became a rare window into the family secrets projected onto the infants. A Japanese proverb of "Silence is gold" silences family secrets from being revealed. Under the veneer of the postwar economic prosperity, Japan remains a land of sorrow having been repressed to mourn the massive war loss of 3.1 million with many victims whose remains are yet to be retrieved. Some aged war victims and bereft families have at long last opened their mouth before it is too late. On August 6th, 9th, and 15th, the nation commemorates Hiroshima, Nagasaki, and the defeat of World War II. Infant-parent psychotherapy in Japan provides a rare window into unresolved family trauma. The infant's subtle movements, gestures, and repetitive behaviors in the room in relationship with its mother unfold family secrets and relieve the mother of her unspoken family conflicts, (Watanabe, 2007). The following is a case that could not have been dealt with without the IMH approach.

When a mother, depressed and unkempt, entered the therapy room with a baby boy carried in his father's arms, she muttered harshly, "I don't want this boy!" The baby froze and was swiftly whisked out of the room. Left alone with the therapist, the mother remained in deadly silence expressing suicidal intention. The therapist promptly recognized her first words as denoting her core conflict. The mother revealed that her father's parents were killed in the Asian continent right after the defeat of the Second World War. On his return to Japan as an orphan, he was discriminated and unwelcomed. He strove to rise out of poverty and finally married a woman, who also was a war orphan with a shameful background. He doted on his daughter, the mother of the baby boy, and pressured her in her childhood to pass exams to enter a prestigious university. When this mother gave birth to a boy, her father, instead of blessing her, cursed her as becoming a mere housewife. Shocked by such explicit denigration, this mother lapsed into despair and rage. The mother's first words in the therapy, "I don't want this boy!" carried multiple layers of wartime and post-war abandonment and trauma that had been unresolved and passed down the generations. Through this IPP, the mother was supported over time to reclaim her true self, talked through with her own parents and solved the family trauma to be shared and redeemed.

Infant Mental Health Efforts in Japan: Through the Journey of the FOUR WINDS to the Birth of the Japanese Association for Infant Mental Health (JAIMH)

During the 1980s through the 1990s, there steadily emerged a handful of IMH learning opportunities in large cities in Japan in the forms of books, seminars, and lectures (Watanabe, 1988, 2000). Examples included courses on infant observation, perinatal bereavement, infant-parent psychotherapy, and transgenerational transmission of trauma, intended for psychiatrists, psychologists, pediatricians, and nurses (Watanabe et al., 1995). In 1994, Regional Tokyo WAIMH meeting was held, and the WAIMH leaders strongly advised the Japanese academics to reach out to the IMH community. Soon after, B. Cramer visited Kochi in Shikoku, an island to the south of mainland Japan, where the local leader Kei Sawada welcomed him with local government administrators and clinicians. In 1996, interested local leaders participated in the 6th WAIMH World Congress in Tampere, and established the FOUR WINDS (acronym for the Forum Of Universal Research and Workings of Infant and Neonatal Developmental Support) in 1997.

The name FOUR WINDS was derived from the traditional Four Winds hat in Lapland. The four-colored pointed hat symbolized a humble yet courageous adventure in the uncharted waters of the unpredictable modern world, with an image of moments of *Kairos*. From the start, FOUR WINDS aimed to create a forum truly rooted in local cultures, where the ethos of Japanese affinity for interdependence prevailed. To cultivate transdisciplinary collaboration, hierarchical structures within professional fields would be a hindrance and carefully avoided. Pioneering neonatologist and pediatrician Kei Sawada played a leading role. From the outset, the FOUR WINDS aimed to create an open forum for genuinely motivated infant and child clinicians nationwide. Following the ethos of the process of life, simple, small, slow, and steady steps were taken to advance, and the FOUR WINDS grew into a unique non-hierarchical forum of outreach and collaboration. FOUR WINDS held each annual congress in rural city. In the spirit of *amae,* academic learning with foreign and Japanese speakers, local and nationwide participants met and befriended. Thus, seeds of infant mental health were sown steadily around Japan. Each chair of the local organization joined the FOUR WINDS board, and manifold views and ideas converged to create a transdisciplinary relationship-based collaboration.

Application of Infant Mental Health to a Wider Clinical Practice in Japan

Application of IMH principles that aligned with the cultural context of *amae* was used in this author's pediatric practice. Children with social-emotional problems, in particular anorexia nervosa, benefited from an inpatient treatment designed and based on IMH principles. The daily inpatient routine was based on attachment and emotional availability to promote human-to-human connections in the pediatric ward. The children fully recovered as whole persons, with improvement in family and social relationships. This approach facilitated the Japanese parents to de-Westernize the internalized perceptions of Western values of visible academic achievement and recognize the importance of respecting the gut feelings of the child. The program tapped into the inner self-corrective potentials of each developing child and the family. The author maintains that the specialized study of infancy and the earliest years of development should always take place within the broader context of the entire life cycle, including succession of generations. This author also recognizes that many contributions to an understanding of infancy come from a wide variety of disciplines and that such understanding will be enriched by transdisciplinary discussions of research from many regions and contrasting cultures.

Anorexia Nervosa Intensive Care Unit (ANICU): Reviving Primordial Vitality to Retrieve a True and Whole Self

This author was given an opportunity from 1993 to 2013 to serve as a full-time child psychiatrist in the Department of Pediatrics, Keio University Hospital, to train infant and child psychiatry to pediatric trainees. Saving the lives of teens with severe emation and critical vital signs posed a particular challenge to pediatricians. The following inpatient program of child psychiatry applying IMH principles and psychodynamic approach rendered the firsthand in-patient treatment experience to the pediatricians (Watanabe, 1998a, b). The program was the tertiary care of a systematic comprehensive care for anorexia nervosa (later known as "the Keio Method"), which included primary, secondary, and tertiary care. It entailed a rigorous around-the-clock care named Anorexia Nervosa Intensive Care Unit (ANICU).

The ANICU combined the essence of amae therapy and aimed at facilitating the child to understand the plight of her emaciating body and choose to pluck up her courage and initiate her own revival as part of her retrieving true self. ANICU entailed sincere around-the-clock care and commitment of a specialist-pediatrician team for the children trapped in an illusion of self-control through refusing to eat. The child was provided with an explanation that as emaciation increased endorphin secretion in the brain would lead to an addictive cycle of weight loss inducing endorphin "high." This was damaging to her brain, bone, and endocrine systems and adolescent development. Each pediatric trainee was assigned to one or two patients and was closely guided and supervised by the author and a senior pediatrician. Without ever using psychiatric or psychological jargons, they were guided to attend to each child, carefully examining her emaciated body, touching her cold hand, counting her pulse, and pointing to bradycardia and hypothermia as a dying body's plea for rest. With supportive firmness, the trainee would take time to explain that there was no magic to stop the body's catabolism, a process destroying cells to produce survival energy. The child had to realize the risk of life and take the initiative to thwart this process jointly with the team. Only by lying down and giving the body rest and regular daily necessary nutrients, steadily in small portions, could she give the ailing heart and body a chance of survival. Thus, through accumulation of such slow and steady daily maternal care, a trainee could earn the trust and urge the child to become the master of herself to survival and revive her healthy true self (Winnicott, 1960; Watanabe, 2002a, b).

In the physical recovery process, it was anticipated that the patient would have her unresolved conflicts from her infancy and toddlerhood reemerged. The team was thus prepared to contain a challenging tumultuous period ahead. With steady recovery of vital functions such as hormonal cycle, emotional energy resurged with ambivalent feelings. The attending trainee had to endure a difficult phase where the child would become expressive, demanding, assertive and explosive, throwing tantrums like a toddler in the crisis of rapprochement (Mahler et al., 1975). This was the nodal point where the child hatched into her true self, discarding her false self. At this juncture, the whole inpatient ward had to unite to contain the child with her primitive negative emotions, which eventually led to a new secure sense of self. One patient who recovered from extreme emaciation through shifting into a mindset of a baby, clinging, demanding, wailing, and crying for hours hatched from a false self into a true, open self. She acquired a new creativity and became a picture book artist (Kumon, 2009) and proceeded into happy motherhood. She produced a poem that conveyed the essence of amae and human moral of kindness:

> 'Deep down in every heart, lie things long forgot
> Each of us, a babe in arms
> Each of us, in someone's arms
> Such sweet memories'
>
> (translated by David Dutcher)

The inpatient ANICU program implemented from 1993 to 2013 yielded 330 pediatricians trained in the basics of IMH and more than 100 cases of full satisfactory recovery without a single death. The longitudinal support and follow-up of patients into adulthood revealed a later fulfilling social life and parenthood in those who received the ANICU program. The rigorously trained pediatricians subsequently became leaders of major universities and hospitals and incorporated the basics of IMH in their practice and education (Watanabe, 2015).

The First WAIMH World Congress in Asia

In 2008, the FOUR WINDS led an all-Japan child mental health local organization to host the 11th WAIMH World Congress in Yokohama, the first congress ever to be held in Asia. The theme was "Akachan ni Kanpai! Celebrating the Baby: Baby, Family and Culture", aiming to create an inclusive society where each infant regardless of their problem had a secure respected place (Watanabe, 2011). This set the tone for the subsequent WAIMH proposal on the Rights of the Infant. The congress welcomed 2019 participants from 39 countries, including 10 from Asia with a taste of *amae,* an open-armed "come as you are" welcome with fireworks and traditional experience of kimono wearing, calligraphy, origami, and others. The congress included such nondidactic symposia as one on the impact of secrecy on the offspring of donor insemination in Japan. Shared with all congress participants was the "Birthday Cake," an enigmatic contemporary play combined with traditional Noh dance shot by 4K camera, symbolizing silent alienation of Japanese souls locked up in cold mental asylum yearning to be reunited with the maternal spirit. This congress was another pivotal moment in the growth of the IMH field in Japan. Numerous members of different infant mental health–related organizations, such as the Newborn Behavior International Japan and the Japanese Association for the Medical and Psychological Study of Infants, got together to deepen common recognition that early life mattered. Many young people decided to proceed to become infant mental health specialists.

Attuning to the Local Community Culture in Learning Facilitation

The 2008 Yokohama WAIMH congress provided a critical turning point and aroused new motivation for learning in IMH field workers on the ground to acquire competency in IMH. The FOUR WINDS leaders endeavored to create effective learning opportunities through meaningful interactive dialogue. One project to this end was a series of Robertson films that went around Japan to cultivate observational and reflective skills, facilitated in intentional ways respecting the culture of the local communities. For example, in a Robertson Film seminar held in a remote northern city of Japan, the seminar leader considered the generally quieter traits of the local participants. She had understood that asking these participants to raise their hands to ask a question or to comment would silence them with pressure and tension. She delivered her seminar showing a Robertson film with accessible words for translation and explanation. She paid extra attention to the facial and bodily expressions of each audience member as they listened and watched the film. She carefully attuned to the affective, visceral flow created in the group, as each one warmed up to relax and attune more and more to the feelings of the infant in the film. When the film ended, on a gentle invitation of the seminar leader, everyone in the room volunteered their spontaneous thoughts and feelings. In a similar manner, the FOUR WINDS leaders around the country spread the Robertson Film Seminars not only in their own local geographical areas but beyond the IMH field, such as in the annual meetings of the Japan Society of Ambulatory and General Pediatrics for 5 consecutive years. It was unprecedented for an IMH seminar to be accepted in such a large medical conference.

Communicative Musicality (CM): A Window into *amae* and Affective Communication

Cross-cultural infant studies such as those by Kosawa and Negayama (Kosawa & Shand, 1985; Negayama et al., 2015) clarified the cultural propensity of Japanese mothers to use less verbalization and more physical proximity and tactile interaction with their babies than Western counterparts. Contrasting with the language-heavy Western culture, daily communication in Japan is tacit understanding and more intersubjective perception and sympathy. The theory of communicative musicality (CM) was introduced to Japan in 2004 and swiftly spread through the FOUR WINDS, most probably because of Japanese people's affinity for tacit communication. Teams of NICU in three hospitals in Tokyo joined the PRENEVE: the Network on Emotional Vocal Expression in Proto-conversation Before Term as part of an international study of the CM in premature babies (Malloch & Trevarthen, 2009). Using audio-visual analysis, spectrograph analysis of Japanese prematurely born and full-term babies revealed components of CM, namely pulse, quality, and narrative. The narrative had a structure of four phases of interactions: introduction, development, climax, and resolution. This proved the universality of premature babies in manifesting sophisticated communicative capacity (Watanabe, 2006).

Though scientifically grounded, CM is useful in clinical work, allowing parents, caregivers, day nursery teachers and others to see and understand the flow of interaction and quality of relationships through various senses, enriching total understanding of the effect of relationships on relationships in the moment. CM offers a way of capturing a resonance between an infant and caregiver similar to that in *amae*. A Japanese saying of *A-Un no Kokyu* seems to resonate. *A-Un no Kokyu* literally translates to "joint breathing of Ah and Un" of resonating intimacy on visceral levels between two people. The theory of CM provides a new dimension into the musicality of *A-Un no Kokyu*, which otherwise would have been dismissed. Also, CM resonates with Japanese expressions of gut feelings graphically expressed by ordinary people without any medical knowledge of the sympathetic nervous system. They express gut feelings as authentic emotions generating from the person's intuition. *Haragatatsu* (guts are erected), *haraga niekurikaeru* (guts are boiling), and *hara fukukuru omoi* (feelings of guts swelling up) are all examples of expressing outrage. A wide range of gut feelings from sorrow to excitement are available in Japanese.

The Japanese *amae* belongs to a wider realm of nonverbal affective communication belonging to a deeper realm of subconscious or unconscious. Recent affective neuroscience studies suggest that amae could belong to a sphere of expressing a conscious core self (Solms & Panksepp, 2012; Trevarthen & Delafield-Butt, 2017). Thus, as CM generates and coordinates the creative intersubjective space, amae seems to do the same and lies within a deeper space in our mind (Trevarthen et al 2006; Trevarthen, 2011; Malloch & Trevarthen, 2009). In our practice of mental health where people suffer from moments of existential crisis, we are invited to attune to the more primitive deeper layer of our mind. Thus, tapping into *amae* and CM would enhance meaningful therapeutic interaction. The author applies CM and *amae* as useful way of relating in off-the-cuff crisis interventions in evacuation centers and refugee camps of post-disaster areas.

Post-disaster Response to 2011 Great Northeastern Earthquake: An Account of the Koriyama Post-disaster Child Care Project

Against the backdrop of increasing worldwide disasters, infant and early childhood professionals today are urged to step up and develop competencies in responding to diverse and multi-layered needs of infants, families, and communities in adverse situations. Navigating such a momentous task requires IMH workers to be emotionally available and able to explore and track the “felt sense” (Levine, 1997) not only in infants and families but also in the workers themselves. Exposed to massive threats of unprecedented nature, one’s primitive instincts are instantaneously switched on, inviting both victims and supporters into a vigilant mode of survival and adaptation with visceral affective communication.

On March 11 This Great East Japan Earthquake and Tsunami wiped the 500 km coastal line of northeast Japan. This yielded 18,000 deaths, including 700 children, 2500 orphaned children, and 1500 bereft children. About 380,000 had to stay in makeshift houses. When the Fukushima Daiichi Nuclear Plants (FDNP) exploded and emitted radiation plumes, the residents had to flee in panic and fear. When the author visited an inland Koriyama City, where evacuees had sought shelter from the coastal towns and villages, she was joined by pediatricians Shintaro Kikuchi and his father. He had firsthand training in Keio Pediatrics under the author and swiftly organized a multidisciplinary team of the Koriyama Post Disaster Child Care Project (KPDCCP) to protect local children from radiation and its harm and to provide a play space to feel safe and protected. The project resolved to commit to the community children with three credos: to unite, to build a clear structure, and to commit for the minimum of a decade. Experts from WAIMH also came and helped the project with their wisdom. The project has become a model of child-centered post-disaster care in Japan today (Watanabe et al. 2019).

While no information was forthcoming, the members of the project discussed about the situations: While acts of reaching out to the community could be felt as a dim light of fireflies in the darkness of this massive unprecedented triple disaster, even flickering lights in the abyss of despair can send a hopeful message to the people in the darkness to persevere and mobilize their inner strength to survive. Eventually, they will converge with all those who are toiling in different ways but with the same resolve to protect the children in the communities (Rutter, 2012).

In evacuation centers, there were terrified parents embracing infants and young children with frozen gaze. To prevent negative consequences from these experiences the KPDCCP acted right away. As Koriyama City prides in being the best city for children’s picture book reading in Japan, with more than 300 picture book reading volunteers and a quality children’s library, we persuaded the local administration to open all the public facilities for children with play space and picturebook reading. After prolonged confinement at home, the children were reunited with peers, and the sound of their playing and laughter offered a sense of relief to everyone. Retrieving vitality affect through infants and children was a central effective approach.

A newspaper article struck a chord in the project. It was in the Asahi Shimbun (a major newspaper in Japan) submitted by a psychiatrist and a survivor of the Kobe Earthquake in 1995, encouraging the readers to see the world through the eyes of the victims of the massive disaster.

His following message became the reference for the basic disaster care for the KPDCCP:

> Hold the plight of the victims in your mind; to be forgotten is the worst blow to the victims; Listen quietly to their breathing and the sighs that convey their unspoken internal truths. Don’t intrude with questions and jargons, which are what the victims dislike the most; convey utmost respect and trust that they will eventually recover. Warm meals and comfortable places to sleep are crucial. Respond swiftly to the survivors within fifty days (Nakai, 2011).

Nakane warned about the harm of applying questionnaires and verbal interventions. From his experience such a mode was out of kilter for victims in existential crisis. He guided supporters to attuning to the victims’ gut feelings of awe and fear in silent sympathetic presence. Interventions aligned to the mode of vigilance in crisis, anchored in primitive mode of intersubjective affective visceral communication of breathing, rhythms of movement, and voices from the body became crucial (Trevarthen & Butt, 2013). Years later, the local children and adults alike voiced their frustration in having had to put up with intruding supporters coming in and out. In a state of stark vigilance to survive and pull through, they perceived superficial short-lived support as intrusion and a second trauma. The nature and the scale of GEJET and FDNP disasters defied any manualized approach to recovery efforts.

The priority was to help retrieve people's sense of agency and morale. The importance of *primum non nocere* (first do no harm) and of conveying utmost respect to the survivors provided a base for offering a supportive presence. The team explored effective approaches and engaged the survivors to determine what sort of intervention would help create relationships that felt safe, validating, and emotionally accessible in the local community. In Fukushima, the chaos was further aggravated by incessant aftershocks, fears of radiation contamination, and raging victim stigmatizations. Thus, our support work became the building relationships of trust at the gut level with unity, structure, and continuity, always giving credit to the victims and local community.

Our support work made it a rule to put the infant–mother relationships at the center of its efforts and to reinforce mothers for moments of positive encounter within the dyads. KPDCCP produced a flier that conveyed the message "Mother, You are the root of the child's security and happiness." The two-page flyers distributed by the local government in 50,000 copies contained the following messages with colorful pictures:

> Mother is the one who can soothe her child
> Contain your child's worries by trying the following:
> Embrace and hug your child
> Listen to your child
> Tell your child, "It is not your fault"
> Tell your child, "It is OK to be scared.
> I will find a way to make you feel safe."
> Tell your child, "It is OK to be baby
> like. Come and cuddle with me."
> Tell your child, "If you have tummy ache or headache,
> I will hold you till they go away."

Residents in Tohoku, who were in the throes of primitive anxieties, proved receptive to this metaphor of interpersonal trust. A universal image for reciprocal interaction and empathic support yielded a sense of unity and structure and promoted positive self-identity (Stern, 1985; Emde, 1992). By Christmas Eve of 2011, PEP Kids Koriyama, the largest indoor playground in Tohoku was opened. It continues to accept 300,000 visitors annually with the sum reaching 2.8 million. Other effective measures as the Parent-Child Play team visiting evacuation centers and the Mother's Radiation Lab, initiated in Iwaki, steadily developed play spaces for children. Such efforts are not always rosy in outcome. Despite all these endeavors in Fukushima, child obesity increased by 1.5 times. Scores on children's motor skill tests have markedly dropped. During the COVID-19 pandemic, children's activities were greatly restricted again.

Creating spaces where people felt a sense of belonging and felt protected is urgent in the aftermath along with indoor play areas for children where parents/caregivers could hear their children play. In effect, this project was creating "villages" in the aftermath because the evacuees from Fukushima had been ostracized from the rest of Japan for having come from the radiation-contaminated areas. This could best be initiated by adults in the community. For implementation of such a child-centered long-term plan, it is crucial to build disaster-preparedness ahead in the community on a regular basis.

Nonverbal, affective communications, which prevail in infancy, would become activated in times of crisis. Analyzing the wisdom of ancestors yields enriching elements of disaster preparedness squeezed into simple small silent deed. Regaining secure familiar relationships, infants feel free to play and interact and learn. Laughing from their heart healed their wounds and revived their familiar adults. The adults wished to be assured that the next generation was safe. For infants and families, a sense of belonging and connection to their own familiar community was the key to their revival. Provided with age-appropriate play space and programs that honored the generational wisdom of the community, they became relaxed and vibrant, making adults feel relieved with a sense of joy, pride, and dignity. Infants are agents of hope, revitalizing their communities. When the ensuing COVID-19 pandemic complicated the ongoing hardships, the communities were able to endure. Memories of trauma may not fade easily, but a newly acquired resiliency helped them move forward. After all, people have survived and are surviving now in good spirits in the quagmires of conflicts and primitive anxieties. We need to learn more from them. The experience of disaster restoration in Tohoku and others opened our eyes to the basic principles of life in which infants lived, survived, and adapted. The goal of IMH in Japan was to return to the basics of our rooted way of living.

Reflection and Future Tasks

When the war defeat shattered the Japanese pride and spread confusion among the academic world, a paradigm shift from Japanese reflective thinking to Western dichotomy took place. With pressure to "catch up to the West" in the postwar period pressured professionals in related fields to abandon relationship-based values in collective cultures of traditional Japan. Professionalization of the field in Japan meant Westernization of values that were promoted as "valid." This led to a trend of postwar academism and education to be superficially absorbing Western knowledge without critical thinking. This permeated across Japan and yielded harmful slack ways of handling problems. For example, the field of child psychiatry were deeply divided since the 1960s, labelling children and medication prevailed to the detriment of creating massive malpractice. This applies also to the rise of IMH in Japan. As it became popular, jargons of IMH polluted the clinical field without essence, creating "intellectual pollution." The FOUR WINDS became a platform to scrutinize and discuss all the harm created by so-called experts. In the field of child psychiatry, based on such patchy knowledge absorption through papers, such malpractice of excessive medication, misdiagnoses, or/and overdiagnoses of children with panneruotic symptoms, autism, and pervasive developmental disorders has sadly been prevailing.

The past IMH movement in Japan over the three decades has taught us that simply devouring the so-called Western approach is not only ineffective but also harmful. To promote authentic communication, it is important to consider creating in-between space for each person to be themselves, de-westernize the internalized perceptions of Japanese parents, and help them retrieve sense of their natural self. While appreciating numerous endeavors, we need to advance IMH as an accountable field that can address complex issues of the current world. We need to go back to the basics of life and reflect on where we have made mistakes over the years and how we are to repair them in ways that promote reclaiming ancestral wisdom that promoted healing in families and communities. There are multiple ways the IMH field in Japan can move forward:

- Reexamine implementing Western ways of evaluating professional competencies within the infant mental health field and work to find ways that de-center the academic institutions and Western-oriented practices
- Cultivate workforce of professionals, who can offer family-centered support that validates intuitive wisdom in parenting
- Learn from approaches that are rooted in the regional cultural traditions, and ones that have maintained intuitive parenting and child-centered approaches have much to teach the rest of the country.
- The birth of Japanese IMH work should be anchored in "intuitive knowledge" embodied as a firmly rooted practice in the everyday wisdom of the ordinary people. What has been denigrated as grassroots needs to be reappreciated. These should be carried out based on deeply attuned observation. We need to begin by discarding presumptions, prejudice, and stigma and weakening our defensive mode of intellectualization.
- IMH works to guide us back to the principles of our cultural practices and ancestral wisdom. But more importantly, it guides us to reflect on the meaning of being a human, having the responsibility to sustain this planet as a livable milieu to hand down the generations.
- Amplify approaches of regions that have maintained and supported intuitive parenting

and child-centered approaches have much to teach the rest of the country.

- From the very moment of their life, infants actively interact with the environment around them. In order to survive the abnormal climate disasters and ecological upheaval of wildfires and torrential rains, IMH will need to interact more with the realm of environmental ethics and justice.

Summary and Key Points

Drawing on infants without and within ourselves, the knowledge and wisdom of IMH accumulated over the years should be aligned with the environmental ethics inherent in the wisdom of our ancestors handed down in non-verbal affective embodied communication. We have to preserve and revive our inner resources of humanity which is evident in the powerful lived moments of the infant.

Feeling secure and restored again in familiar relationships, infants who received the community-based interventions became playful again. Provided with age-appropriate play space and programs that honored the generational wisdom of the community, they became relaxed and vibrant, making adults feel relieved with a sense of joy, pride, and dignity. Infants became agents of hope, revitalizing their communities. When the ensuing COVID -19 pandemic complicated the ongoing hardships, the communities were able to endure. Memories of trauma may not fade easily, but a newly acquired resiliency helped them move forward. Focusing on the sensitive world of infants and attuning to their non-verbal visceral affective communication would help infant mental health professionals to deepen their competencies. While this approach is universal, there is much that can be learned from Asian communities that value interdependence.

Infant mental health is seen as a Western-originated field of discipline not generalizable to Eastern culture. To make it truly work in Japan, which has qualitatively different ways of handling infant care embedded in culture and traditions, it will have to be modified and integrated to be effectively used. IMH in Japan needs to be anchored in the cultural ethos of Japanese *amae*. *Amae* needs to be studied further as it overlaps with developmental theories of IMH as attachment, interdependency, and more. *Amae* needs to be scrutinized further from anthropological and primatological viewpoints. As the fetus proceeds its development in the womb following the steps of human evolution and born into the world with a social brain, it embodies the basics of human survival, adaptation, and evolution. Japanese IMH work needs to be anchored in “intuitive knowledge,” which is rooted in everyday wisdom or ordinary people. Therefore, grassroots work needs to be the center of our activity more than ever.

The basic principles of IMH will render a vision that would guide the world constructively to solve complex issues of survival and adaptation. Juichi Yamagiwa, a primatologist, alerts us to realign human species in the whole picture of the earth’s ecosystem with a quest into philosophy and art as well as science and technology (Dissanayake, 1996):

> With global warming, complex disasters, loss of biodiversity and other signs that alert us that the global environment is facing crisis, we need an ethic that harmonizes the connections and cycles of various lives, including non-human lives, on earth. We also need to review the fundamental principles of modern philosophy and scientism: objectivism, dualism, and the law of excluded middle. Japanese philosopher Nishida’s logic of place and the idea of “ma” (space), which emphasizes the law of included middle, are still firmly rooted in the Japanese people’s view of the nature and their emotions (Yamagiwa, 2022; Nishida, 1965; Krueger, 2013, Watsuji 1988).

IMH embraces a view of the effects of relationships on relationships and can mutually enrich the world and individual lives.

The postwar struggle to rebuild the nation has resulted in destroying people’s lives in harmony with nature. Japan as well as other Westernized industrialized countries have veered away from the environment of adaptive evolution, which had assured our survival with all other life on earth. Anthropocene Epoch, the geological time of human, is defined by the traces of plutonium in the layers of sediments. We have the responsibility to recreate a more accountable credible economics and politics. We need to converge on the effort of recreating an environment for all kinds of life. As infants guide us closer and closer to the essence of the early life of human being, we are made more and more humble and aware that we are but a dust in the vast universe. Yet each of us has a role to play and a doom to carry to pass onto the next generation. As we open ourselves to the story of each infant and young child, we might start to find our way out from this nightmare and back to where we have started. The IMH in Japan heads towards this direction, to retrieve our inner resources to explore a feasible way for each of us with the leverage of the wisdom that IMH imparts us. So far, we know that the West and the East need to come together to complement each other to retrieve the potential of human being embedded in the endowment of human morality.

In early relationships, we find the true reality of a baby being born into the world to survive, adapt, and develop in closely-knit relationship networks of the environment of evolutional adaptation. As the world becomes increasingly unpredictable and critical, we are warned to go back to the basics of the principles of life process. This is something we have been oblivious to while attracted to visible outcome of industrialization and technological advancement. The greed of men has exploited nature and now we are being retaliated. Also, now Japan has much to learn from the two unprecedented drastic changes of life in children: 3 years of COVID-19 restrictions and more than 2 years of restriction of outdoor activities in Fukushima after the nuclear disasters. How have the children been affected by the way the adults handled the threat of unprecedented threats of innovative virus and radiation? The law of nature demands the priority of life before any other things. Before the law of life, we are exposed to the reality that we are equal creatures having fleeting unpredictable future.

As Japan faces a relentless challenge of plummeting population with a super-aging society amidst an increasingly unpredictable world of manmade climate change and wars, IMH is needed more than ever to help Japan reflect and go back to its principles of life process. Japanese IMH work needs to be anchored in "intuitive knowledge," which is rooted in everyday wisdom or ordinary people. Therefore, grassroots work needs to be the center of our activity more than ever. We must weaken our defensive mode of intellectualization, a trend in Japanese professionals not processing information from the West. We must learn more humbly from those who live it.

As we look for ways to address the enormous political, social, and environmental difficulties, IMH provides a powerful fundamental perspective to revive our human morals. Going back to the basics of life, to retrieve in oneself the inner resources of our human moral endowment. IMH in Japan takes us on a journey through today's most urgent issues of humanity. In understanding infancy, we can converge and unite to become humble and reflect to reform our way of being, overcome differences of gender, age, race, language, and culture and understand how to survive, adapt, and live in peace together. As we face an existential crisis of humanity and planet, we are urged to learn from infants who are born ready to interact with anyone regardless of differences in gender, age, race, language, culture, and ways of living. In the coming years, IMH will be more open to welcome all the citizens of Japan and around the world who wish to endeavor to understand who we are and what makes us human.

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6

Parenting and Infant Mental Health in European Countries

Kaija Puura and Reija Latva

During the past decades, many changes have affected parenting in European countries. Since the 1990s, Western European countries have had multiple economic crises and rising unemployment rates as well as rising international competition. At the same time, Eastern European countries changed from socialist systems to market economies. This led to the increasing integration of the female work force into the economic system in Western countries and to the need for many couples to earn two incomes both in the West and in the East (Ochsner & Szalma, 2017). Many studies indicate that the dual-earner model has increased both in western and eastern European countries (McGinnity & Whelan, 2009; Ochsner & Szalma, 2017). As a result, recently a lot has been written about the experienced conflict between career or worklife expectations and family life, particularly among young women (McGinnity & Whelan, 2009; Bonache et al., 2022), and also of family burnout (Roskam et al., 2017). All over Europe, young people are migrating from rural areas to urban cities seeking education and better jobs and often losing their natural social network of relatives (see Ch 8 Vol 2, pp. xx). As a consequence, particularly first-time mothers often end up feeling socially isolated and without help from their own parents (Lee et al., 2019). Lack of support from previous generations may be one of the reasons why transition to parenthood is considered to be the most difficult transitions of adult life, with a majority of couples reporting a sudden decline in relationship satisfaction (Doss et al., 2009; Feinberg et al., 2016), and often unrealistic expectations concerning parenthood (Flykt et al., 2014). Not surprisingly in many European countries, there has been a marked increase in parental age and fewer children are born to parents (Andersson et al., 2009; Barbieri et al., 2015; Schmidt et al., 2012).

Technological development is another factor affecting parenting in Europe, particularly the rapid increase of digital devices and services. While using internet and social media can provide useful information and social support particularly for first-time parents, it can at the same time increase anxiety in parents with often conflicting information on child development and child rearing practices (Moon et al., 2019). With its unrealistic portrayals of parenthood and family life, the content of the social media can also exacerbate the difficult transition to parenthood (Vliegen et al., 2014). Young children's increased use of digital technologies has been documented in different countries by numerous researchers (Konca & Koksalan, 2017; Ofcom,

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2019). Parents' perspective on young children's use of tablets and other digital devices has been positive, but there have been concerns voiced over the potential overuse and misuse of tablets at home suggesting that more guidance for parents is needed to support young children's experiences with digital devices (Neumann et al., 2020; Ofcom, 2019).

Finally, as a result of armed conflicts and economic crises in the world, European countries have faced high arrivals of asylum seekers over the past decades. In 1992, the EU member states received 672,000 asylum seekers from former Yugoslavia. In both 2015 and 2016, the EU received 1.3 million arrivals, mainly from Syria, Afghanistan, and Iraq and also from Africa (European Commission, 2018). Since February 2022, 7.7 million refugees fleeing from Ukraine have been recorded across Europe. Ninety percent of the Ukrainian asylum seekers are children and women.

In spite of many advances in European societies, many children still grow up in poverty, and child poverty rates have in fact increased in half of the EU countries since the global recession (Bradshaw & Chzhen, 2015). Especially in Latvia, Lithuania, Hungary, Romania, and Bulgaria, poverty rates are high ranging from 30% to 42% of the population, but even in the richest European countries, poverty rates are around 15%. Poverty rates are especially high for young children growing up with several siblings in low-income single-parent families and in families with an immigrant background. The Indigenous Roma people in Europe have especially high rates of poverty (Robila, 2020). In face of these old and new challenges, there has been an increase in awareness of infant mental health and actions for supporting parents and families with young children in European countries. In this chapter, we will review studies concerning infant mental health in Europe, cultural differences concerning parenting, and different approaches for supporting parents that have been developed.

Infant Mental Health in Europe

Infancy and early childhood are periods where parental mental health has a major impact of the development and mental health of children. The negative impact of maternal perinatal depression and anxiety has been recognized and widely studied, and in recent decades also the importance of mental health of fathers has been emphasized.

A systematic review of 58 studies (*N* = 37,294 previously healthy women) reported an incidence estimate of 12% for postnatal depression and a prevalence of 17% (Shorey et al., 2018). The prevalence rates are higher in low- to middle-income countries (LMIC) than in high-income countries (HIC) (Fisher et al., 2012). In their review, Shorey et al. (2018) estimated the prevalence of maternal perinatal depression in Europe to be 8%. Systematic reviews report a prevalence of 15–20% for maternal antenatal and 10% for maternal postnatal anxiety disorders (Dennis et al., 2017; Fawcett et al., 2019), with higher rates in LMICs.

In a meta-analyses by Cameron et al. (2016) involving 74 studies with 41,480 participants, the meta-estimate for paternal depression was 8.4%. The prevalence of paternal perinatal depression was estimated to be 6.5% in Europe. In a systematic review of 23 studies, representing 40,124 participants, the overall random effects estimate of paternal perinatal anxiety was 10.7% (Leiferman et al., 2021).

Most studies concerning infants' mental health problems, symptoms, or disorders in Europe have been conducted in Central or Northern Europe. In studies looking at excessive crying, sleeping problems, and feeding problems severe enough to produce stress to parents, prevalence rates vary depending on the definition and methodological approaches applied. In a Norwegian study, 14% of 1-year-olds were reported to have concerns with negative emotionality, sleep, eating, and sensory sensitivity (Sanner et al., 2016), while as high as 30% of infants have been found to suffer from single or multiple problems of crying, sleeping, or feeding in their first year of life (Schmid et al., 2011; Wolke et al., 1995). Prevalence rates of eating problems in infancy in studies from Sweden and United Kingdom ranged from 20% to 25% in the normal population and from 40% to 80% in children with disabilities (Steinberg, 2007). Prevalence rates for excessive crying varied from 1.5% in the Netherlands (Reijneveld et al., 2001) to 9.2% in Denmark (Alvarez, 2004) and 16.3% in Germany (von Kries et al., 2006). In a relatively recent study by Martini et al. (2017), excessive crying and feeding problems, as well as feeding and sleeping problems, co-occurred in about 7% of full-term infants, while co-occurrence of excessive crying and sleeping problems was reported for only 2.0%. In the same study, 2% of the infants had all three problems. Although problems with regulation constitute transient problems in many cases, they persist in some infants. Longitudinal studies indicate that early regulatory problems are relatively stable across the early years and childhood (Schmid et al., 2010; Winsper & Wolke, 2014), and infants and toddlers with multiple or persistent problems with excessive crying, sleeping, or feeding may have an increased risk of attention problems in childhood and adulthood (Bilgin et al., 2020). In addition to studies on excessive crying, sleeping, and feeding problems, symptoms of sustained social withdrawal in infancy as an unspecific sign of infant psychological distress have been studied (Guedeney & Fermanian, 2001; Guedeney et al., 2013). Prevalence rates of sustained social withdrawal in infancy have varied from 3% in Finland (Puura et al., 2010) to 14% in France (Guedeney et al., 2012) in population-based samples. The variation in the prevalence rates is most likely due to differences in samples; for example, the Finnish sample was biased toward well-to-do families while the French sample had more families with several risk factors.

Epidemiological studies from Denmark and Norway using diagnostic measures have revealed a 16–18% prevalence of mental disorders among children aged 1–5 years, with 8–9% of children being severely affected (von Klitzing et al., 2015). In surveys of children aged 1–3 years, prevalence of deviant behavior or behavioral and emotional syndromes ranged from 7.3% (Richman et al., 1975) to 7.8–7.9% (Koot & Verhulst, 1991; Sourander, 2001) to 12–16% (Briggs-Gowan et al., 2001). In a Danish study of toddlers aged 18 months, the prevalence of a primary child psychiatric syndrome was 16% using the ICD-10 and 18% using the DC:0–3 (Skovgaard et al., 2007).

To our knowledge, there are no epidemiological studies of infant mental health from Eastern European countries. Instead, Hughes et al. (2019) studied the prevalence of Adverse Childhood Experiences (ACE) in Moldova, North Macedonia, and Romania. They found prevalence rates of 12% for physical abuse, 25% for corporal punishment, 12% for psychological abuse, and 3% for sexual abuse. In North Macedonia, 21% experienced physical abuse, 11% psychological abuse, 6% sexual abuse, 20% physical neglect, and 31% emotional neglect. In Romania, 27% reported physical abuse during their first 18 years of life, 24% reported psychological abuse, and 9% reported sexual abuse.

Some European studies have also investigated particularly vulnerable groups of young children. In their study on preschool aged children in care in the United Kingdom, Hillen et al. (2012) found that in their sample of 43 children, at least one mental health disorder was found in 26 (60.5%) of children, and at least one developmental disorder was found in 11 (25.6%). When mental health and/or developmental disorders were considered together, 30 (69.8%) preschoolers fulfilled criteria for at least one diagnosis and 18 (41.9%) had two or more comorbid conditions.

Petrovic et al. (2016) found that in their sample of 2- to 14-year-old children from Bosnia and Herzegovina, Macedonia, and Serbia, over 80% of parents of the Roma children in Macedonia and Serbia had used physical punishment. The risk for physical punishment was higher for younger children and for children living in urban environments.

The recent COVID-19 pandemic has had a negative effect on infant mental health. Racine et al. (2022) in their systematic review and meta-analysis pooled prevalence estimates for clinically significant depression and anxiety symptoms for mothers of young children during the COVID-19 pandemic were 26.9% (95% CI: 21.3–33.4) and 41.9% (95% CI: 26.7–58.8), respectively. The prevalence of clinically elevated depression and anxiety symptoms was higher in Europe and North America and among older mothers. In a study conducted in Austria, Germany, Liechtenstein, and Switzerland (Schmidt et al., 2021), being upset by separation increased among 1- to 3--year-olds during COVID pandemic, and oppositional symptoms, crying, sleeping problems, clinging, sadness, and not sleeping alone increased in more than 20% of the children.

Cultural Differences in Parenting in European Countries

According to Bronfenbrenner's ecological systems theory (1974), culture that individuals are immersed within may influence their beliefs and perceptions about events that transpire in life. In ecological systems theory, the already established society and culture which the parent and child live in is called the macrosystem and can include the socioeconomic status, ethnicity, geographic location, and ideologies of the culture. The macrosystem affects parenting behaviors, which may differ across various countries as they reflect relationships between family and other community members and values within the cultural context. While European countries are often categorized into individualistic cultures or cultures of separateness (Northern, Western and Central Europe) or collectivist cultures (Southern Europe, non-Western countries) (Kacitçibaci, 2006), there are differences within countries among different socioeconomic and ethnic groups and also between geographical areas (Pinquart & Kauser, 2018).

Parents in individualistic cultures emphasize the value of autonomy of each family member, foster self-reliance in child-rearing, and encourage children to achieve their full potential (Tamis-LeMonda et al., 2008). Social welfare or wealth makes family interdependency less necessary in individualistic cultures than in collectivist cultures. On the other hand, parents in collectivist cultures highlight the importance of loyalty to family and the larger group, respect and obedience to elders, and valuing the good of the group more than individual interests (Kacitçibaci, 2006; Tamis-LeMonda et al., 2008).

Parenting style refers to a set of parenting behaviors contributing to a persistent emotional climate in various contexts and situations (Baumrind, 1971, 1978; Coplan et al., 2002). According to Baumrind, parenting styles vary along two dimensions—parental responsiveness and control. Parental responsiveness refers to parental nurturance, warmth, and positive reinforcement in response to children's emotional and psychological needs, while parental demandingness refers to behavioral control over the child's actions and the use of authority and disciplinary practices. Based on these dimensions, Baumrind identified three parenting styles: authoritative (high on both dimensions), authoritarian (high demandingness, low responsiveness), and permissive (low demandingness, high responsiveness (Baumrind, 1971). Later studies identified a fourth style, neglectful parenting characterized by low demandingness and low responsiveness. Authoritative parenting style has been thought to be more typical in individualistic cultures which endorse children's autonomy and self-expression as socialization goals (Tamis-LeMonda et al., 2008). In contrast, authoritarian parenting style, in which dependency, obedience, and respect are central, has been associated typically with collectivist cultures (Kacitçibaci, 2006).

Associations of parenting styles with child internalizing and externalizing problems, academic achievement, and whether they vary between ethnic groups in Western countries, between different regions of the globe, and by level of collectivism/individualism of individual countries, have been widely studied. In earlier literature Western children and adolescents have described the authoritative parenting style as more representative and the authoritarian parenting style as less representative of their parents (Garg et al., 2005; Jambunathan & Counselman, 2002; Porter et al., 2005). However, findings from later cross-cultural studies have also found a high percentage of Western adults and children choosing the authoritarian parenting style as more reflective of their own parents than non-Western participants (Barnhart et al. 2013; Gherasim et al., 2017). In their meta-analysis, Pinquart and Kauser (2018) identified more ethnic and regional similarities than differences. In the meta-analysis, authoritative parenting was associated with some positive child outcomes and authoritarian parenting with some negative outcomes in all regions of the globe. The authors conclude that parents across the globe could be recommended to behave authoritatively, although authoritarian and permissive parenting seem to associate with good child outcome in some cultural contexts. For example, Parra et al. (2019) came to the conclusion that the optimum parenting style in Spain and Portugal is permissive, as scores in the four sets of socialization outcomes among children and teenagers from permissive families were always equal to or better than the authoritative parenting style.

Family Support in European Countries

Family support can be defined as a range of measures that society provides to parents to develop the best possible parent-child relationship and promote child development, all the while balancing a working life and responding to societal demands. The most important family supports that enable healthy child development in a societal context are different kinds of family leaves, family support within primary health care, as well as early childcare and education. Effective family support policies can mitigate negative impacts of stress on the family and to the development of the children. There is no single global policy ensuring family support in European countries, but most countries prioritize implementing policies to support families and children. International treaties also affect family policies in European countries, one of which is the Convention of the Rights of Children (United Nations, 1989).

Family Leave Policies

Family leave policies offer some of the most important benefits that governments can provide for working families with a newborn baby and young child. The protection of the mother and infant has been the key element of the family leave policy, and the women's right to maternity leave is well recognized in all European countries. The recognition of men's right to parental leave and the growing knowledge of the positive effects of paternal leave to parenthood have slowly influenced the change of social attitudes regarding paternal and parental leaves shared by both parents (Janta & Stewart, 2018; Huerta et al., 2014). Still in most European countries, mothers use the majority of family leaves. The level of compensation, the flexibility of leave arrangement, gender norms, and cultural expectations are the main factors that affect father's possibility to use parental leave (Karu & Tremblay, 2018)

Maternity leave All European countries offer at least 14 weeks maternity leave, which is according to the recommendation of International Labor Office (ILO) in the Convention on Maternity Protection (No. 183, 2000) (Jurviste & Lecerf, 2022; Addati et al., 2014). The EU legislation has also set 14 weeks as the minimum period for maternity leave, of which 2 weeks are mandatory. The longest maternity leave offered in European countries is 58 weeks (Belgium and United Kingdom). The majority of 86% of the European countries offer paid maternity leave amounting to at least two-thirds of the salary level received before the pregnancy, and in almost all countries, the payment for mothers is financed through social security systems (Addati et al., 2014).

Paternity leave Paternity leave is usually a short period of leave for new fathers to care for the infant, the mother, and the family. Despite the increasing recognition of the importance of paternity leave, the right to paternity leave is much less common in European countries than maternity leave, and it varies with respect to duration and cash benefits (Addati et al., 2014; Jurviste & Lecerf, 2022). The survey made by the ILO in 2010 revealed that half of the European countries provide paternity leave, and in Eastern Europe countries, 36% of the countries offer less than 1 week paternal leave (Addati et al., 2014). During the last decade, fathers' possibility to obtain paternity leave in European countries has improved. In EU a right to 2 weeks' paternity leave was introduced in a new directive on work-life balance for parents (Directive (EU), 2019/1185), who entered the workforce in 2019. Yet, there are still some EU countries that do not offer paternity leave (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2018).

Parental leave Parental leave is another support system for families. Parental leave allows parents to stay home to care for their child after the period of maternity or paternity leave. It is typically available to one, but can be available to both parents. The purpose of parental leave is to help parents maintain a balance of care for their child in the first few years of a child's life. Almost all European countries offer parental leave, but the length of the leave, payment, possible flexibility in usage, and transferability between parents differs by country (Addati et al., 2014). In three EU countries, Sweden, Finland, and Portugal, family leave support is more gender neutral than in other countries, and rather than maternity leave, there is only parental leave for which each parent is eligible (Janta & Stewart, 2018; Finnish Ministry of Social Affairs and Health, 2022). Gender-neutral family leave aims at better equality between parents and between different family constellations. However, mothers are most often the ones who stay at home with the child during parental leave, and in the EU, 90% of fathers do not take parental leave (Janta & Stewart, 2018). This may be explained by workplace cultures not supporting fathers taking longer leaves, family economy considerations, and a greater emphasis on maternal over paternal bonding (Kaufman, 2018; Reimer, 2020).

Adoption leave Adoption leave is a family leave to allow time for the new adoptive parents to adapt to the arrival of the child. According to the EU directive on parental leave, the parents' right to have parental leave should also apply in the case of adoption (European Parliament, 2017). In many European countries, leave for adoptive parents is shorter than for biological parents; however, there are countries that offer the same parental leave benefits for the adoptive parent and biological parents, such as United Kingdom and Finland (Addati et al., 2014; Finnish Ministry of Social Affairs and Health, 2022). Almost all EU countries have some kind of family leave to adoptive families, but access to parental leave is more complicated for families with same-sex parents and families with step parents and step children (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2020). The same-sex couples' access to different types of family leave depends almost entirely on their legal rights to become parents, and only a minority of EU countries allow the partner of a parent to take parental leave to look after a child to whom they have no legal relationship (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2020).

One possible benefit for new parents in some countries is a maternity package consisting of items of importance when caring for infants. In Finland, a maternity package has been given to expectant mothers since 1949. In Finland, the package or an equivalent grant is given to every expectant mother before the child is born. However, in order to qualify for a grant, the mother must first undergo a medical examination at the Well Baby Clinic. The idea of Finnish maternity package has been adopted to a "baby box" and piloted in several countries (Koivu et al., 2020). The baby box has also spurred criticism of not being a one-size-fits-all solution to intricate health challenges (Koivu et al., 2020; Reid & Swann, 2019).

An emerging trend in many countries is that parents have the right to take part-time childcare leave when they go back to work after family leaves. European women in marginal part-time work are more satisfied than men in a similar situation (Beham et al., 2019). Part-time childcare leave allows younger children to have a shorter day in a daycare center outside of the home and gives parents an improved work-life balance. In most countries that offer part-time childcare leave, the benefits usually end when the child reaches 1.5–3 years of age. A supportive gender climate and institutional support might make it easier for working parents to reduce working hours moderately, which would result in increased levels of satisfaction with work-life balance and allow young children to have more time with their parents (Beham et al., 2019).

Family Support Systems in the Primary Health Care

The term child health care is often used to specify the preventive health care targeting children within the Primary Health Care services. Child health care services are essential not only for the child's health and development but also for the child's social and emotional well-being and support of parents and family. Child health care generally includes child physical and mental health supervision, immunization, examinations, and health advice. The young child's early dependence on caregivers requires a different approach to ensure children's mental health, which means focusing on supporting the parents as they are central for well-being of children.

According to the Convention on the Rights of the Child, which is ratified by all European countries, all children have a right to receive the highest level of health care possible (United Nations, 2004). In Europe there are different models to organize child health care services; however, there are many similarities, particularly in the basic activities of child health care such as immunizations, monitoring and detection, screenings and epidemiological research (Wieske et al., 2012). In many European countries, child health care is provided by the primary health care system and organized nationally (Hiilamo, 2008; Vannaste et al., 2022; Wettergren et al., 2016; Wieske et al., 2012). Some countries have kept the family doctor system (e.g., Ireland), but in other countries, these practices have multidisciplinary teams offering complex child health care by nurse practitioners, psychologists, and pediatricians (e.g., Nordic countries). Some countries have a pediatric system (e.g., France and Italy) and others a general practice system (e.g., Macedonia) (Ehrich et al., 2016).

The European countries, in which the child health care services are also covering the family support, are the Nordic countries and west Europe. In the Nordic countries and in the Netherlands, child health care is offered by interdisciplinary medical groups in public health centers (Hiilamo, 2008; Vannaste et al., 2022). In Germany, Switzerland, and Austria, those responsible for preventive care are primary care providers, pediatricians, and general practitioners (Wieske et al., 2012).

All Nordic countries – Denmark, Finland, Iceland, Norway, and Sweden – offer a wide range of health care services to expecting mothers, children from birth to 6 years of age, and school aged children (Hiilamo, 2008). Free antenatal care and child health care are integrated parts of the primary health care system, and the role of the private sector is marginal or nonexistent in all Nordic countries. Expectant mothers have a certain number of appointments during pregnancy. Well Baby services offer prenatal classes for prospective parents, preparing them for birth and the new baby. After birth, most families with newborns are offered nurse home visits within 2 weeks postpartum. The family is then seen in child health care for a certain number of appointments in a comprehensive health coverage during the first year of the child's life and annually thereafter. Families can drop by for unscheduled visits with a nurse and, on occasions, a pediatrician. Topics covered during visits are geared toward supporting the family, including discussions about the couple's relationship, economic security, employment, well-being of any siblings, and general home atmosphere (Hiilamo, 2008). Child-parent interactions and child-rearing practices are observed. Parent support groups are provided. Mothers are screened using the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 2014) at given time points and offered counseling if needed, and in some cases referral to a psychologist. Both parents are expected to attend visits, and in Sweden, a special father visit has been made routine.

Besides the Nordic countries, the Netherland is one of the world leaders in child welfare (UNICEF, 2007). The Netherland also offers a wide range of health care services to expecting mothers, under school-aged children, and school-aged children (Vannaste et al., 2022). The Netherlands has a unique system for promoting child and youth health, known as the preventive Child and Youth Healthcare service. It makes an important contribution to the development and health of children and young people by offering information, immunization, and screening, identifying care needs and providing preventive support to children and their families from birth up to the age of 18 years. The professionals in the Child and Youth Healthcare services work in multidisciplinary teams with specialized physicians, nurses, and physician assistants, and occasionally with dietitians, speech therapists, or educationalists. The early detection of parenting and developmental problems almost exclusively takes place in the child health care. The service is offered free of charge and offers basic preventive care to all children and special preventive care to children who grow up in disadvantaged situations (Vannaste et al., 2022).

Early Childcare and Education Policies

Childcare may be seen as a number of services, including the provision of nurturance and learning opportunities for children, preparation for school, support for working parents, and reduction of poverty. Early childhood education mainly refers to services offered to children from age 3 and older focusing on learning, aiming to prepare children for school. In many countries, childcare and early childhood education are integrated in the same childcare setting. In many European countries, dual-earner families have become the norm and for most parents, balancing work commitments and family responsibilities is a challenge (Bonache et al., 2022; McGinnity & Whelan, 2009; Ochsner & Szalma, 2017). For parents in dual-earner families, finding adequate childcare is an issue of utmost importance. Many European countries help fund early childcare and education in some way either through providing lower cost childcare directly or through subsidizing and/or reimbursing part of the costs of care paid by parents (Akgündüz et al., 2015). However, many countries are struggling to provide affordable and accessible high-quality childcare for families.

In the Nordic countries, the public childcare systems are under the purview of the national social welfare program and uniquely offer a nearly universal entitlement for childcare prior to primary school. Early childcare and education is traditionally publicly provided, but private care provision has increased during the past decade due to the promotion of market ideology and market based reforms (Adamsson & Brennan, 2014). However, there is a keen interest in maintaining public control over local childcare and education provision (Ruutiainen et al., 2020). Early childcare and education is offered to children aged 1–6 years. The childcare is provided on a full-day and full-year basis, and some childcare centers stay open overnight for parents who work at nighttime. The possibility to use early childcare systems is irrespective of parents' employment status. In some of the Nordic countries, when the family has an additional baby, any child in the family is allowed to stay at childcare, even when parents are on parental leave with the newborn. In the Nordic countries, there is a tradition of combining education and care in the same setting, oftentimes adhering to formal educational acts. Training of staff and quality of childcare is quite high (Broström et al., 2018). However, there is increasing discussion in the Nordic countries about the quality of the care and education provided in the early education and care as group sizes increase, staff numbers dwindle, and quality varies.

A policy ensures that a cash benefit is provided to parents of children between 1 and 3 years of age who are not using the publicly funded early education and care systems. Families with a child in part-time early childcare are entitled to a partial cash benefit according to the number of hours used. The cash benefit is financed by the state and at the same level as the subsidy provided to parents whose children attend early education and care. This rationale was designed to increase options and choices for parents such that they would be free to choose whether they wish to stay at home with their young children, use some private form of childcare, or enroll their children in the public early childcare centers.

Continental European nations provide early childcare in conjunction with universal education programs. The childcare is publicly funded, subsidized through both national and local taxes and parental co-payment services. Childcare is usually not an entitlement for children prior to entering public preschool programs, but some countries provide early universal public preschool programs for children from 2.5 years of age. For instance, in both Belgium and France, care for children from approximately 3 years of age is available and free for parents, and nearly all children are enrolled in preschool programs from the age of 3. On the more generous end of the spectrum is France. Children aged 3 years and older are legally guaranteed preschool education, and the French government has instituted a highly developed universal preschool system for children aged 2–6 years. Most other European countries, such as Belgium, Germany, and Italy, legally guarantee children a place in preschool programs at 3 years of age. Hours of operation are more inconsistent in Continental European nations due to extended lunch breaks and afternoon closings.

European Recommendations for Supporting Early Childhood and Parenting

The Council of Europe is an international organization founded in 1949 to uphold human rights, democracy, and the rule of law in Europe, and currently has 46 member states. The council has two statutory bodies: Committee of Ministers, comprising the foreign ministers of each member state, and the Parliamentary Assembly of the Council of Europe (PACE), which is composed of members of the national parliaments of each member state. The Committee of Ministers of the Council of Europe launched Recommendation 19 (2006) on "Policy to Support Positive Parenting" as being of high importance for developmental and educational science, for family and social policy, and society in general. Positive parenting is defined as "parental behaviour based on the best interest of the child that is nurturing, empowering, non-violent and provides recognition and guidance which involves setting of boundaries to enable the full development of the child." The concept of positive parenting focuses on a view of parenting that is respectful of the child's best interests and rights as articulated by the United Nations Convention on the Rights of the Child (UNCRC) in 1989 (United Nations, 1989). In the Recommendation, the importance to children of growing up in a positive family environment is endorsed, and the responsibility of the state to create the right conditions for positive parenting is emphasized. The Recommendation also encourages parents to seek assistance if they encounter difficulties in bringing up their children as well as to encourage them to eliminate the use of corporal punishment in disciplining children and to acquire alternative methods. Promoting positive parenting is of particular importance in the times of crises, due to the increased tensions within families caused by unemployment or other economic difficulties, or general insecurity caused by natural disasters and geopolitical instability.

After the launch of the Recommendation, progress has been registered on family life education and specifically parenting education in Europe, including Eastern and Southeastern Europe (Jansen et al., 2020; Lachman et al., 2019). There has been an increase in the scope and number of evidence-based parent education programs and parenting support initiatives and services in Europe (Robila, 2020). Examples include the GenerationPMTO, that was developed from the Parent Management Training – Oregon Model (PMTO) in the United States. It is an effective program for child and adolescent behavior problems that was implemented nationwide in Norway (Ogden et al., 2005) and contributed to improvements in parenting practices from pre- to post-treatment (Forgatch & DeGarmo, 2011). The program has been implemented also in Iceland, Denmark, and the Netherlands (Sigmarsdóttir et al., 2019). Another successfully implemented parenting program in Europe is the Positive Parenting Program (Triple P) developed in Australia (Sanders, 1999). The success of the Triple P system in Europe has been evidenced through its positive impact in transforming the lives of children, parents, and communities (Sanders & Mazzucchelli, 2018). The program is focused on self-regulation of parental skills, is administered in different ways (individual face-to-face, group), and has been adopted in Belgium, Germany, the Netherlands, Switzerland.

Another program widely used in Europe is Incredible Years, developed in the United States, which is a parenting program for reducing conduct problems. It is a group-based strategy program targeting children with ages up to 12 years and with behavioral issues, and focuses on the parent-child relationship and developing parenting skills (Webster-Stratton & Hancock, 1998). Incredible Years has been used successfully in Sweden (Axberg et al., 2007) and has been implemented nationwide in Norway after successful randomized control trials showing reduction in child conduct problems, parental stress, and use of harsh and inconsistent discipline (Larsson et al., 2009).

An example of a parenting program adapted and used particularly in Eastern Europe is the Parenting for Lifelong Health (PLH) developed initially in South Africa. The 12-session group-based parenting intervention is using collaborative social learning behavioral change strategies to encourage parents to reduce harsh discipline and improve positive parenting behaviors and parent-child relationship, through discussions, role-play, and home activity assignments (Lachman et al., 2017). Randomized trials are being conducted in Macedonia, Moldova, and Romania (Heinrichs et al., 2020).

Experiences from the use of interventions in Europe support selecting interventions based on the evidence of their effectiveness. In their multilevel meta-regression study of randomized trials, Leijten et al. (2016) showed that transported and locally developed interventions did not differ in their effectiveness to reduce disruptive child behavior across various intervention programs and geographical regions.

The European Commission (EC) is the executive of the European Union (EU). It operates as a cabinet government, with 27 members of the Commission headed by a president. The 2013 Commission Recommendation on Investing in children: breaking the cycle of disadvantage stressed the importance of early intervention and an integrated preventative approach. It called on EU countries to improve children's access to adequate resources, to provide children with access to affordable early childhood education, care, and health care services, to support children's right to participate in play, recreation, sport, and cultural activities, and to promote children's participation in decision-making that affects their lives. In a strategic dialogue meeting of the main European NGOs working on children-related policies, the positive results of the Recommendation were that it worked as an important agenda-setter for all stakeholders and allowed NGOs to persuade several Member States to use the Structural Funds more efficiently for children. It also led some Member States (Belgium, Ireland, Portugal, and Estonia) to adopt an integrated policy approach to children-related issues. The Recommendation's key message to focus on the early years and on ECEC was taken up in most Member States. The Recommendation also generated more financial support for de-institutionalization projects and for Roma children. However, only four European countries referred to the Recommendation in their national reform programs, and many ministers responsible for social affairs were unfamiliar with it.

In 2021, European Commission launched the European Child Guarantee Recommendation. The objective of the European Child Guarantee is to prevent and combat social exclusion by guaranteeing effective access of children in need to a set of key services such as free early childhood education and care, free education, free health care, healthy nutrition, and adequate housing. While most children in the EU already have access to these services, ensuring equal opportunities for all children, and particularly for children who experience social exclusion due to poverty or other forms of a disadvantage, still needs commitment from member states. For implementing the Recommendation, the Member States have nominated their Child Guarantee Coordinators and are preparing national action plans for time period until 2030. All the Member States are required to allocate an appropriate amount of their European Social Fund resources to reduce child poverty, particularly those Member States where child poverty exceeds the EU average. By November 2022, 15 countries had submitted their national action plans.

Summary and Keypoints

Parenting in European countries has undergone several changes in the past decades. Some factors producing stress to parents are old, like the continuing migration of young people from rural areas to urban cities in search of education and better jobs, and child poverty. Some stress factors are more recent, like the parents' dual-earner model that has increased both in Western and Eastern European countries, which has exacerbated the experienced conflict between career or work life expectations and family life, particularly among young women. A new concept of family burnout is known both in Eastern and Western Europe, but interestingly, full-time employment was also a protective factor against maternal burnout for some women (Lebert-Charron et al., 2018). Another new stress factor affecting parenting also in Europe is the rapid increase of digital devices and services. Frequent use of digital devices and social media has increased anxiety in parents with often conflicting information on child development and child rearing practices and with its unrealistic portrayals of parenthood and family life. Similarly, young children's increased use of digital technologies has been documented in different countries with concerns of potential overuse and misuse. As a result of armed conflicts and economic crises in the world, European countries have faced high arrivals of asylum seekers over the past decades, creating new challenges in providing services and jobs for the immigrants in several countries.

Regarding infant mental health in Europe, there is a considerable lack of current studies from north and west and lack of studies from eastern European countries on the prevalence of mental health problems, symptoms, and disorders. What can be deduced from previous studies and from studies with older children is that mental health problems in infancy seem to be as prevalent as mental health problems later in childhood, although the spectrum may be different in infancy and early childhood. The number of children at-risk for mental health problems seems to be higher in Eastern European countries and in vulnerable populations. Even though in earlier studies of parental perinatal depression and anxiety, the prevalence rates were lower in European countries than in other parts of the world, in most recent studies, the COVID pandemic seems to have increased parental isolation and perinatal mental health problems.

Parenting styles in different parts of Europe have in earlier studies differed between individualistic cultures in Western and Northern Europe, and collectivist cultures in Eastern and Southern Europe. However, in a recent meta-analyses, more ethnic and regional similarities than differences were found. Authoritative parenting was associated with some positive child outcomes and authoritarian parenting with some negative outcomes in all regions of the globe.

All European countries have at least some forms of support for families, offering at least 14 weeks maternity leave as a means of family support, and different types of parental leaves or financial support exist for families with young children. In three EU countries, Sweden, Finland, and Portugal, family leave support is more gender neutral than in others, and rather than maternity leave, there is only parental leave for which each parent is eligible. However, mothers are most often the ones who stay at home with the child during parental leave. Recently it has been argued that well-compensated, individualized, nontransferable rights to parental leave could strengthen men's entitlement to take time off to spend time with their families (Haas & Hwang, 2019). This would be highly beneficial for infants and young children as fathers spent more time in taking care of and playing with their infants were more likely to develop secure attachment relationship (Brown et al., 2018). Fathers who took more pleasure in parenting also interacted more sensitively during father–infant interaction (Aytuglu & Brown, 2022). Both secure mother-child and father-child attachment relationships seem to be associated with better outcome in children's development (Dagan et al., 2021). And even after parental leave, supportive attitudes towards parenting together with institutional support might make it easier for working parents, both mothers and fathers, to reduce working hours moderately allowing young children to have more time with their parents.

All European countries have ratified the Convention on the Rights of the Child which defines that all children have a right to receive the highest level of health care possible (United Nations, 2004). Despite different models to organize child health care services, all countries provide the basic activities of child health care such as immunizations, monitoring and detection, screenings, and epidemiological research. Both in the Eastern and Western European countries, dual-earner families have become the norm and finding adequate childcare is an issue of utmost importance. Many European countries help fund early childcare and education in some way either by providing low-cost childcare directly or by subsidizing or reimbursing part of the costs of care paid by parents. However, many countries are struggling to provide affordable and accessible high-quality childcare for families. The gains of early education and care are particularly notable within children from lower socio-economical status (SES) families (van Huizen & Plantenga, 2018).

In addition to individual countries' endeavors for supporting young children and their families, both European Council and European Commission have had numerous initiatives and recommendations for European countries. Though the results of these recommendations may not always meet expectations, for example in the amount of money spent in fighting family poverty, they are still important. An example of at least relative success is Recommendation 19 (2006) on "Policy to Support Positive Parenting" with the change in attitudes and legislation concerning parenting and corporeal punishment of children in European countries. The Recommendation encourages parents to seek assistance if they encounter difficulties in bringing up their children as well as to encourage them to eliminate the use of corporal punishment in disciplining children and to acquire alternative methods. Corporeal punishment of children is now illegal in most European countries. This has a huge meaning also for infants and young children, as the possibility for corporeal punishment tends to be quite high in this age group. In context of the challenges Europe is facing, the latest European Child Guarantee Recommendation launched in 2021 by the European Commission is an important program for fighting child and family poverty in all EU countries, and particularly those member states with higher rates of poverty. Striving for better infant mental health in Europe needs initiatives and work in all levels of the ecosystem, from individuals to societies, and from individual countries to the whole continent.

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Parenting and Infant Mental Health in South America

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In this chapter, we present some experiences in the Infant Mental Health (IMH) field carried out in Argentina and Uruguay, and outcomes of research projects conducted by the authors, that contribute to the building of bridges between psychoanalysis, infant research, and infant mental health in South America.

Historical Background in Argentina and Uruguay

Our countries have a long and strong psychoanalytic tradition due to the early translation of Freud's Complete Works into Spanish in 1923 and the dissemination of psychoanalysis in public and free universities, in the mental health services of public hospitals, and in the community, in general. Since then, Spanish translations of the work of Anna Freud, Melanie Klein, Donald Winnicott, and Rene Spitz, among others, have been used to train pediatricians, teachers, psychologists, and other professionals in charge of children's health and development. These inspiring influences enhanced the early awareness of our professionals about the importance of early signs of infant mental health concerns.

Academic dialogues have been conducted with figures such as Zeynep Biringen, Patricia Crittenden, Robert Emde, Peter Fonagy, Antoine Guedeney, Bernard Golse, Alexandra Harrison, Miri Keren, Martín Maldonado, Juan Manzano, Francisco Palacio Espasa, Alan Schore, Arietta Slade, and Edward Tronick.

Florencio Escardó was a leading pediatrician in the IMH field in Argentina. He brought a pioneering change in the 1960s at the Central Children's Hospital in Buenos Aires, when he suggested that children should be hospitalized with their mothers to preserve the dyad's affective bond, showing evidence that this practice

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was beneficial to the child's recovery from different medical conditions. Also in Argentina, a group of renowned children's psychoanalysts, such as Arminda Aberastury, Elizabeth Garma, Susana Lustig de Ferrer, Arnaldo Rascovsky, Marilú Pelento, and Silvia Bleichmar, have trained several generations of psychologists that related children's suffering to parent's childhood history and who received referrals by teachers and pediatricians. They worked in public and private mental health services, mainly in urban middle-class environments and also in public hospitals and programs for vulnerable populations. Nowadays, the psychodynamic approach is still central but also integrates active contributions from empirical research, developmental psychology, neurosciences, and cognitive approaches.

Empirical research in developmental psychology in Argentina started relatively later than in the central countries. Miguel Hoffmann (Hoffmann et al., 1998), Celia Galperin (1990), and Clara Schejtman (1998) teams, among others, were pioneers in conducting research based on videotaped material analyzed with a systematic empirical methodology.

Argentina is a country with a very large territory that presents significant inner sociocultural differences and includes very disadvantaged and impoverished areas. This, in addition to a series of economic and political crises, made health programs and public policies very heterogeneous. In this sense, this chapter does not pretend to be representative of the whole scope of theories and clinical approaches in practice in Argentina today. Likewise, Uruguay, yet being a smaller and more cohesive country, presents the challenge of economic difficulties and an impoverished population. Regarding IMH, Uruguay has a long tradition of clinical work and research. The work of Miguel Cherro (1992) is a highlight of the latter. The research and screening guidelines of the Interdisciplinary Group of Psychosocial Studies (GIEP) (lead by Schwartzmann, Cerutti, and Canetti) were crucial for the health care policies for infants, as well as the studies of Bernardi et al. (1982) and of Mercedes Freire de Garbarino (1992). A longitudinal national survey (ENDIS) is being conducted since 2013 to assess infant development, nutrition, and parenting practices of infants from 0 to 3 years old. Therefore, the Uruguayan research presented here is not an isolated project in Uruguay and owes much to this background. Some contributions and results produced by two groups with a long-lasting trajectory are presented.

Research Contributions from Argentina

The Argentinian group, funded by the Faculty of Psychology of the University of Buenos Aires and the International Psychoanalytic Association, brought together researchers and university professors who also work as clinicians[1] specialized in infants, young children, and their families. This research program was focused on two foundational stages of development: 6 months and 4 years. Its main goal was to study the early parent-infant relationship, linking data from two sources: mother-infant videotaped play interaction and the intrapsychic parental perspective through in-depth interviews. The central interactive variables studied were dyadic affective regulation and infant-self regulation, dysregulation signs in preschool mother-child interactive play, parental interactive styles, and emotional availability. We also studied the symbolization level in preschool children and, as a central parental variable, the parental reflective function.

Theoretical Background

Affect Regulation and Dyadic Emotional Availability Healthy very young infants are open to the world and display their own internal activity to elicit interaction and achieve a strong

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[1] The current members of the research group, directed by Clara Raznoszczyk Schejtman and co-directed by Constanza Duhalde, are Vanina Huerin, María Pía Vernengo, Inés Vardy, Milagros Maurette (a special acknowledgment for her help in editing this paper), Paula Adelardi, Malvina Escalera, Camila Schulz, Federico Bernao, Sandra Casabianca, and Rosa Silver.

emotional connection with the environment. At birth, they present an embryonic regulatory capacity with individual differences in sensory reactivity and in achieving homeostasis. However, this capacity is initially labile and requires the regulatory and intersubjective scaffolding of the caregiving environment for developing the infant's affective, psychomotor, social, and cognitive potentialities.

Affect regulation (AR) could be defined as the capacity to control and modulate affective responses. In everyday life, affect regulates our interests as well as our frustrations and contributes to shaping the core of the self (Emde, 1999). Infants are motivated to communicate and to co-create intersubjective states with their caretakers. And, as suggested above, their affective organization depends simultaneously on the baby's self-regulatory capacity and the regulatory scaffolding provided by the caring environment. In this sense, the Mutual Regulation Model (Tronick, 1989) conceptualizes infant and mother as components of a larger dyadic affective regulatory system, in which each one – infant and adult – influences and is being influenced by the communications of the other. Since the organization of the system is inherently messy, a co-created relationship emerges out of the ongoing process of matches and mismatches in the mutual exchange of affect expression and relational intentions. Dyadic regulation enables the child to modulate increasingly complex states of mind and to scaffold the achievement of self-regulation. Parents provide "hidden regulators" (Hofer, 1995) of the infant's states of consciousness and work as affect transformation agents, repairing negative affect and collaborating with the infant's affective self-regulation, such as oral self-comforting and distancing.

Another contribution regarding the study of adult-infant affectivity and affective regulation is the concept of emotional availability proposed originally by Emde (1980) and further developed by Biringen (Biringen, 2008, Biringen et al., 2014). This perspective highlights the importance of the wide range of emotional exchanges between infants and their caregivers. It includes the basic principles of attachment theory to which it adds the value of the presence and extension of genuine positive affect in dyadic interactions. Of particular importance within this framework are Ainsworth et al.'s (1978) thoughts on caregiver's sensitivity: adequate perception and response of the child's communications as a central support for the child's secure attachment. The sensitive response of the caregiver is an important aspect of the psychic, emotional, and relational organization. A present, continent, and thinking adult will contribute to the affective regulation and the integration of the psyche in the infant's structuring. From the framework of emotional availability, maternal sensitivity is considered in tandem with the child's responsivity to the adult's emotional communications.

Interactive Play, Symbolization, and Parental Reflective Functioning The experience of play in the first years of life facilitates the emergence of the self and subjectivity and provides a sense of trust in oneself and others. According to Winnicott (1971), play builds a creative potential space between the mother (or main caregiver) and infant, which facilitates the infant's transition from omnipotence and subjective object to external reality. At 6 months, a transition from body holding to gaze and voice holding takes place, creating a new space between the caregiver and the child and a consequent internal mental separation between an emergent self and the other (Stern, 1985). This new space is particularly significant in the mother-infant play scene. Later, the adult-child play situation expands interactional opportunities and scaffolds the child's feelings of self-affirmation and a sense of agency, as well as more complex self-representations. Infant play is particularly related to feelings of joy and pleasure, allowing the child's exploratory actions.

At the age of three, within the fictional play between child and adult, children can perceive how the adult reflects on mental states. The mentalizing attitude of the parents during the play situation provides the children (or confronts them) with a representation of the content of their minds and their parent's mind. During interactive play, the adult can offer a link between reality and "as if" ideas and feelings, showing that they can share an experience that "suspends" their asymmetrical situation in the real world (Sroufe, 1996). Symbolic play is a process that unfolds in time with clear sequential relations between the parent's facilitation of child symbolization and the complexity of the child's symbolic expression (Feldman, 2007). Complex and fictional symbolic play, moreover, implies the notion of separate minds, with autonomous reflective processes leading (Fonagy & Target, 1996).

In our studies (Duhalde et al., 2022), one parental variable that has shown an impact on children's achievement of affect regulation and symbolic play is parental reflective functioning. This variable, along with unconscious representations and parental narcissism, is closely related to dyadic affective regulation. Mentalization, or Reflective Function, has been defined as the ability to perceive and understand oneself, as well as others, in terms of mental states, that is feelings, thoughts, beliefs, and desires (Fonagy & Target, 1998). It is considered a key factor to understand the organization of the self and affective regulation. Focusing on parenthood, Slade (2002) points out that the parental reflective capacity allows the child to discover his/her own internal experience via the experience that the caregiver has of him/her. This parental feature not only contributes to the infant's increasing achievement of affective self-regulation but also scaffolds the acquisition of the child's capacity to modulate and symbolize affective experience through language.

Parental Styles and Dysregulation Signs Parental interactive styles are defined as a set of attitudes that the adult displays during play interactions, creating an emotional climate. Feldman (2007) identified interactive styles that tend to facilitate the flow of play, characterized by elaboration and decontextualization, nonjudgmental verbalization, positive affect, and creativity. She differentiates these styles from a restrictive style, characterized by intrusiveness, criticism, and directivity in the parent's discourse, and the presence of negative affect. Parental interactive play style (facilitating or restrictive) is related to the child's level of symbolic play (Keren et al., 2005; Schejtman, 2018).

Affective dysregulation in the child, when not satisfactorily repaired by the adult, may have a potentially traumatic effect, may produce difficulties in the processing of stimuli and in the process of symbolization, and may constitute a psychopathological trigger with lasting consequences in the psychic structuring of the subject. Aggressiveness, impulsiveness, withdrawal, and inhibition, observed in the child or the mother during play, are dysregulation signs that can slow down or interrupt the playing display.

Research Studies and Outcomes

Study 1: Affect Regulation and Dyadic Emotional Availability Forty-eight mothers and their healthy babies (23–31 weeks of age, 50% female) from Buenos Aires city were videotaped in a lab setting in two interactive situations: 3-minute face-to-face interaction and 5 minutes of free play with toys. The purpose of the study was to compare the outcomes from the two evaluation systems of mother-infant interaction very frequently used in infant mental health research today: global analysis and microanalysis.

In the first stage, the 3-minute face-to-face (FF) interaction, affective regulation was analyzed by microanalysis, second by second, using the Infant and Caregiver Engagement Phases Scoring System (ICEP) (Tronick & Weinberg, 2000). For the 5-minute free play with toys episodes, affective regulation was assessed with the "Free Play Scale" (FP) (Tronick, 2000), every 5 seconds. The variables derived from ICEP and Free Play Scale scoring are as follows: (1) positive, neutral, and negative affect in the infant and in the mother; (2) affective matches and mismatches between mother and infant and; (3) infants' self-regulation signs such as oral self-comfort and distancing.

In the second stage, the same interactive situations were studied with the Emotional Availability Scales System (EAS) (Biringen, 2008) which proposes a global assessment of a dyad's ability to share an emotionally healthy relationship. This assessment approaches a dyadic perspective of the adult-child relationship using a multidimensional framework, with six scales that measure affect and behavior of both child and adult. The system comprehends four scales for the caregiver, Sensitivity, Structuring, Non-intrusiveness, and Non-hostility, and two scales for the infant, Responsiveness and Involvement. It also determines the extent to which an adult-infant relationship is considered emotionally available or not.

The obtained results were as follows: microanalysis of dyadic affective regulation showed that, in the FF situation, mothers spent 99% of the valid coded time looking at their infants, while infants looked at their mother's faces 50% of the time. In terms of expression of affect, mothers showed 5 times more positive affect than infants. On the other hand, infants showed 78.3% of neutral affect, 16.6% of positive affect, and 5% of negative affect. Mother and infant spent only around 16% of the valid coded time in dyadic positive matching. In the FP situation, the rate of the positive match was very similar, 14.8%. Most of the mismatch states showed the following pattern: mothers displaying positive affect while their infants display neutral affect. Although eye-contact interaction proved to be crucial to affective development, we found that infants are engaged in this kind of interaction for a limited period.

Regarding affective self-regulation, in the FF situation, 21 of 48 infants presented at least once a self-regulation sign, such as Oral Self-Comforting (OSC), while in the FP situation, only 2 of 48 infants presented OSC. This means that in a FP situation, with toys available, infants displayed much fewer self-regulation resources. In other words, infants at 6 months do become more object-oriented, showing more interest in exploring the outside world than their mother's body or their own. We infer that, as mother-infant FF interaction is somehow a stressful and demanding situation, infant OSC may constitute a resource for the child to deal with potential maternal over-engagement. In contrast, in the FP situation, toys and objects are used by the infant to self-regulate and by the mother to regulate the infant's affect as well as to scaffold a developmental shift in the infant toward greater agency and independence.

Concerning dyadic emotional availability (EA), the mean obtained by using the EAS coding system scales was 5.47 (SD 0.95) for maternal sensitivity; 5.46 (SD 0.90) for maternal structuring; 5.30 (SD 1,06) for maternal non-intrusiveness; 6.05 (SD 0.73) for maternal non-hostility; 5.28 (SD 1.02) for infant responsiveness; and 5.06 (SD 0.85) for infant involvement. Globally, these results are similar in studies with nonclinical dyads at the studied infants' age (Biringen et al., 2014).

Regarding the relation between dyadic emotional availability measured by the EAS global coding system and dyadic affective regulation and infant self-regulation measured by ICEP microanalytic system, we found a positive correlation between infant's positive affect and maternal sensitivity (0.313, $p < 0.01$) and non-hostility (0.285, $p < 0.05$), and infant's responsiveness (0.319, $p < 0,05$) and involvement (0.381, $p < 0.01$). Infant's negative affect, instead, shows a negative correlation with maternal sensitivity (−0.285, $p < 0.05$). Positive matches (reciprocal positive affect expression in mother and infant) show a positive correlation with maternal sensitivity (0.313, $p < 0,01$), infant's responsiveness (0.310, $p < 0.01$), and infant's involvement (0.359, $p < 0.01$). Finally, we found a negative correlation between infant's oral self-comforting, infant self-regulation signs, and maternal sensitivity (−0.345, $p < 0.01$, structuring (−0.306, $p < 0.01$), and non-hostility (−0.324 $p < 0.01$).

These findings tend to express convergent validity between these two systems of observation centered on mother-infant affective regulation. Specifically, the mother's sensitivity – her capacity to accurately read the infant's affective signals and display a genuine positive affective connection – captured by global analysis (EAS) is connected both to more positive affect and less negative affect in the infant as measured by microanalysis (ICEP). Another outcome that should be mentioned is that infants use fewer self-regulation resources when mothers are more sensitive. Pleasurable interaction, where the infant's affective needs are met, positive affect is present, and negative affect is well integrated, could work as an affective regulator by itself. In this sense, through videotaped material, crucial differences can be observed between self-regulation linked to a healthy autoerotic structure and signs of defensive self-regulation with the risk of withdrawal in the infant.

Study 2. Parental Reflective Functioning and Symbolization in Mother-Child Interactive Play Parent's history and psychic structure have a strong impact on the symbolization and mentalization processes in their children. This study is centered on Parental Reflective Function (PRF) and its relation to dyadic interaction, maternal interactive style, child's symbolization processes, and dysregulation signs in a videotaped adult-child (4–5 years old) dyadic play interaction. 20 mothers from Buenos Aires city were interviewed for 90 minutes using the PDI (Parent Development Interview – a semi-structured clinical interview) (Slade et al., 2003) and, in a second session, they were videotaped in a 15-minute interactive free play with their children aged 4–5 years old.

The Reflective Functioning assessment arises from an exhaustive reading of the transcript of the PDI-R II interview, which provides a vision of the parent about himself/herself, his/her child, and their mutual relationship. The interview also provides elements to explore affective regulation in the dyadic relationship. This assessment follows the general criteria established by Fonagy and Target (1998), with specific criteria related to reflective functioning linked to parenthood (Slade et al., 2005). The evaluation proposes a continuous scale from −1 or 0 to 9. A "reflexive ordinary" (5 or higher) response is one in which mental states are linked to behavior or other mental states.

The videotaped play interaction was assessed using the Observational System of Interactive Play (OSIP) (Duhalde et al., 2022). This system is the result of meticulous construction, developed in different stages by our team, including pilot tests and validity and reliability analyses (Duhalde et al., 2016; Huerin et al., 2021; Schejtman et al., 2012, 2013). Recently this instrument was applied by a research team led by Rogerio Lerner at São Paulo University, in a study with children on the autistic spectrum and their families (Moraes et al., 2021).

OSIP assesses four central variables coded through a segmented analysis of 20-second units. The specificities and instructions for this coding are reflected in the Coding Manual that, together, allows the application of the instrument (Huerin et al., 2021). The variables are as follows:

Mode of affective interaction: scores the tone and modality of the affective interaction displayed in the play situation in each segment, considering whether the dyad is in *convergent mode* (there is agreement and a shared program of action in a positive affective mood), *divergent mode* (adult and child fail to establish a common agenda, there are disagreements or unsuccessful attempts at convergence in an affective atmosphere that reflects a certain degree of conflict), *non-interactive/play* (adult and child play separately or one of them plays while the other observes).

Affective dysregulation signs, impulsivity or *aggressiveness, inhibition,* or *withdrawal* in both mother and child, *crying* in the child, and *complaining* in the mother.

Level of symbolization in the child's play, according to the following categories: *functional play* (the play is carried out using the objects in their conventional instrumental function in a simple and isolated way), *basic symbolic play* (involves an imaginary situation, "as if" (pretend mode), e.g., drinking tea, fixing cars, cooking to the baby), *complex symbolic play* (a fictional imaginary situation; the child either assigns roles, distant from one's identity, or makes a substitute use of the object, separate from its conventional use), and *no playing activity* in the segment.

Parental interactive styles. Adult interventions are classified according to two axes: *restrictive style*, which includes intrusiveness, directedness, critical verbalizations, and lack of connection, and *facilitating style,* which includes lack of intrusiveness and directedness, positive verbalizations, and connection with the child's activities.

The results showed that affective dysregulation signs were more frequent in children whose mothers showed low parental reflective functioning (PRF) (Mann-Whitney U test, Z, 1.98, $p = <0.05$). Also, children who presented a higher frequency of dysregulation signs showed more functional play (Rho 0.44, $p = <0.05$) instead of symbolic play. The adult symbolizing offer in the interactive play is central to enriching the child's proposal, adding complexity. If the adult does not perceive and appreciate the proposal, the child may feel disconnected for longer than is convenient, with the risk of withdrawal and slowing down the symbolic complexity derived from the dyadic co-construction process.

Mothers showing low PRF, when referring to their own or their child's anger, showed a more restrictive (intrusive directive) style during dyadic play interaction with their children (rho −.42, $p = <0.05$). Mothers showing low PRF, when referring to their children's feeling upset, showed more critical verbalization in the interaction play (rho −.54, $p = <0.05$). It could be inferred that less reflective mothers present more difficulties to perceive and deal with the aggressiveness/impulsivity of their children and, to a certain extent, fail to perceive the discomfort as a message.

Conclusions Implications for Clinical Work in Early Infancy

In the last decades, we witnessed an expansion of children's rights and the awareness of parental responsibility for children's well-being. As mental health professionals and researchers, we are committed to building bridges between research outcomes and clinical work. Currently, there is a profusion of theories and approaches to the study of parenthood. In our work, we address the overlapping of theories that privilege parental psychic structure and theories that prioritize interactive bidirectionality in the adult-child relationship.

We relate intersubjectivity to subjectivation in the developmental process, connecting developmental theories with psychoanalytic concepts. Intersubjectivity flows between external reality and interpersonal inscription, while subjectivation conforms and structures internal reality and intrapsychic realm. A bidirectional relational matrix, continuously co-constructed and transformed by the experience, can be thought of as a unit of analysis in its own right and as a promoter and organizer of psychic life (Dio Bleichmar, 2005). The results reported above are in line with a conception of early mother-infant interaction that is less idealized than the one that conceives the primary dyad as highly synchronized and characterized by the predominant display of mutual positive affect. Early interaction is an interplay between matches and mismatches that allows the baby to cope with the presence-absence of the primary caretaker. We have worked on 6-month-old infants and 4- to 5-year old children. These ages are marking the beginning of transformational changes in early development and are related to the main concepts involved in our research.

Around 6 months of age, there is a shift from dyadic affective regulation to self-regulation (Tronick & Weinberg, 1997). As expressed above, in our healthy sample, only 2 of 48 infants were engaged in oral self-comforting (OSC) in a free-play situation, while in the face-to-face situation almost half of the babies in the sample were engaged in OSC. We may infer then that when OSC behaviors are present in a dyadic play with toys, it could be understood as a signal of self-exploration that helps to establish a first distance from the mother and shows the baby's desire for seeking or pausing interaction. Toys or inanimate objects, as a source of self-regulation, organize subjectivity. In this regard, we also suggest that self-regulatory resources can be related to a structuring autoeroticism that helps the infant to bind surplus arousal during the short necessary maternal distancing, preparing him/her to process the periods of caregiver's absence and to cope with separation anxiety. In this line, Christine Anzieu (2022) associates the autoerotic creative healthy capacities in the baby with the fantasy of plenitude during the mother's absence. In contrast, compulsive, self-soothing behavior can lead to fetishistic and addictive behaviors.

The above results show that when infants explore toys and the environment in the presence of a libidinally connected caregiver, there is a healthy shift from dyadic affective regulation to self-regulation. This caregiver's available presence implies a sensitive and non-intrusive, non-hostile response, interpreting the infant's message and adjusting the interactive space and distance. Conversely, when the connection between the dyad is interrupted, either because of emotional maternal detachment or because of the child's over-engagement in oral self-comforting and rejection of maternal interactive proposals, including toys offer, it is worth exploring the risk of withdrawal.

Sometimes, very dedicated mothers find it difficult to tolerate the infant's immediate non-response and impose their presence without perceiving the communicative signals of the infant, who seeks self-exploration. This is particularly observed in dyads with babies suffering communication disturbances, mainly in the autistic spectrum (Keren et al., 2017; Keren, 2022).

From our clinical perspective, acknowledging the inevitable moments of the infant's unintended disconnection allows focusing on repairing negative affect and repeated mismatches. The capacity to tolerate increasing levels of emotional intensity lowers the effects of extreme vulnerability. The extreme sensitivity of infants toward internal and external stimuli may lead them to develop a protective envelope. The adult is part of the infant's protective system and his capacity to transform and repair affects may diminish the potentiality of overwhelming threatening early affects. The parent's psychic structure and unconscious conflicts, sensitivity, and reflective functioning have a strong impact on this crucial parental function.

Environmental failure in building connections and in repairing negative affects may produce emotional pain, and deep anxiety of loss, and may result in physical, emotional, and mental developmental impairment as well as a defensive closure toward the outside world. The protective envelope may then become a rigid shield. We can consider these circumstances as maladaptive affect regulation and there is a proven link between these early experiences and severe personality disorders.

We suggest the importances of discriminating infant's self-regulation as a resource to repair negative affect and as a message to the adult to regulate interaction, from an oral self-comforting defensive response, with a withdrawal risk. We also suggest to detect the early presence of partial withdrawal and rigid defenses in normal development linked to parental intrusiveness or low emotional availability and promote in these cases early clinical interventions. The dynamic observed in normal development may have a crucial impact on IMH promotion.

Regarding the second project described above, parental reflective function proves to be a strong tool to amplify parental resources to deal with the daily challenges around the achievement of affective regulation and its influence on the symbolization process. Our findings show that the high frequency of dysregulation signs is related to less frequency of complex symbolic play. The adult convergent symbolizing offer in interactive play is central to enriching the child's proposal, adding complexity, and promoting a higher level of symbolic play. If the adult does not perceive nor appreciate the proposal, the child may feel disconnected, with risks of withdrawal, slowing the co-construction process of symbolic complexity. Moreover, low-reflective parents may fail to interpret the child's dysregulated behavior as a challenging expression to seek self-affirmation and may respond intrusively or critically. In such a case, two paths are possible: retraction and inhibition of complex symbolic play, or defensive opposition, stubborn tantrums, and dysregulation, which can lead to behavior or attention disorders.

Parents' reflective capacity does not imply the immediate resolution of conflicts, but rather the possibility of containing the emotional impact of the child's dysregulation linking their own affect with their state of mind and, thus, giving a reflective response to the child's emotional state instead of responding immediately and impulsively.

Regarding the interactive playing display, in another study (Duhalde et al., 2022), we observed that the convergent mode of interaction, in which parent and child mutually enrich the play proposal, was associated with a higher frequency of complex symbolic play, while the divergent mode of interaction, in which a common play agenda is not achieved, was associated with a higher presence of functional play, that is, a non-symbolic play. This reaffirms the conceptualization of the contribution of a fluid bidirectional intersubjective exchange to the unfolding of symbolization, which is a crucial capacity in child development.

In turn, we have distinguished two types of divergence: one presents dysregulation, while the other doesn't. The delimitation of these two modes of divergence allows us to further understand the moments of play dynamics, and the fluctuation between convergence and divergence states, that accounts for the nature of any relationship, which includes matches and mismatches. In a divergent interactive situation, if the dyad manages to resume a state of convergence by negotiation without dysregulation, the play continues and is enriched by the contribution of each member of the dyad. On the other hand, when divergence is accompanied by affective disregulation, the return to convergence is more difficult and the play loses complexity. This finding contributes to the clinical view, since the early detection of interactive mismatches and the resulting discomfort in the child not sufficiently repaired (dysregulation), also related to the restrictive parental style, could constitute an emerging diagnostic element that allows interventions in early childhood for clinical and preventive purposes.

Parent recognition of a link between the infant's mental states and their behavior will contribute to developing a mental model of the affective experience and, thus, to the evolving capacities for affective self-regulation. Likewise, the adult's capacity to appreciate the dynamics of his own affective experience is regulating as well. We suggest that brief early clinical interventions when interactive or developmental drawbacks are detected, may have a critical impact on promoting and protecting infant's mental health. These interventions decrease the effects of extreme vulnerability by allowing the infant to cope with increasing levels of emotional intensity (positive and negative), and promote meaningful, close, and nurturing relationships. In our view, diagnosing should mean capturing the unique qualities of each baby and family, focusing on healthy resources, and on the child's emotional, cognitive, and social developmental potentialities. In the same vein, flexible clinical settings are required for early interventions, in order to move from interactive sessions to sessions with parents alone, so as to display their own history and early suffering and work to amplify the mentalization process.

Research Contributions from Uruguay

Team Background to the Project

The book "*Juegos de amor y magia entre la madre y su bebé: la canción de cuna*" [Games of love and magic between mother and baby: the lullaby] (Altmann de Litvan, 1998) shows empirical research about mother-baby interaction, accompanied by the study of anthropological characteristics of mothering practices, especially the use of lullabies, resulting in a study which enabled to delve into understanding the value of lullabies to strengthen attachment and to establishing regulation mechanisms between mother and baby. This research was most relevant to the origin of ATI.

The Brief Psychoanalytically Oriented Consultation Model (Altmann de Litvan & Gril, 2000) was developed at the Asthma Unit of the Children's Hospital of Montevideo. It proposes psychoanalytically oriented consultations with mothers and their babies with the aim of helping the mother to better understand her emotions. This goal is pursued both when the mother interacts with her child in the therapeutic situation itself and retrospectively, when she relates narratives about past events that include the baby. A psychotherapeutic objective is to enable the mother to (re) adjust to her baby in direct response to its non-verbal interventions by connecting the baby's gestures and behavior with emotions and by verbally expressing about them. The intervention model takes into account both the interpretation of the meaning and different projections the mother does on the baby and the observation of the interaction as it takes place in the session. These psychotherapeutic interventions aim at the reorganization of the mother-baby bond and do not attempt to encourage regressive processes within the mother.

Research "Comparing Verbal Exchange of Mother and Analyst and Non-Verbal Interaction of Mother and Babies with Psychofunctional Problems. It was an exploratory Study based on the Components of the Cycles Model (Mergenthaler-Bucci) and the Infant's Attachment Indicators (Massie-Campbell Scale) (1998–2000). (Gril et al., 2000). The results showed that there was no significant correlation between verbal and non-verbal measures. At the beginning of the project, we also believed that the productive moments of the speech, in terms of insight, were also rich moments of nonverbal interaction between the mother and the baby. Our findings about two different information processing modalities – the verbal processing through the speech in the session and the nonverbal interaction between the mother and the baby as another way of processing information – are consistent with Wilma Bucci's Multiple Code Theory (1997). According to these results, it seems to be important to stimulate the mother to develop non-verbal communications with the baby, especially through gazing, touching, and vocalizing. We also found that the use of abstract language is not helpful for the attachment relationship. The narratives and the reflective processes that took place in the verbal exchange contributed to the attachment bond.

Assessment of the Emotional State and Mothering of Women Who Live with Their Children in Prison in Uruguay: A Storybook and a Guide as Tools for Interventions

The project "Emotional state and maternal bonding of imprisoned women in Uruguay" was conducted by the NGO ATI (*Atención a la Temprana Infancia y su Familia*, in English: Attention to Early Infancy and Families) and the School of Sciences of Universidad de la República[2] and coordinated by Anabel Ferreira and Marina Altmann (2015–2022) in two prisons with mothers and their infants in Uruguay (Ferreira et al., 2018). The book "*Abrazarte entre muros*" (Embracing you within walls) that resulted from that project was supported by UNICEF and the Uruguayan Parliamentary Commissioner for Penitentiaries.

Although in mental health policies the quantitative perspective is important, subjectivity in the sense of connecting with our true self is also essential. This has been a long-standing approach of the working group that continues in the experience we present here, in which we introduce the subjectivity of mothers in a high-risk context and attempt to propose different forms of intervention.

Study and outcomes In Uruguay, mothers can live together with their children in prison until they are 4 years old – a period that can be extended up to 8 years for special considerations (article 29 of Decree-Law 14,470) – but there are no studies in the country that have described women's emotions and considered the influence of early traumatic experiences on their emotional state and motherhood. Based on this background, the aims of this study were firstly to describe the population of imprisoned women with children in Uruguay, as well as to assess mothers' emotional state and evaluate the influence of early traumatic experiences on their perception of mothering. A second objective was to write a storybook based on the experiences reported by women about their motherhood and their children inside and outside the prison and a guide with questions and basic concepts aimed at people who work with this population. To assess these aims we used personal interviews, workshops, and validated questionnaires. The storybook was

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based on the reports of the mothers during the workshops and interviews and the guide was based on some basic concepts related to mothering. Results show that a high percentage (41%) of these women reported having suffered sexual abuse during childhood and adolescence. The levels of depressive symptomatology (Edinburgh Postnatal Depression Scale) and trait anxiety (Anxiety Inventory-Trait) were higher in those women who reported having suffered sexual abuse compared to those who did not. None of the variables associated with the perception of motherhood (Childbearing Attitudes Questionnaire) differed between the two groups. As a result of this study, we wrote a storybook "Abrazarte entre muros" [Embracing you within walls]. The book was accompanied by a guide consisting of questions related to the story as well as basic concepts concerning emotional aspects of mothering. In conclusion, the present study shows that the levels of anxiety and depression were high in this population and that sexual abuse, added to the stressful prison environment, has a negative impact on the emotional state of women. However, the perception of motherhood reported by women was not affected by early sexual abuse. This is in line with the central place that children occupy in the affects' descriptions expressed by women. Therefore, interventions that focus on reducing stress and promoting the mother-infant bond could be useful for the well-being of this population. In this sense, the storybook and the guide could be useful tools in future interventions that focus on coping with stress and promoting mother-infant healthy relationships.

Mothering is a process of great emotional lability, highly vulnerable to adverse present and past experiences that could affect the well-being of children and mothers. Stressful situations as imprissionment togehter with early traumatic experiences found in this population, could affect the emotional state of women and, in turn, their motherhood.

The number of imprisoned mothers with their children is low in the country and has remained relatively stable in the last decade (ranging between 16 and 22; Vigna, 2012). Despite the evidence in other countries of the prevalence of early traumatic experiences in the prison population, and its negative consequences on women and their children, there are no studies in the country that have evaluated the influence of early traumatic experiences in the emotional state and the perception of maternal attitudes of women who live with their children in prison.

The population that participated in this study consisted of seventeen women, four of them pregnant. They lived with their children in the Penitentiary Unit 9 (El Molino) and in Unit 5, Montevideo, Uruguay. It is worth mentioning that practically the entire population in both prisons was covered. The study was carried out for a year and a half by a team made up of, among others, psychologists with vast experience in mother-infant bond.

We asked the mothers to fill in questionnaires about their sociodemographic backgrounds, their experiences of sexual abuse (De Bellis & Thomas, 2003; Mesa-Gresa & Moya-Albiol, 2011), and emotions. We applied the *Edinburgh Postnatal Depression Scale* (EDS; Cox et al., 1987, Spanish translation version – University of Iowa) and the *Child Bearing Attitudes Questionnaire* (CBA; Fleming et al., 1988) that includes response options on a four-point Likert scale, related to mood, physical well-being, social support, the baby's condition, and maternal attitudes.

Results

The sociodemographic data were expressed as means (standard error, SE) and maximum and minimum ranges or percentages (number/total), while the data obtained from the anxiety, depression, and parenting attitudes questionnaires were expressed as medians (semi-interquartile ranges, RSI) and were analyzed using non-parametric tests (Mann-Whitney U test). The qualitative analysis of the answers about emotions consisted of identifying thematic categories and accounting for the presence of words related to children, motherhood, and bonding (for example, son, mother, baby, separation).

The population was made up of young women, mostly without a partner and with children outside of prison. Nearly, 31% of women had not completed primary school and none completed the initial 10 years of basic education. In total, 41% of the women did not have any occupation before their arrest and the rest stated that they had worked as cleaners, clothing sellers, manicurists, kitchen helpers, drug dealers, or prostitutes as a source of livelihood.

The reason for the imprisonment of 35% of the women was drug trafficking, while for the remaining 65%, it was participation in other criminal acts such as homicides and robberies, according to data provided by the authorities and corroborated by the women. The length of stay in prison, at the time of the study, varied between 2 months and 6 years. More than half of the women did not have a judicial sentence.

The ages of the children, who lived with their mothers in prison, ranged from 0 to 4 years. From the age of two, they attended an educational center (CAIF), with the authorization of their mothers. A total of 82.3% of the women also had between one and seven children outside of prison, aged between 1 and 22 years who lived with adoptive families or were institutionalized.

The pediatric evaluation showed that the children, who lived with their mothers in prison, had no major problems in terms of health, nutrition, sleep disorders, or growth failure. This information was also corroborated by the doctor in charge of Unit 9.

According to the questions asked in the sociodemographic form, 41% (7/17) of the women declared having suffered sexual abuse in childhood and adolescence. This information was corroborated in the clinical interviews.

Women who reported experiencing sexual abuse had significantly higher levels of trait anxiety compared to those who did not report it (U (10.7) = 64.0, p = 0.003) (STAI-Trait Anxiety Inventory), while state anxiety levels did not differ between groups (U(10.7) = 51.5, p = 0.11) (STAI-State Anxiety Inventory). In total, 71% (trait anxiety) and 81% (state anxiety) of the women had values above 40, which is considered the cut-off line for pregnant and postpartum women in other research indicating that the anxiety levels of this population are very high regardless of the experiences of sexual abuse.

Women who reported having suffered sexual abuse presented significantly higher levels of depressive symptomatology than those who did not report it (U (10.7) = 54.5; p = 0.05). Interestingly, 72% of the women who reported having suffered sexual abuse and 50% of those who declared not having suffered it had values greater than 10, the cut-off line for postpartum women (Wisner et al., 2002), indicating that both groups had important values of depressive symptomatology, independently of the experiences of abuse.

No significant differences were found in any of the variables evaluated by the CBA between women who reported having suffered sexual abuse, early in life, or who did not.

The qualitative analysis related to the answers of the women to the open questions about emotions shows that in 100% of the answers about fear and anger, the children were mentioned or directly alluded to. Regarding fear, the women expressed that this emotion originated mainly in the possibility of separation from the small children with whom they lived in prison, in possible illnesses that could afflict them, and in the uncertainty regarding the situation of the children who were outside jail. Some representative examples of the main topics addressed in the responses about what fear was for them were as follows: “losing my children, not having my children with me, not being able to see them grow up, my children getting sick, having my baby in the prison, that my children make the same mistakes as me.” In relation to the question about how the separation from their children would affect them, some representative answers were as follows: “death, very badly, I couldn’t stand it, I would get sick, I would go crazy, I feel guilty.” As for the concrete actions they would take in situations that caused them fear, some of the women’s answers were as follows: “give love to my children, I regret it for my children, take care of my children, stop using for my children, do things good for my children, help my children.”

In the same sense, 100% of the answers about anger referred to situations directly related to the defense of the children against possible threats inside and outside the prison. When asked how they would react if someone attacked their children, some representative answers were as follows: “I would react with tremendous hatred, I would attack badly.” In the same sense, the responses on how to contain anger refer directly to the child, for example, “I think of my child”.

Storybook and Guide[3]

Based on the above-detailed research, including workshops and personal interviews, the team decided to create a storybook and a guide to be used by the prison personnel that would enable mothers to get in contact with certain aspects of their human condition. The authors expect these to be a valuable tool to reflect upon the situations this population is living. The storybook was an attempt to rescue the voices of imprisoned women and was based on women’s own experiences, concerns, dreams, frustrations, and hopes. It is firstly intended for mothers in prison, who through an identification with the character in the story, could reflect on their own situation. But the book could also be of interest to their families and children and other women in similar situations. Also, it is our hope that it will be useful to the prison staff. These materials are helpful to approach this population in a more sensitive way and reflect on the importance of the bond between mother and children for women and society.

The book is divided into four chapters. It is written in simple language and includes illustrations that complement the text with elements that are usually not expressed with words.

Chapter 1: The goodbye Detention is a very stressful event for the mother and children. It involves an unexpected situation, a break from family life, public exposure, and forced separation from children and loved ones, which can be traumatic and leave negative marks throughout life. For children, detention represents a separation from the mother and a situation that they cannot understand. Dominated by these emotions, women must sign papers and follow procedures that they cannot understand. There is a lot of evidence that shows that stress and fear block cognition. In the guide, the key ideas regarding the detention were traumatic events and separation distress.

Chapter 2: The birth Many women were pregnant or became pregnant during conjugal visits and spent pregnancy and childbirth in prison. During pregnancy, women experience physiological changes and different sensations, as well as worries about mothering and the baby. At this stage, all women, not only prisoners, wonder if they will be able to care for their baby. Some women told us that pregnancy rescues them from loneliness, but they also experienced increased worries for the baby. Childbirth in prison not only implies pains and possible complications but also the lack of someone close and reliable that can support women. Early mothering is a process of mutual adjustments in the day-to-day interaction between the mother and the baby. This interaction allows the building of a close bond. Mothers reported that motherhood can be the most rewarding and transformative experience but the most devastating in the face of loss or separation. In the guide, the key ideas were the transformation during pregnancy, childbirth, and the postpartum period, the early maternal preoccupations, and the mother-infant bond.

Chapter 3: The visit Visits were spaced out and mothers were overly concerned about reuniting with their children who lived outside prison. Meeting their children includes aspects such as word exchanges, gazing, gestures, voice tone, proximity or distance, and shared games, which for some of these women was a challenge. For children who live outside the prison, contact with their mothers is also crucial. Taking this into account, the guide emphasizes as key ideas the influence of mothers’ and children’s emotions during the visits, as well as the capacity of the mothers to cope with stress, tolerate subsequent separations, and improve emotional regulation, mentalizing, and empathy.

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[3] Authors of the Guide: Altmann de Litvan, M.; Ferreira, A.; González, E.; Iraola, I. Sasson, E. and Weigensberg de Perkal, A.

Chapter 4: The release The proximity of release from jail generates great uncertainty in mothers. The release means a milestone, which would need special support. This process involves life history, dreams, and hopes, projects for the future, experiences, and proposals offered in prison. Preparing the release is therefore very important. The key ideas that were considered in the guide were as follows: the uncertainty linked to the return to life outside of prison; the ability to learn and the changes achieved; dreams and reality, what is desirable, and what is possible tolerance and frustrations; and recovery of affective bonds and social integration.

Guide to Be Used by the Prison Personnel and Other Professionals

The Guide is intended to help the prison personnel to use the book to the prisoner's benefit, regarding the situational and emotional aspects involved. Throughout this project, it became evident that the prison staff was unaware of many of the situations and experiences, and the guide was meant to help operators and inmates to understand human beings better.

This is the first study in the country that describes the population of imprisoned mothers with their children and analyzes the influence of sexual abuse on aspects related to their emotionality and perception of motherhood. The women who reported having suffered sexual abuse in childhood and/or adolescence showed higher rates of anxious and depressive symptomatology compared to those of the prisoners who declared they had not suffered this type of abuse, in agreement with ample evidence on the effect of experiencing early adverse reactions in emotional disorders during motherhood (Agrati et al., 2015). In contrast, no differences were found in the perception of parenting attitudes between both groups, a result that could be explained by the central place that children occupied for mothers.

Regarding sociodemographic data, it is a small population made up of young women, more than half without a partner, with children outside prison, little family support, and low levels of formal education and job training. A high percentage of women reported having suffered sexual abuse early in life. These data coincide with those of multiple investigations in other countries (Cassidy et al., 2010; Myers et al., 1999) that show that between 65% and 95% of pregnant women or women with children in prison report low income, low educational level, problematic family histories, drug abuse. It should be noted that in this study, 41% of the women reported having suffered sexual abuse, a result even higher than that found by Fogel and Belyea (2001), which indicates that 24% of pregnant women in prison suffered sexual abuse and 60% physical violence in childhood and adolescence. In the same sense, Sable et al. (1999) indicate that women prisoners during pregnancy and motherhood have experienced three times more sexual and physical violence compared to those who are not prisoners of the same sociodemographic level.

The ages of children who lived with their mothers in prison ranged from the first days of life to 4 years old. These children attended a CAIF center from the age of two and did not present significant health problems, sleep disorders, feeding, or growth failure. Although in this work we did not assess the emotional and cognitive aspects of children or the quality of the bond with the mother, it could be hypothesized that the absence of health, eating, and sleeping disorders could be due to the prolonged time of contact with their mothers. In fact, Poehlmann et al. (2010) point out that not only the quality but also the frequency of contact of children with their mothers in prison is key to their adequate social and emotional development. A comprehensive evaluation shows that children who live with their mothers in prison for more than a year are more likely to develop a secure attachment than those who separate from them early (Byrne et al., 2010).

The observation that women who reported having suffered sexual abuse in childhood and adolescence showed higher rates of anxious and depressive symptomatology compared to those who did not report having suffered this type of abuse coincides with an extensive international bibliography that shows that more than 50% of female prisoners experience emotional disturbances associated with early traumatic experiences and family violence (Martin et al., 1995). In particular, retrospective studies, using a large amount of data in different countries, show that there is a significant association between childhood sexual abuse and suicidal ideation and behavior, anxiety disorders and depression, and substance abuse (Fergusson et al., 2008).

It is necessary to take into account that all women who reported of having suffered sexual abuse also mentioned of having suffered physical abuse in the early stages of life. This suggests that a combination of early adverse experiences, not exclusively those of abuse, could explain the higher levels of anxious and depressive symptomatology in sexually abused women.

Despite the differences found between both groups, it should be noted that the levels of anxious and depressive symptoms in women were significantly higher than the general values of the population, including those of pregnancy and postpartum. Therefore, other factors, in addition to sexual abuse, affect their emotional state. In particular, women mentioned that social isolation, separation from the family, conflicts with their partners and prison staff, the situation of children and the family inside and outside of prison, substance abuse, etc., affected their emotional state. Although the long-term effects of sexual abuse on emotional aspects do not necessarily differ in different contexts (Fergusson et al., 2008), observations of women suggest that forced confinement in prison could constitute a stressful event that increases the negative effects of adverse early experiences (Sleed et al., 2013). It would be interesting to contrast these results with similar studies in non-incarcerated populations to determine whether the stressful situation of prison potentiates the effects of early trauma.

However, the fact that only trait anxiety, but not state anxiety, differed between groups, could reflect that early traumatic situations predispose to the development of anxiety, regardless of the confinement context, a result that is consistent with several studies showing that women who suffered early adverse experiences have higher levels of trait anxiety, even in non-stressful situations (Agrati et al., 2015).

There are several mechanisms involved in the effects of early adverse experiences on long-term emotional processes. Among others, they are associated with modifications in the functioning of the hypothalamic-pituitary-adrenal (HHA) axis, which affects the trajectory of neural systems (amygdala, prefrontal cortex, hippocampus) related to the control of anxiety and depression (Agrati & Lonstein, 2016; Suderman et al., 2012). In this sense, Schechter et al. (2015) recently showed that the severity of symptoms of post-traumatic stress, anxiety, and depression in mothers with a history of early mistreatment and sexual abuse was associated with epigenetic effects involved in the response and adaptation to HPA axis stressors.

In contrast to the influence of sexual abuse on emotional aspects, we found no differences in the perception of maternal attitudes between women who reported being abused and those who did not. This result contrasts with several findings showing that early adverse experiences influence the affective and cognitive aspects of motherhood (Fleming et al., 1988). Some possible sources of discrepancy between previous studies and the results of this study are the small number of imprisoned mothers, the heterogeneity between them, and the fact that in this study we determine the effect of sexual abuse on the subjective perception of motherhood expressed by women but not in the type of attachment or in their maternal sensitivity.

It is also probable that this discrepancy is based on the fact that, in the particular situation of prison, the child acquires a special relevance for the mothers. Indeed, both in the interviews and in the open questions, motherhood was perceived by the women as an instance of personal transformation and hope: “since she arrived, I stopped taking drugs,” “now I am a different person.” Interestingly, Cassidy et al. (2010) pointed out that, after an intervention program in prison (Tamar’s children), mothers did not show differences in the indicators of secure attachment compared to those observed in low-risk populations and had better rates than other high-risk populations. The authors suggest that the fact that they have been allowed to stay with their children in prison, rather than send them to other institutions or with other caregivers, would be enough to reduce the risk of insecure attachment (Cassidy et al., 2010).

It is also necessary to point out that not all mothers with histories of mistreatment and abuse in early periods of life experience problems in motherhood (Gonzalez & Fleming, 2002). In many cases, mothers who suffered extreme adversity, for example, physical and sexual abuse early in life, do not adopt the same pattern with their children (Gonzalez & Fleming, 2002). Individual, genetic, and temperamental factors of the mother and child, the support of a partner, the family, and the environment, the relationship with their own mothers in the past, etc., can mitigate the risk of suffering from emotional disorders that affect motherhood (Agrati et al., 2015; Caspi et al., 2002). These results suggest that one should be cautious about an unequivocal interpretation that traumatic experiences invariably negatively affect motherhood.

The absence of differences between the groups regarding the perception of motherhood may correspond to the central place that the child occupied for mothers. Indeed, all women expressed that their fear was related to separation from their children, suggesting the existence of a strong bond with them. The fear of separation from children is one of the most painful and widespread feelings, both in humans and in other mammalian species (Panksepp, 2003), and is an emotion that is probably exacerbated in the prison context. It is associated with high levels of stress, depression, somatization, and disconnection in present and future affective relationships.

Although all women expressed that the greatest cause of fear was based on separation from their children, the majority stated that they aimed to be reunited with them when they were released from prison. This observation, which coincides with other studies (Enos, 1996; Poehlmann et al., 2010), suggests that mothers see separation from their children as a passing event.

Women also expressed that their anger was related to situations in which the child was threatened. Maternal aggression in hostile situations is widespread in the animal kingdom and has a high adaptive value since it allows mothers to defend their children against threats or risk situations (Ferreira et al., 2002).

An important aspect to keep in mind is that this study is based on the subjective evocation of early traumatic experiences that may have left traces in implicit memories with little access to consciousness (post-traumatic stress, LeDoux, 2012). Interestingly, although the mothers expressed feelings of sadness and distress, they were not reluctant to recount experiences of abuse, even expressing a need to talk about them. This fact could constitute a first step in the elaboration and reorganization of emotional processes of implicit memory, affected by the traumatic experience (dating). It is known that emotional memories influence and are influenced by declarative memory systems. Lieberman et al. (2005) propose that recounting traumatic experiences, and placing them in perspective, in an environment of trust and intimacy, is essential to mitigate the trauma and allow the transition to greater integrity and dignity.

It should be noted that the results have limitations due to the fact that the group of women with children in prison was small and heterogeneous in terms of factors that influence emotional state and motherhood (life history, age of the women and their children, children out of prison, relationship with their mothers and fathers, partner and family support, substance abuse, early adverse experiences, endocrine status, type of delivery, etc.). On the other hand, it must be considered that much of the information obtained is based on the explicit subjective reporter of the women.

Although practically the entire population of imprisoned mothers with children in Montevideo was covered, the reduced number and the variability among them constitute a limitation and, therefore, this study must be considered as a first advance for the understanding of some factors that affect a highly vulnerable population.

Summary and Key Points

A brief history of the Infant Mental Health (IMH) field in Argentina and Uruguay is described, together with the outcomes of research projects conducted by the authors. The chapter's general perspective is to offer some views on parenthood presenting research projects conducted in Argentina and Uruguay, whose rationale includes the mutual fertilization between psychoanalysis, infant research, and infant mental health.

The Argentinian program relates maternal reflective function – studied through the Parental Developmental Interview (PDI R II) (Slade et al., 2003) – with interactive variables: dyadic affective regulation and infant self-regulation (Tronick & Weinberg, 1997), dysregulation signs in preschool mother-child interactive play, parental interactive styles, and emotional availability (Biringen, 2008).

One of the key points emerging from these studies was to deepen the knowledge about the shift from dyadic affective regulation to infant self-regulation. Self-regulation behaviors with toys or objects may be a signal of self-exploration, in order to establish a first distance from the mother. Failure in building a meaningful connection between the child and the mother may produce emotional pain, deep anxiety, and the building of a rigid shield toward the inside and outside world.

Another key point is the finding that shows that the high frequency of dysregulation signs is related to less frequency of complex symbolic play. Moreover, low-reflective parents may fail to interpret the child's dysregulated behavior as a challenging expression to seek self-affirmation and may respond intrusively or critically. In this case, two paths are possible: retraction and inhibition of complex symbolic play, or defensive opposition, stubborn tantrums, and dysregulation that can lead to behavior or attention disorders.

Early detection of the presence of partial withdrawal in normal development, rigid defenses, parental intrusiveness, low parental reflective function, or difficulties in the dyadic emotional availability have a crucial impact on promoting infant mental health. Flexible clinical settings for early interventions must move from interactive sessions to sessions with the parents alone, in order to display their own history and early suffering and to work to amplify the mentalization process.

The Uruguayan project shows that the levels of anxiety and depression were high in mothers who were imprisoned and that adverse early experiences, added to the stressful prison environment, have a negative impact on the emotional state of women. However, the perception of motherhood reported by women was not affected by early sexual abuse, a result that is in line with the central place that children occupy in the affects' descriptions expressed by women. Getting closer to understanding some of these factors is critical for planning interventions that focalize on mothering and prevent the intergenerational cycle of adversity and trauma. In this sense, given that children occupy a central place in the affects and concerns of imprisoned mothers, the creation of a storybook and a guide could be a useful tool for those interventions that focus on the emotional regulation of stress situations and on the promotion of a close bond between mothers and children, inside and outside prison. Considering that for the prison population it may be difficult to connect with their emotions and to express them, it is advisable to promote the creation of simple storybooks and guidelines that are keys to work with the mothers and, also, with the personnel in charge in these institutions.

The studies presented in this paper show a deep concern about further exploring the subject of parenting, in particular, maternal function. Subjectivity and the emotional regulation process of the adult in charge of young infants are crucial for mental health, as was shown in the Uruguayan case, with mothers coping with situations of high anxiety, stress, and vulnerability. Nevertheless, one aspect that still appears as a limit in both countries is how the research findings could be transferred and implemented in child mental health interventions and public policies.

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Parenting in the Middle East: A Cross-Cultural Longitudinal Perspective

Miri Keren, Laila Warwar, and Ghassan Abdallah

Parenting is a complex task that comprises many behaviors that influence child development. Culture affects parenting styles and practices because most parents raise their children according to the values and norms from their own culture (Bronfenbrenner, 1979; Dwairy & Achoui, 2006). The Middle East includes 18 countries, namely, Bahrain, Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, the Syrian Arab Republic, Turkey, the United Arab Emirates, and Yemen. It is beyond the scope of this chapter to review parenting practices in each of these, we have therefore chosen our own countries and our neighbors, namely, Egypt, Lebanon, Syria, and Jordan. As we will see throughout this chapter, we live in a highly diverse society that encompasses various national, ethnic, and religious groups. In addition, parents, children, and professionals are very much impacted by the multifaceted consequences of the ongoing Israeli-Palestinian violent conflict that has been lasting for more than 70 years.

Three main models of parenting have been described in the literature (Baumrind, 1991): authoritative (values participation, sharing, clear limits, positive reinforcements), authoritarian (values strict supervision, unquestioning obedience, restricted autonomy, corporal punishment), and permissive (no control over the child, no expectation of taking responsibilities, disregard of misbehaviors). Parents with authoritative and permissive styles will object to corporal punishment (CP) to a much greater degree than authoritarian parents will. Studies have shown the advantages of authoritative parenting, as manifested in children's adaptive behavior, academic achievements, psychological maturity, emotional autonomy, and leadership skills (Kudo et al., 2012; Rinaldi & Howe, 2012). As we will see later in this chapter, parenting styles differ from one culture to another in the Middle East.

In addition to the obvious care giving tasks, specific geo-socio-political context brings the challenge to convey values, such as mutual respect, democracy, dignity, diversity, empathy, dialogue, and sharing responsibility, although these are very much not to be taken for granted in conflicted regions. Each of the three authors of

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this chapter belongs to a different society within the Middle East, but our common denominator is our being Infant Mental Health professionals. Hence, writing of this chapter together was in itself an endeavor with both a professional and an emotional significance for us. Indeed, we believe that the ultimate goal of parenting in our troubled region is to secure sustainable peaceful safety for our children, from infancy through adolescence.

In this chapter, we will review Arabic Palestinian, Egyptian, Jordanian, Lebanese, Syrian, and Israeli parenting beliefs, values, and practices along the years, while emphasizing the changes that have taken place in each society. For instance, we will describe the unique parenting practices in Kibbutzim that were predominant until the 1990s in Israel, as well as the changing traditional patriarchal structure of Arab families. We will also address the specific challenges we, as infant mental health clinicians, encounter while working with parents and infants in our complex geo-socio-political context.

Parenting Attitudes, Styles, and Practices in the Israeli Jewish Society

Within the Jewish community, there is a high diversity of values, beliefs, and practices (Younse, 2007). The different cultural groups are often defined based on their countries of origin (those who immigrated from Western countries, called Ashkenazim, and those who came from Muslim countries, called Sephardim), or to their level of religiosity (secular, traditional, ultraorthodox). Beginning in the 1990s, there was a large wave of immigration from Russia and Ethiopia. Most recent has been the wave of immigration from Ukraine. Motives for immigration are varied: ideology, war, economic precarity in the country of origin, or racism. These immigration-related experiences obviously impact on the parents' emotional well-being and on their adaptation to Israel. In addition, complex interactions take place between the diverse groups, with many ethnic stereotypes and social distance (Shechory, 2006). These social processes have a significant impact on the children and adolescents whose parents have immigrated and often experience racial discrimination (Shechory & Ben David, 2010).

A review of family patterns within Israeli society (Lavee & Katz, 2003) has shown two opposite main trends: one prods the family toward greater modernization and Westernization, while the other acts to strengthen traditional values. Despite some convergence among different socio-ethnic groups, marked differences are prevalent within these groups in every aspect of family life, thus maintaining a vast diversity in family structures and lifestyles. Within the secular Jewish society in Israel, the tendency is to adopt the authoritative or the permissive style of parenting. Since 1991, the Israeli legislation has officially prohibited the use of any form of violence against children. The tendency is to encourage children's individuality and autonomy (Khoury-Kassabri, 2010). Still, as we will see later, the authoritative style is quite common, as well as the use of corporal punishment (CP) within the more traditional groups.

As mentioned above, Israel has been a country of immigration since 1945, following the Second World War. When people move to a new culture, a process of acculturation—the impact of the dominant society culture on the newcomer's original cultural values and beliefs—takes place. Acculturation may take various forms, such as separation, assimilation, integration, or marginalization within the host society. The issue of parenting styles is especially relevant to acculturation processes, as immigrant parents may feel conflicted between parenting practices existing in their country of origin and the authoritative parenting style that is prominent in the secular Israeli society. Generally speaking, the immigrants' level of integration into a new society is also very much influenced by the host society's policy. For instance, immigrant housing policies (dispersion versus concentration) will determine the subculture to which the new immigrants will be exposed to. Israel's immigration policies have been until recently very much focused on integration into the host society that was mainly Western-oriented. Hence, immigrant Ashkenazi Jews had much less difficulties to integrate Israeli society than Jewish immigrants from Muslim countries (the Mizrahi group). A huge cultural gap raised between the Ashkenazi and the Mizrahi Jews, as the latter are mostly traditional religious, have a patriarchal structure and conservative child-rearing practices and beliefs, quite similar to those of traditional Muslim society (Smooha, 2008). Pervasive feelings of discrimination and inferiority among the Mizrahi Jews resulted from the Ashkenazi's tendency to be contemptuous of them. The social tension between the two groups, though lessened across the years, has not yet completely dissipated (Schwarzwald et al., 1992; Ben-Ur, 2012).

A relatively recent study (Shechory-Bitton et al., 2015) has examined parenting styles and attitudes toward CP among three groups of mothers and daughters: Native-born Jewish, Native-born Muslims, and Mizrahi Jews. They found that Muslim mothers were lower on authoritative style and higher on both authoritarian and permissive styles, and more tolerant of CP than Jewish mothers. Mizrahi mothers were more similar to the native Jewish mothers than to the Arab native ones as they appear to have tried to assimilate their parenting style to the Western-oriented approach. Also, Muslim daughters were found to be similar to their mothers to a far greater extent than their Jewish counterparts. Very interestingly, generational differences in parenting style were found in the three groups: the daughters scored higher in authoritative parenting style than their mothers, meaning democratization of the intra-family relationships, encouragement of autonomy and independence, and less use of CP. The immigration of Ethiopian Jewish families has been very challenging, with long-term psychosocial consequences up to today (Dolev & Hasin, 2001). Traditions practiced for many generations, such as clear leadership of elderly men and religious figures, very strict purity rituals, and early marriage practices, were totally disrupted on the journey to Israel and became irrelevant in their new country. The majority of them came in the 1990s, while half of them were age 19 or under. The large number of children had a significant impact on their acculturation process. Also, many adults had no education and were illiterate in their native language, making the acquisition of Hebrew very difficult. Some 50% of the parents did not speak Hebrew, and some 75% could not write nor read Hebrew. As the result, most Ethiopian families had great difficulties in finding employment and in helping their children to integrate the Israeli society. Still today, a large percentage of Ethiopian Jews in Israel live under the national poverty line in peripheral areas and poorer neighborhoods.

Many Ethiopian mothers went out for work, making their husbands feel humiliated, even more so when their husbands were 10–25 years older than them and unemployed. Domestic tension consequent to the changes in power balance within the family became very common. A wide gap between parents and children developed and many Ethiopian children became marginal adolescents and young adults. Also, a very large gap exists between the family backgrounds of Ethiopian and other Jewish children. For example, 61% of Ethiopian Jewish children have a non-educated father compared to only 3.3% of Jewish children, and 11% of children have a father over age 65, as compared to 0.5% in the non-Ethiopian Jews. Nearly 60% of Ethiopian families have 5 or more children, compared to 22% in the general Israeli population. Twenty percent are single parent compared with 9.4%, and many have 3 or more children. Forty-nine percent of the fathers are over the age of 45, and 11% are over the age of 65. Approximately 45% of the parents cannot afford basic supplies such as toys, books, and school supplies. Many of these children do not have their own beds. Based on all these worrisome data, some 28 programs for Ethiopian preschool-aged children and their parents have been developed since 2000 (Dolev & Hasin, 2001). Several broad categories of programs have been implemented, namely, home-based programs, daycare programs, after-school programs, school readiness programs, general enrichments programs, and father's groups. A recent qualitative study (Baum & Nissan, 2017) has examined the feelings, thoughts, and experiences of first- and second-generation Ethiopian immigrant mothers in Israel. Both first- and second-generation immigrants identified motherhood as the essence of life for women, defined a "good mother" as one who is there to meet all her children's needs at all times, and expressed a strong wish to combine Ethiopian and Israeli values. The first generation emphasized the need to give the baby space to grow, whereas the second generation viewed the baby as needing to be molded. The second generation also emphasized the importance of expressing feelings of love and playing with their babies, in contrast with their first-generation mothers who were much more introverted.

The profile of Russian immigrants is quite different from the Ethiopian immigrants, but their immigration experiences were not less challenging. In contrast with Ethiopian immigration where men suffered the most, Russian immigrant women faced many more challenges than their male counterparts. Approximately one million Russian Jews emigrated to Israel after 1989, 350,000 of them women between the ages of 20 and 55 (IMIA, 2010). Over 60% of men and women were highly educated and were employed in their country of origin as professionals or white-collar workers. Ninety-five percent of the immigrant women combined full-time employment and motherhood in the former Soviet Union. Among key issues faced by Russian immigrant women in Israel were occupational downgrading (Lithwick & Habib, 1996), sexuality and family life, sexual harassment, marital distress, and single-parent families. Many middle-aged women were bitter at the host society not recognizing their knowledge and skills. For instance, many women physicians, engineers, and musicians ended at working in supermarkets. Age was the main predictor of occupational success with the cutoff point being around 45. Younger women with education and greater cultural flexibility found their path into the host society, while older women tended to confine with the ethnic community. Also, the gender roles and family life in the host society are very different from the those among Russian immigrants. For instance, the average Israeli secular family has about 3 to 4 children, Russian families tend to have 1 to 2. Many couples divorced in the post-immigration period, as the stress-related fragility of marriage was augmented by the normative acceptance of divorce in their country of origin. Some 15% of all Russian families were headed by a single parent, usually mother and young child. Single mothers arriving with their children were often accompanied with their own mothers. Commonly, the child was raised by the grandmother as the mother had to find a job. Negative stigma developed toward Russian women (Remennick, 1999). Obviously, the mothers' situation impacted negatively on their young child's emotional development and adjustment to the new country. Married immigrant couples also suffered from marital tension as many of them had to share very small apartments with the grandparents, had low income, and disagreed about child education (religious versus secular kindergarten, Hebrew-speaking versus Russian-speaking ones). The massive immigration of Russian-speaking single mothers, poorly adapted to the Israeli job market, without Hebrew language skills, and with no personal means, was perceived by the Israeli society as a burden on the welfare system (Amir et al., 1997). The first generation of adult ex-Soviet immigrants in the 1990s has endured the cumulative adversity described above. Socialized under the Soviet code of passive resistance, this generation did not engage in any political or civic action to change their second-class citizens status in Israel. In contrast, their daughters who graduated from local Israeli schools have adopted the local code of civic action and are determined to change the situation for themselves and their children (Remennick, 2018). Still, many Russian parents, who immigrated in the last 5 years and have adolescent children, try to cope with the immigration challenges by keeping child-rearing practices in the Former Soviet Union, and report feelings of helpless and unsuccessful at parenting (Yakhnich, 2016). Besides the waves of mass immigration from Russia and Ethiopia, there has been a continuous immigration from different countries, such as South Africa, South America, and Europe. These are individual immigrations, whose acculturation process has not been systematically studied. Overall, the impression is that the success of their integration is very much dependent on their socio-economical status, education, and support from relatives who came before.

To conclude, immigration is a major source of parental stress, as it often involves coping with traumatic experiences in the country of origin, dealing with multiple stressors in the host country (Israel), such as employment, language, and housing problems. All these impinge on parental functioning as parents are less able to mobilize effort, attention, and support for their children (Cohen, 2007).

At the creation of the Israeli State in 1948, collective-socialistic ideology communities ("Kibbutzim" in Hebrew) were built around the country and adopted a radical collective child-rearing, with children spending limited hours each day with their parents and sleeping communally in a separate children's home without their parents. The basic principle of education was that native children of the kibbutz were to be fully socialized within the community, as if every child belongs to the entire kibbutz, which, in turn, assumes full responsibility for his/her physical, emotional, and educational needs. The second ideological principle was gender equality, meaning that mothers could work outside their home, exactly like fathers. The third principle was to educate the children on the basis of educational theorists, such as Piaget (Piaget, 1962), rather than on the parents' intuitions (Lieblich, 2010). Besides these main factors, one has to note that parents in the early kibbutzim were new immigrants, of which many had survived concentration camps and lost their families in the Holocaust. As such, they lacked the support and guidance grandparents often provide, in addition to the fact that they themselves often suffered from unrecognized and untreated post-traumatic stress disorder. Talking about their traumatic experiences and losses was almost taboo, but the impact of their prior experiences on their parenting behaviors became clear over time. Education and authority were therefore taken from the parents by the kibbutz, and child caregivers ("Metapelet") were extremely significant in the children's lives. Parents were supposed to provide only fun and love during the daily few "hours of love" in the afternoons.

Over the years, significant ideological differences emerged between the various kibbutzim. Inner struggles and inter-kibbutzim ideological and economical conflicts emerged. As the kibbutzim underwent deep changes, the educational rules also changed, and different communities adopted different approaches. This seemingly naturalistic "social experiment" lasted until the 1990s, but already between the 1980s and 1990s, the second generation of parents, who were themselves born in the Kibbutz, opposed more and more to the communal sleeping of their infants and finally "won." As a result, families of contemporary kibbutzim have assumed many educational roles and responsibilities. An early study (Sagi et al., 1985) showed a lower percentage of secure attachment (59%) among kibbutz infants than among non-kibbutz infants (65–70%). Security of attachment among kibbutz infants reared in communal sleeping arrangements was significantly lower (48%) than among kibbutz infants with familial sleeping arrangements (80%) (Sagi et al., 1994). The percentage of secure attachment among kibbutzim infants with familial sleeping arrangements was actually similar to that of city-raised Israeli infants (Mayseless & Scher, 2000). The intergenerational transmission of attachment was also different: in spite of a similar percentage of security of attachment among mothers in communal sleeping arrangement (CAS) and mothers in family sleeping arrangement (FSA), the percentage of CAS securely attached infants to their mothers was lower (40%) than among FAS infants (Sagi et al., 1997). Interestingly, the CAS children attached to their non-parent caregiver and security of attachment was the best predictor of empathy levels, IQ, social independence, and leadership at age 5, while the security of attachment to parents did not predict these (van Ijzendoorn et al., 1992). Also, CSA children tended to turn into adolescents with lower levels of intimacy, more limited emotional expression, and lower general openness (Sharabany & Wiseman, 1993). The review (Lieblich, 2010) of both objective-quantitative and subjective-qualitative studies on kibbutzim emphasizes the different layers of a multi-dimensional and multi-faceted phenomenon, which cannot be embraced under simplistic conclusions.

The Jewish religion emphasizes values of family, parenting, and community. Cohesion, with weekly religious ceremonies, and long-term relationships with the extended family are the norms (Ben Raphael & Ben Haim, 2006). In the Orthodox society, marriages are pre-arranged. Reproduction is considered as a collective goal with the aim of multiplying Jewish communities; therefore, religious families marry very young (beginning in the twenties) and have a very high birth rate. For instance, 11 child-families are not uncommon among orthodox communities. In these families, the oldest daughters take care of the youngest, as mothers work and are the primary money-earning adult while fathers study religion at the Yeshiva. In the past 15 years, there is an increasing awareness of postpartum depression among the non-orthodox religious families, and of its impact on maternal parenting behaviors. Once, the very words "mental health" were taboo, postpartum depression was not recognized and therefore was left undetected and untreated. Today, even among Orthodox communities, in some instances, the Rabbi of the community will give the woman authorization to use contraceptives and may even refer to a mental health clinician. Still, in our clinical experience, in these families, children are not prepared for the birth of a new sibling, the mother's new pregnancy is not mentioned, because pregnancy relates to the parents' sexuality, which is in itself taboo. As a result, indirect significant manifestations of strong jealousy, such as irritability, temper tantrums, physical aggression, and sleep and eating problems, are common causes for referral to our community-based infant mental health clinic and parents are very reluctant to make the link between their child's behavior and the pregnancy. Overall, there is a slow but positive trend toward opening up to consulting mental health professionals, both among adults and children, at least among the less closed communities. Indeed, many twenty-first-century religious families in Israel need to find ways and compromises to adapt to the processes of modernization (Shalev et al., 2012).

The role of fathers has changed enormously in many countries around the world, as a result of several societal processes, including a major shift in mothers' ambition for having a career of their own, the increased labor force participation of women, and the growing divorce rate. Parenting is becoming a more equalitarian task. For many of the traditional families in Israel, these changes are difficult and challenging for men, who saw themselves as the head of the family and the key authority figure. On the policy level, some efforts have been made to ease the task for fathers. For instance, new fathers may take half of the mother's maternity leave (as long as mothers agree to), single fathers are entitled to day care services, shortened work days, six paid absences a year for a child's illness, and many work places grant additional benefits. There have been sporadic early intervention programs for fathers (while there are still much more of them aimed at mothers). Specific recommendations for the success of fathering skills programs (Doherty et al., 1998) include involving the mothers, enhancing the fathers' self-esteem in their paternity, addressing the critical transition points for fathers, providing psychoeducation about the child's developmental and emotional needs, and addressing the father's work status (as unemployed fathers are at greater risk for becoming uninvolved fathers). In the clinical practice in Israel, there is a growing trend of involving fathers in mental health and developmental assessments and interventions, though working mainly with mothers is still the default practice.

Last but not least, the Israeli Jewish society faces a major change in the family structure, as more and more lesbian and homosexual couples have children (by different means, including in vitro fertilization, surrogate pregnancy, adoption), and heterosexual men and women make co-parenting agreements without living together and being intimate partners. It is to note that as long as the parents are not in conflict, these children are not over-represented in our child and adolescent clinics.

Parenting Styles, Attitudes, and Practices in Arab Societies

Thirteen out of the eighteen countries in the Middle East are Arabs, but despite the fact that they all share the same language (Arabic), the Arab population is a very diverse population that extends on a broad spectrum of heterogeneous socioeconomic, religious, and political contexts. Therefore, making general statements or conclusions regarding parenting practices and infant mental health to such a large population must be done with caution (Zreik, 2015). Despite the multiple variations among Arab families that are due to traditionalism, religiosity, and modernization (Joseph, 1999), the common denominator is the high prevalence of collective, patriarchal hierarchical authoritarian style (Dwairy & Achoui, 2006). As such, the individual is mostly submissive and dependent on their families. Family cohesion, economy, status, and reputation are in turn dependent on its individual members' behavior and achievements (Abu-Baker, 2007). Hence, unacceptable or unusual behaviors of individual members often become the concern of the immediate and extended family (Dwairy & Achoui, 2006). The individual member is expected to serve the collective in order to receive his/her family support. Decisions concerning social activity, career, marriage, housing, and child-rearing are made within the family context, where the individual has sometimes limited space for personal and autonomous choices. Within this system, in which others make important and daily decisions, the individual expects and prefers matters to be arranged and solved within the immediate or extended family, especially when the problems, such as mental health ones, are stigmatic, shameful, and potentially detrimental to the family's reputation.

In the Arab culture, age, gender, and level of education affect a person's status, rights, duties, and expectations. The older the person is, the more educated one is, the higher one's status is, and the more influential one is. In addition, Arab society regards their elders as wise, knowledgeable, and experienced, and therefore their needs, opinions, and decisions have to be respected and fulfilled (Al-krenawi, 1998; Barakat, 2009). In addition, fathers in the Arab patriarchal society are the head of the family, and therefore they determine their children upbringing and disciplining (Saleh, 2011).

Despite the Arab collective, authoritarian and patriarchal culture, one cannot ignore the transformation that Arab society is going through from its traditional extended structure to the nuclear one, and the contingent effects on the Arab family structure and parenting practices (Karadsheh et al., 2017). Rapid modernization and urbanization, and the resultant exposure to Western values, may have created wider variation between Arab countries, with some of them embracing more liberal ways of parenting upbringing style. This process of modernization, with exposure to social and cultural networks, such as schools, means of communication, and media, impact greatly on the traditional roles that the family used to play in the upbringing of children. When looking at these processes, it is important to understand differences between the Israeli Arab population and the Palestinian Arab population.

The Israeli Arab Population

According to the latest statistical report on Arab society in Israel (Hadda Haj Yahya et al., 2022), based on the Central Bureau of Statistics, Arabs in Israel constitute some 17.2% of the total population. The large majority of them are Muslim (82.9%), and the remainder is either Druze (9.2%) or Christian (7.9%). The Muslims are mostly Sunni, tend to live in small towns, villages, and refugees' camps and hold traditional Muslim beliefs, including patriarchal and authoritarian values (Haj-Yahia, 2000). The Israeli Arab society is going through changes in different life domains. The report shows a clear rise in the standard of living, life expectancy, and education, besides a decline in fertility rates, changes in the structure of the Arab family (rise in women employment, higher education, digital accessibility, and internet use) and the desire to realize individual aspirations at the expense of collective values. These are changes that undermine traditional patterns and revolutionize Arab society (Hadda Haj Yahya et al., 2022). This process of change in the traditional family structure and roles opens space for getting support from outside figures and institutions (including mental health providers).

Muslim Arab societies tended to adopt more traditional, collective, and authoritarian parenting style, including the use of corporal punishment, as compared to the Jewish secular society (Khoury-Kassabri & Straus, 2011). More recently, as the result of their exposition to Israeli Western culture, children are increasingly exposed to a cultural mix, as it is reflected in the way Arab adolescents rated their parents high in the authoritarian as well as permissive parenting style (Dwairy & Achoui, 2006).

Within the Arab population, the Bedouin society is special in the sense that it still retains ancient norms (e.g., family honor, strict rules and monitoring, obedience and respect toward elders, and endorsement of legitimate parental authority), despite the fact that its members are also undergoing major changes in all areas of life. Bedouins from Northern Israel are more exposed to the mainstream population than their brothers in the Negev area (Southern Israel), and they have to integrate their cultural legacy with modern life (Schohat & Ben David, 2000). In a comparative study of parenting styles of Bedouin and Jewish parents (Yaffe, 2020), Bedouin parents were found to be more authoritarian and less authoritative and permissive than Jewish parents. The same pattern was observed in the Northern Bedouin parents, but to a lesser degree, suggesting that the Northern Bedouin families are undergoing a gradual change in their parental style.

Still, it is very interesting to note that besides these factors of change, intergenerational transmission of parenting style is even a stronger factor, as it has been shown in a comparative study among Jewish and Arab mothers in Israel (Pasternak, 2014). Young mothers were found to reproduce their parents' style, irrespective of their social or religious backgrounds. Modeling and imitation of their parents' behavior had a deeper effect in both groups of mothers. An additional comparative study of Jewish, Israeli Arab, and Palestinian Arab families (Feldman & Masalha, 2010) showed that maternal sensitivity in infancy facilitated social competence only among Israeli children. Paternal control in toddlerhood interfered with Israeli children's functioning but contributed to competence among Palestinian families. This study is very important as it suggests that parental style that is growth promoting in one culture may not be so in another one, and vice versa.

At the economical level, it is unfortunate to note that in spite of the official equal rights between Israeli Jews and Israeli Arabs, the Arab population is still characterized by higher rates of unemployment and poverty compared with the Jewish one (Khoury-Kassabri, 2010).

Parenting Patterns in the Palestinian Arab Population

The problematic political situation that is consequent to the Israeli occupation of Palestinian territories since June 1967, with its violent confrontations, mutual hate and fear, augmented by ignorance, media, dehumanization and miscommunication, feelings of discrimination and inferiority, has considerably impacted the adults' mental health and parenting in the West Bank and Gaza.

The historical context is important to understand, as it is part of the cultural narrative conveyed to the children. Palestinians, who remained in their homes and lands and were not evacuated in 1948 during the Nakaba, as well as those who were forced to leave, known later as Palestinian refugees, experienced displacement from their native villages (e.g., Iqrit, Buroam, Safforeya, Ein-hod, Miar, and Safoutta), and following the 1967 war, hundreds of thousands of Palestinians left the West Bank and Gaza, and later referred to as Nazehin (as named by United Nations Work and Relief Agency UNRWA). These mass displacements became the basis of intergenerational transmission of trauma among Palestinians, as the young generation of parents were the children who grew up in the context of the collective traumatic narrative (Abdallah et al., 2021; Barron & Abdallah, 2015).

The science of parenting is to some extent new in the Palestinian community, and the rate of illiteracy is sadly high among mothers. Hence, the promotion of interactive, healthy, and positive parenting is a main goal among Palestinian educators and mental health professionals. Training workshops for parents are encouraged and focus on enhancing the values of democracy, tolerance, sharing, and forgiveness. The use of formal and informal education activities at schools, starting at preschools, is more widely applied, and a special effort is made to destigmatize asking for mental health support. A rapid increase of educational opportunities, mainly for females, is observed in the last years, as education is considered as the main tool for improving the family's economic and social situation. The family structure is moving from extended to nuclear families, together with the spread of daily childcare centers. Different approaches to parenting are now heard of, and the debate between the permissive parenting and the authoritative parenting leads to marital conflict, domestic violence, and divorce, mainly among new married couples in the most vulnerable and conservative regions such as the north and south of the West Bank and Gaza, where high rates of unemployment and poor housing are prevalent.

In contrast to Israeli society, single-parent families are rare in the Palestinian community (with the exception of widowed parents). The underlying reason is religious and traditional, as the widowed mother is allowed to keep her child until the age of 7 years, and then the child must move to the father's family, whose parenting style may be different from hers. The fundamentalist tradition places the husband as the source of authority in the family ("You have to obey God and your parents"— a statement from Koran, sentence 18 al isra chapter), as well as the Bible (Paul to Ephesians 5:23–24). Rural communities tend to be more religious and traditional than urban ones, and this is probably the reason why parenting education and understanding of the long-term impact of healthy parenting on the children's outcome has developed earlier in cities. Also, co-parenting has become much more frequent among urban Palestinian families than in rural ones. Values of shared responsibility, self-reliance, forgiveness, and emotional communication are still lacking in many families, although in the Arabic language, parenting ("Al walideya") means shared responsibility between the parents following mutual agreement and despite their different cultural backgrounds.

A small, still unpublished, qualitative pilot study was recently conducted by Dr Abdallah. He randomly selected and interviewed face to face five fathers and five mothers with different educational levels from five different geographical areas in the West Bank (the fathers Mohamad, Nizar, Ali, Adel, and Anwar; the mothers Juhainah, Itidal, Muna, Mary, and Hinriet. Also, two fathers, Amer and Mahmoud, and two mothers, Salwa and Reema (all the names are pseudonyms), from Gaza were interviewed by phone, from Gaza. The first question was "*What are in your view, the factors that determine the nature of parenting in a Palestinian family?*" The five West Bank fathers' reasons to leave the parenting task to their wives were as follows: "*I lack appropriate tools and mood,*" "*I feel exhausted after my hard work day,*" "*I am stressed because of my daily unpleasant life,*" "*Being unemployed makes me feel embarrassed to get involved in family issues,*" "*I prefer to stay away, as if I get involved, we will have a fight and I may become violent.*" The fathers from Gaza answered: "*I respect and acknowledge my wife's role in life,*" "*My main goal is to protect my family.*" The five West Bank mothers thoughts about leaving parenting tasks to them were as follows: *"My husband is more educated than me," "He is the only one who works in the family and I am a housewife, so I get guidelines and instructions from him," "Better not to add a violent atmosphere at home to the one that is outside," "For the sake of my children's dignity, I always do my best to find compromises," "My goal is to have my children feel that their home is a safe place for them."* The answers of the two mothers from Gaza were as follows: "*My husband works hard, I do my best to take some daily responsibilities from his shoulders,*" *"I respect my role in life and thus I feel I* *am not a marginalized person."* The third question was "*From your own experience and what you observe around you, what are the most common parenting practices?"* Here we could see the dichotomy between the authoritative/permissive style among urban parents versus the authoritarian style among rural parents: The West Bank urban parents answered *"Providing education and guidance, Love with flexibility and without intrusiveness."* The Gaza and West Bank rural parents answered *"Coercive authority and corporal punishments."*

Socialization, meaning acquiring social skills and humanitarian values, is one of the major parenting tasks, as no child is born with it. Starting from early childhood, cultural beliefs and parental history play a major role in developing and building the culture of trust, dialogue, sharing, and tolerance. For example, in many cultures, children are expected to share their toys and other belongings from an early age. Social media is playing an important role in this process, often negatively as it enables to express negative psychological, moral, and cultural problematic messages. Another significant factor, unique to our region is the dynamic "spillover" of the Israeli culture upon the Palestinian and Israeli Arab ones, through music, language, dressing, foods, and at a deeper level, moral values. Some may view this process as "invasion" by the ruling society (Israel), and others may view it as acculturation phenomena. These cross-cultural influences are speeded up by the continuously developing communication means (Facebook, Twitter, WhatsApp, and TikTok), while some important traditional values are lost on the way. For instance, our clinical impression is that many children seem to have less interest in playing with peers and tend to be aggressive one toward the other.

The dynamics between the occupied and the occupying societies is such that under the term of "normalization" of the relationship between the two, and in the context of economical dependency of the former on the latter, a change in the psychology and behavior of the occupied people can be observed, including social fragmentation, decrease in the level of moral values, anxiety, tension, mood swings, poor self-esteem and confidence, conduct disorders, and domestic violence. Consequent to this situation, signs of PTSD among parents and children have been reported (Barron et al., 2016a), as well as poor academic and interpersonal functioning. As the political situation is very unstable, new traumatic events are a daily reality for the Palestinian parents and children in the West Bank and in Gaza. Children become adolescents, and they become young adults and parents. Hence, the ideal would be to try and treat these emotional and behavioral symptoms, and especially posttraumatic symptoms following domestic violence, war, acts of terror, accidents, and natural disasters, before entry into parenthood (Barron et al., 2013, 2016b; Barron & Abdallah, 2017). The massive explosion of information includes agnotology, that is, the spread of fake culture (smoking, unhealthy food and drinks, cosmetics, etc.) as well as the spread of fake scientific information that has led for instance to opposition to the COVID vaccination.

In the light of all these, we need a cultural change that ensures the necessity of fostering efficient cooperative parenting through adopting dialogue at all levels instead of resorting to fighting, taking revenge, dehumanizing the other, especially in light of the prominent atmosphere of frustration and despair. Palestinian mental health professionals and educators need to work hard with, for, and by the community to recognize mental health disorders rather than avoid such topics as a cultural taboo, for example embedding psychological first aid into family and community supports from the early years of development.

Parenting Patterns in Egypt

Two Egyptian rearing practices have been described: *Takafol* (translated as mutual care) and the observance of family rituals (Henry & Elwy, 2020). *Takafol* is the expectation that parents and children will continue to care for each other throughout life. This value of interconnectedness reflects a collectivist, rather than an individualistic approach toward life, and thus gives priority to interdependence, communalism, and mutual give-and-take. Collectivistic Egyptian families emphasize conformity, obedience, security, and reliability. Egyptian parents, like Israeli Arab parents, tend to be very much involved in their children's education and to invest time and efforts to promote good scholastic achievements and later higher social status (Freund et al., 2018). Indeed, parents' involvement in their children's education has been associated with fewer behavioral problems and improved social functioning (El Nokali et al., 2010). In the *Takafol* approach, married children are expected to host their elderly parents. The main downside of *Takafol* is the young adults' lack of freedom in seeking careers or domains of interest that do not fit gender or cultural expectations, as well as in choosing their spouse (Henry & Elwy, 2020). The second main component in the Egyptian parenting approach is the observance of family rituals and rules, such as praying together, attending fixed dinnertime.

These two main components of the Egyptian parenting practices are undergoing drastic changes because of globalization and capitalism (Chekir & Diwan, 2014). As we have described the changes in the Israeli Arab society, Egypt is also in a transitional phase between the traditional child-rearing practices and the Western-oriented ones.

Parenting Practices in Jordan

Jordan is predominantly an Arab-Muslim poor country, with a high percentage of children. The structure of Jordanian families have changed from an extended family to a more nuclear one (Dwairy & Achoui, 2006), with more working mothers, increased levels of education, and presence of housemaids. A qualitative descriptive study explored Jordanian parents' understanding of parenting (Oweis et al., 2012) among 110 parents recruited from four health centers. Three main themes emerged: the Islamic teaching and principles should be the basis of parenting, as it emphasizes the rights of children to have a positive first name, to get the best education, to be treated fairly and equitably, and to receive basic psychological and physical needs. The second theme was the parents' obligation to transfer their cultural values and norms from generation to generation. The third theme was the challenges parents encounter while trying to meet these goals in spite of the difficult daily life most of them experience on the concrete level.

A Better Parenting Program was implemented nationally in Jordan to enhance parents' knowledge, attitudes, and behaviors related to caring for young children, and a controlled study of the impact of this program was done on a sample of 337 parents, mostly mothers (Al-Hassan & Lansford, 2011). The main benefits of the intervention were reflected in the parents' level of knowledge, spending more time playing and reading books, using more explanations while disciplining the child, and becoming sensitive to neglectful parenting behaviors.

Parenting Practices in Lebanon and Syria

Lebanese parents have a more lenient parenting style, a combination of authoritative and permissive styles, comparable to the styles found in Jordan and Algeria (Dwairy et al., 2016). Parenting in Syria has been totally disturbed by the war, and Lebanon hosts many Syrian refugee families. Indeed, the war in Syria has resulted in a displacement crisis of unprecedented scale. Approximately 6.3 million Syrians are refugees in other countries, of which 40% are under the age of 12 years. While positive parenting, including warm nurturing and responsive parenting behaviors and interactions, can help to buffer the negative effects of war and forced displacement on children's well-being, the struggle of caregivers to cope with the stressors of war and displacement becomes a source of additional risk. Indeed, war-exposed parents have been shown as exhibiting less warmth and more harshness toward their children, which in turn mediated the association between war exposure and child mental health (Eltanamly et al., 2021). Available data suggest that Syrian refugee children in Lebanon experience high levels of violence in the home: 78% of children are subjected to harsh physical or verbal discipline, including yelling and shouting (54%); spanking (31%); slapping on the hand, arm, or leg (28%); and shaking (19%) (UNHCR, 2017). Furthermore, research with refugee families who have been permanently resettled in a safe country suggests that the effects of war can persist for years after exposure (Eltanamly et al., 2021).

A parenting intervention specifically designed for caregivers affected by the Syrian conflict, The "*Families Make the Difference*" program, a 10-session manualized intervention, has been widely disseminated in Lebanon, Jordan, and Syria since 2014 as part of a broader response to the Syrian crisis by the International Rescue Committee [IRC], (IRC, 2016). A very recent study (Sim et al., 2021) assessed the acceptability and preliminary outcomes of the "*Families Make the Difference*" parenting intervention for Syrian refugees in Lebanon. Significant reductions in harsh punishment and rejecting parenting behavior and improvements in measures of parental and child mental health were observed from pre- to postintervention. On average, parents completed 7.7 of 10 sessions. Hence, high levels of attendance and retention indicate that a structured, group-based parenting intervention is acceptable to Syrian refugee caregivers living in a context of ongoing displacement. These encouraging findings suggest that the intervention may hold promise for preventing violence against children and addressing the significant mental health burden among refugee populations.

Implications of Our Complex Multicultural Context on Working with Parents and Infants

In spite of all the cultural differences we have described in this chapter, there are several common challenging situations for us, as clinicians who work with parents and infants/young children in this region. Religion with inflexible parenting practices, high birth rate in spite of poor family income, and traditionalism are common obstacles. Clinical pediatric situations, such as children with difficult temperament, children with special needs, medically compromised children, are very challenging to all parents, regardless of culture and politics, which often engender inconsistent parenting behaviors. Lack of agreement between parents is mostly frequent and detrimental.

Seeking the help of a mental health professional is usually considered as a final resource, when all else fails, since mental health difficulties and mental health professional aid tend to be perceived as shameful that devalues the sick individual and disgraces his/her family (Al Krenawi & Graham, 2000), not only in the Arab society but also among Orthodox, Ethiopian, and Russian Jews. As a result, the first therapeutic encounter starts with feeling of shame and failure from the parent's side, on top of other expected and normal feelings of tension and anxiety, making it more challenging for the therapist to provide a holding and safe environment. Moreover, many of our clients are mothers and their children, and fathers are less likely to participate in therapy, since raising children is still considered the main role of the women in the family and society. Needing an external help such as psychotherapy in order to deal with the child's difficulty may be perceived as the mother's "failure" to fulfill her main role assigned to her as a woman, exposing her to criticism from her husband and/or his extended family.

As hierarchy and obeying is part of the Arab culture, Arab patients come to therapy with the expectations of being given concrete practical advice. Mothers see the therapist as their teacher, and expect active, immediate, and concrete guidance (Al Krenawi & Graham, 2000). These expectations from the therapist often contradict the therapist's own aim to listen, observe, and reflect. Very often, parents do not understand why they are asked about their background and past experiences, as they came for their child, not for themselves.

In addition, as we mentioned above, many Arab families still live in close proximity to the paternal extended hierarchical family, who is very much involved in decision-making concerning the child, leaving less space for the parents' autonomous standpoint. Very often, members in the extended family do not agree with the therapist's view and recommendations and undermine the therapeutic process.

Another challenge for IMH professionals in our region is the common view that infants and toddlers as immature and unable to comprehend and to react to their caregivers' emotional state and surrounding environment. Consequently, the infants' symptoms are mostly understood as being an intrinsic problem of their own, rather than being linked to the characteristics of the parent-infant relationship. Parents often do not understand why the infant's presence in the therapy sessions is essential. Contrary to the parents' expectation of getting "tips" from the therapist, the IMH therapist tries to speak out the infant's "narrative" as well as the parents', to consider the infant as an active partner in the therapeutic process, and to communicate these understandings to the parents, in order to motivate positive change in the parent-infant relationship. Hence, a few introductory psychosocial sessions with the parents alone are often needed before we can start the actual dyadic/triadic therapeutic process.

Summary and Key Points

In this chapter, we have seen how culture, ethnicity, religion, immigration, and social media impact parenting style. Consequently to the hetero-cultural and geopolitical context in our region, the therapist himself/herself comes from a politico-socio-cultural background different from that of the parents. Therefore, it is essential, and often quite challenging, to understand and to respect the parents' cultural background, beliefs, and values, in order to create a safe therapeutic space where parents will feel safe to open up, with less feelings of shame and incompetency.

In our complex region that we have tried to describe in this chapter, the "good enough" IMH therapist needs to be especially cultural-sensitive, as there is a high probability that the therapist and the family belong to a different cultural and political group. Based on our respective clinical experience, we suggest a few recommendations:

1. Bear in mind that in many cases, our patients are not only the parents and the child but also their families and their communities. You may need to meet the Head of the extended family, or the Rabbi, or the Shaman of the community, to get their support and encourage the parents to come for therapy with their infant.
2. Be sensitive to the parent's level of readiness to share intimate information. For instance, asking direct questions about their antecedents at the first evaluation session is often experienced as intrusive, out of context and threatening, and will lead to superficial and partial answers. Providing the parents with a clear explanation about the potential link between their infant's symptoms and their relationships, and about how knowing them will help us knowing their child better, is usually helpful at lessening parents' reluctance of self-disclosure.
3. Directing the parents to think of the child's needs, desire, feelings, intentions that lay behind his/her behaviors, rather than merely reacting to acts.
4. In-live therapy moments are often useful to show parents that their young child actually reacts to the emotional atmosphere in the room, to link behaviors to emotions, and to reach the understanding that the child's symptoms may be related to the dynamics of the family. Contingent to this new understanding, parents may become less reluctant to self-disclosure.
5. Emphasizing the positive aspects of the parent's parenting behaviors, including overcoming the difficulties inherent to seeking for professional help in her/his specific milieu, will facilitate the development of a positive working alliance.
6. Offering psychoeducation and concrete "tips" may be needed and expected in the first sessions, in order to be perceived as a trustful person of knowledge.

In our clinical experience as mental health therapists working with less psychologically minded populations, taking into consideration all the points mentioned above is actually helpful in building a therapeutic alliance with the parents, without which the young child will not be helped with his/her symptoms.

To conclude, the three authors of this chapter deeply believe that mutual recognition and sharing of values, practices, as well as prejudices and stereotyped views among therapists who belong to different and conflicted communities is a unique role mental health professionals have in conflicted societies, besides treating their own patients. Thus, it is with this belief that we have written together this chapter on parenting in our respective and neighbors' countries of the Middle East.

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Parenting and Infant Mental Health in Global Perspective: Exploring Standards for Virtual Intervention Designs

9

Niels Peter Rygaard

If the mysery of the poor be caused not by the laws of nature, but by our institutions, great is our sin.
–Charles Darwin in “Voyage of the Beagle”. IN: Journal of Researches, Aug. 19th, 1836.

To inspire further designs in infant mental health interventions, this chapter describes the local analyses and program designs of the Danish Fairstart Foundation’s [FS] global intervention program, followed by a discussion of perspectives for future infant mental health interventions.

FS programs are designed in long-term partnerships with local NGOs and government agencies, educating their staff train local foster, kinship, refugee, and high-risk families. In the text, examples of various international partnerships serve to illustrate one example of how the ten principles of Effective Early Childhood Mental Health Consultation Services [ECMHC] can be applied in practice (Bruns et al., 2008).

ECMHC guidelines reflect assumptions shared by FS: successful interventions depend on equal and intimate dialogues between researchers, the executing consultant units, and end users. How does the FS work to make this goal operational? The design of a global intervention must aim to answer basic questions in general as well as regionally: why are so many world parents stressed, sometimes to the point of giving up parenting? How do families in various cultures adapt to urban life, and how can research-based care practices help them? How can virtual classrooms reduce partner costs, and what lessons can be learned for future applications?

Global and Regional Analyses of Parent and Caregiver Stress

After presenting the program’s background in the author’s professional experiences, an ongoing FS analysis of recent developments in global reproduction and infant and childcare serves to identify key topics in FS’s educations and trainings. The global analysis serves to understand how millions of former hunter-gatherer families and rural extended families adapt in their transition to life as urban and suburban families and how they struggle to organize care. The analysis also serves to generate the program’s overall definitions of parent and caregiver stress and trauma, resilience, post-traumatic growth, and quality in early care.

Prior to implementation in each partner country, a regional analysis is conducted in close cooperation with the organization to adapt group training sessions to local cultural mindsets of childcare. Examples from partnerships in three major family cultures are provided to illustrate how the ten ECMHC principles can be unfolded in practice.

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A Short Overview of Fairstart's Educations and Group Training Sessions

For the design of a local caregiver group training program, FS staff travel with the partner and interview local leaders, caregivers, parents, and children about local needs and cultural strengths. Videos of daily care practices are recorded, and caregiver group training sessions in the local language are made available online, demonstrating various aspects of attachment-based daily care and learning.[1]

Next, in a local three-day introduction seminar with FS staff, 20–30 partner staff students are introduced to the eight modules of their future six-month online classroom and the basic group training sessions. In eight four-hour modules, students learn about basic attachment theory, group development and learning theory, in tutorial texts, videos, and research summary papers. To avoid cultural bias, the elements in modules and trainings are based on studies and care recommendations provided by an international network of researchers from all continents. The curriculum is designed by FS on the edX platform from Harvard and MIT for university level education.

As part of each module, a student prepares for conducting three-hour training sessions for a local group of 8–20 caregivers or parents. A student trains his or her caregiver group in eight three-hour sessions. At the end of each training session, the instructor helps caregivers design individual work plans for learned care practices at home between sessions. After a group session, the student performs peer feedback and reflection questions in the classroom, and FS provides daily online support.

For uneducated and illiterate caregivers, FS designed an instructor's guide and simple pre- and post-scorecard questionnaires – one for caregiver well-being and knowledge about care and one for caregiver's assessment of each child's development. Questionnaires are available in partner language versions. An external study confirmed sufficient validity and reliability for ages 0–12 (Hecker et al., 2022). An example of outcome reports is available (Fairstart Foundation & SOS Children's Villages, 2019).

In the final exam module, students reflect on outcomes for their organization, their personal and professional experiences, and for caregivers and children, and plan future trainings with their leaders. At present, 700 partner staff in 28 countries have graduated as instructors and trained the local caregivers and parents of 60,000 children and youth. The majority of the target group are caregivers of infants and children growing up without their parents in alternative care, now also including high-risk parents in major city suburbs. All implemented training sessions are available for interested professionals at the FS site in 20 language versions (Fairstart Foundation, n.d.). A video example of first implementations is available (Fairstart Foundation, 2017).

Project Background: Experiences with Deprived Children and Stressed Staff

From 1981 to 1991, the author worked as a clinical psychologist in the Danish school home and therapeutic facility Himmelbjerggaarden, hosting some of Denmark's most deprived and maltreated children. At the time, groundbreaking neurological research in Eastern Europe's substandard orphanages added to our understanding of infant attachment. Studies demonstrated how infant brain growth and neural activity levels depend entirely on constant physical, social, and emotional rhythmic interactions with caregivers (Crockenberg et al., 2008). Fox describes the negative attitudes in isolated and unsupervised orphanage staff, resulting in depriving and inhuman care practices and mindsets (Fox et al.,

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[1] Group session topics are as follows: Introduction to Your Learning; Understanding Basic Attachment Theory; How to Practice Professional Caregiving and How Children Respond to Care: Attachment Patterns; How to Recognize Insecure Attachment Behavior; Turning Pain into Resilience: Helping Children overcome Loss and Separation Reactions; Parenting and Guiding Teenagers from Childhood to Adulthood; Our professional Experiences from the Learning Process.

2011). In the Danish institution, the author observed high levels of stress and trauma in staff from daily exposure to the children's abnormal sexual, impulsive, and aggressive behavior.

The author conducted a comparative study of 48 children diagnosed with reactive attachment disorder [RAD] and a control group, mapping parental background, children's birth weight, and cognitive profile at age 7–14 (Rygaard, 1998). The study demonstrated nine out of ten mothers suffering from personality disorders, frequent preterm births, and multiple birth complications. Sample birth weight was lowered by 316 g compared to Danish average, and 264 g in control group. Wechsler Intelligence Scale for Children [WISC] tests comparing control group and sample after referral and retest after 18 months showed a characteristic high-low score profile in sample, impeding learning and memory function. Outcomes raised the question about how to determine quality care and milieu therapy for high-risk children, i.e., what early care practices – documented by longitudinal studies in epigenetic, neurological, relational, and social disciplines – have positive effects on adulthood for the development of secure attachments, educational success, and social competences?

From the Clinical to the Global Perspective

The perspective of this work was widened after the author's theoretical and organizational experiences were summed up in the 2006 handbook "Severe Attachment Disorder in Childhood – A Guide to Practical Therapy" (Rygaard, 2006). Editions in 12 languages inspired a world tour of lectures at universities and studies of the organization of government and NGO systems for children in alternative care. The overall observation in most countries was that daily care in orphanages and foster families was performed by an underprivileged, underpaid majority of women, burdened by scores of traumatized children per caregiver, with no guidance from 60 years of child research. One recent example from a 2018 visit to an orphanage in Tijuana, Mexico: 29 abandoned refugee babies were cared for by two exhausted women around the clock and week. The signs of severe deprivation in these babies were similar to that of orphanage infants in Eastern Europe in the 1990s.

Furthermore, many Western interventions seemed to cause resistance when transferred to traditional indigenous and local care cultures, also described by other authors in this volume (please see Chaps. 1, 2, 3, 4, 5 and 6, this volume). And finally, many uncoordinated interventions and research programs targeted limited audiences and very specific child problems, each spending considerable resources on different models. The observed lack of shared knowledge between academic circles, organizational policies, and daily frontline staff inspired the idea of educations and trainings as an interactive meeting ground. A pilot program in Europe preceded the foundation's global outreach. The following text describes the global analysis to extract relevant topics in the educations.

Part 1: Global Causes of Parent and Caregiver Stress

Universal Intentions of Parenting

An intercultural program must be based on the common intentions of parents and caregivers. Cross-cultural research in parenting identifies three parental intentions of upbringing, labeled as "universals": "*…ensuring their children's survival and health, stimulating their children in order to ensure their social and cognitive development, and transmitting culturally adapted values by giving guidelines to their children which will allow them to fit into their society*" (Roskam, 2013, p. 3). The local transmission of these intentions is unfolded in a complex interaction between daily caregivers and their physical, mental, and social environment. Caregiver stress supposedly emerges in case of an imbalance between limitations in the care environment and the caregiver's ability to fulfil these intentions.

The Balance Between Present Childcare Research and Local Care Practices

In Bowlby's (1973) evolutionary view, infant attachment is formed in caregiver-child interactions, ensuring the survival and reproduction of the next generation. Indigenous, traditional, or contemporary care practices may seem to be maladaptive from any ethnocentric point of view, but they each represent millennia of adjustments to diverse environments, adding to our knowledge about the evolution of attachment and reproductive strategies. Historically developed cultures care by the standards of their traditional values, while interventions present contemporary ideals of upbringing. In 1932, Bloch and Ritter (1977) developed the term "non-synchronism", i.e., in today's world, present and past family cultures coexist and conflicts arise between them. To balance and merge past and present infant care values, interventions must involve local partners as active program co-designers, identify local sources of parenting stress, and include traditional care assets.

A Meta-Definition of Parenting Stress, Trauma, Resilience, and Posttraumatic Growth

One challenge in a global program to reduce child and caregiver stress follows from the cultural differences described above: what parents and children experience as stressful or traumatizing interactions or events in care practices varies much from one culture to another. For example, in many countries, disciplining by shaming and slapping a child is still an accepted norm in some cultures and may be considered as traumatizing in others. Program design requires an attempt to create intercultural definitions of the sequential impacts of stress, trauma, resilient responses, and posttraumatic growth in families, infants, and children.

The Delay in Human Adaptations to Environmental Change

Patnaik (2014, p. 281) defines stress as "*A negative emotional experience accompanied by predictable biochemical, physiological, cognitive, and behavioral changes that are directed either towards altering the stressful event or accommodating to its effects.*" As causes of experienced caregiver stress or trauma are culture-dependent, causality can't be identified by any specific event or impact. What is universal is that mobilizing an adaptation response to a change in the care environment takes time – be it from an epigenetical, a neurological, a mental, or a social perspective. In consequence, the onset of a stressful or traumatic response is presumably defined by the relative speed of change in the environment compared to the time it takes the cell, the brain, the individual caregiver mindset, and/or the group to organize a relevant adaptive response.

While a slow or minor environmental change mobilizes an adequate stress response and perpetual stress causes exhaustion, a trauma occurs when the sudden impact of a major change overrides the coping mechanisms developed in a relatively stable environment, causing a disintegration of the coping mechanisms that should lead to reorganization and posttraumatic growth response (PTG). The disintegration of the very coping systems themselves makes recovery almost impossible, as seen in posttraumatic stress disorder [PTSD] where recovery may take up to ten years (Rosellini et al., 2018) or in the lifelong sequelae of severe childhood trauma as seen in substandard orphanages. Instead, maladaptive attempts to adapt occur, such as substance abuse, domestic violence, homelessness, and suicide attempts, creating a negative spiral of further disintegration. In reverse, the term "resilience" can be defined as the ability to respond to environmental change by flexibly modifying former coping strategies to new circumstances (Rasmussen, 2018).

In conclusion, successful recovery in the sequence from stress or trauma to posttraumatic growth depends on the speed of environmental change, relative to the speed of reorganizing a relevant response to adapt (Rygaard, 2022). The term "social acceleration" coined by Rosa (2013) is useful to analyze how parental or caregiver stress is induced. In this tradition, stress and trauma are caused by increasingly rapid environmental and societal change. What, then, is accelerating the global causes of parent and caregiver stress?

Current Universal Causes of Parental Stress, Trauma, and Posttraumatic Growth

One major cause of parental stress is the accelerating process of relocation, uprooting and migration of entire populations to cities, creating a collision between traditional care and urban survival strategies. By 2050, projections indicate that 75–80% of former hunter-gatherer and rural village extended families will have migrated to live in the new environment of cities and megacities. Urbanization is further accelerated by climate change, conflicts over dwindling resources, and increasing economic inequality. Formerly small groups of independent producers become urban consumers, utterly depending on extrafamilial public and private services for infant health and care.

From the author's perspective, in the history of humankind, this major acceleration in the relocation of families is comparable to our species' Exodus from Africa and ignites a twofold response. First, the rise of stress responses and maladaptive breakdowns in protective traditional and indigenous family networks happens, caused by urban network disintegration. Summing up studies in 47 countries, Roskam (2013) and international colleagues describe growing numbers of parental burnout. Well-known risks in urban environments are unemployed fathers who can't provide for their families, substance abuse, growing numbers of children living in the streets and in alternative care, and major political conflicts between traditional and urban mindsets, for example, demonstrated by recent conflicts over women's reproductive rights. Next, attempts to adapt to urban life begin.

While urbanization drastically improves children's physical health and reduces the number of children per family and infant mortality, the traditional need for many childbirths and taboos surrounding prevention still result in overpopulation in some developing countries. In post-industrial developed countries, government budgets are stretched by the prolonged life span of the elderly, leaving fewer resources for parents, social services, and child education. The decrease in child births and the overpopulation of elderly in developed countries predict a collapse in economies due to a lack of future work force – for example, in China, Japan, USA, and Europe, birth rates are far too low to reproduce their populations. In contrast, the young African population is expected to double from 1.3 billion in 2020 to 2.5 billion in 2050 (Statista Research Department, 2022).

Urban lifestyles tend to reduce mental health and coherence in family networks, forcing many parents to give up parenting. Even before COVID-19, UNICEF counted an unfathomable 153,000,000 world orphans (infants and children who lost one or both parents) (SOS Children's Villages, n.d.), notwithstanding today's 50 million children on the move (UNICEF, n.d.). Without early care and education, this population represents a future political risk and economic burden for democracies, impeding the ability of the next generation to resolve our future challenges.

Urban Posttraumatic Stress Responses

Next – with some delay – posttraumatic growth [PTGs) responses emerge to form resilient strategies: numbers of divorces are mildly decreasing (Ortiz-Ospina & Roser, 2020). Fathers and mothers tend to share daily care and new definitions of gender and new mindsets about parental authority occur. Replacing the blood-related family, non-genetic family constructs such as adoptive, same-sex, second- or mixed families are accepted, and public and private consultation facilities for parents grow. In a shift from vertical paternal authority in the family to horizontal social networks, the protective extended family network is gradually replaced by networks in age-defined daily groups – for babies, toddlers, children, teens, parents, and the elderly. These horizontal life ghettoes create a risk for the intergenerational transmission of care practices, leaving young parents insecure without the guidance and cultural inheritance from relatives.

Having identified these risk and adaptation factors for infant and childcare, the next step in the global analysis was to encircle a universal program definition of "quality in early caregiver-child environments."

How Does Research Define Quality Care Environments?

To extract care practices enhancing secure attachments and resilience, definitions of quality care were developed, by selecting longitudinal studies linking early care environments and care practices to success in adulthood in education, employment, and social competences. Six general principles of early care environments linked to success in adulthood were extracted from contributions provided by the FS network of international researchers and summarized by FS:

1. *Continuity in caregiver attachments and relations*. The healthy development of an infant or child requires a long-term relation and secure attachment to one or two parents or caregivers, in particular during infanthood. In the evolution of the attachment system in mammal species, infants in traditional cultures were not separated from parents and their local group during childhood. For the first time in history, few urban women give birth in their community. Early out-of-home care and infanthood separations emerge in urban life as a major evolutionary event, with poorly mapped consequences for the formation of child attachments and the lifespan development of mental health.

   Various studies in daily separations indicate risks for the development of secure early attachments. For example, a comparative study of 13-year-olds whose mothers had a one-month extended maternal leave due to a 2002 change in Danish legislation showed the following: *"Exploiting a Danish reform which extended the length of paid parental leave, we show that children whose mothers were induced to take longer leave were better off many years later. Specifically, we find that longer leave increased the children's well-being, conscientiousness, and emotional stability in adolescence*." (Houmark et al., 2022, p. 31).

   The important continuity in urban children's early caregiver relations no longer depends solely on parents but also on significant external daily relations to daycare and kindergarten staff, pre-school teachers, etc. Long-term secure caregiver relations can erase the impact of former trauma and improve school performance, even when offered in school-age years. Frequent caregiver shifts impede child development and school performance (Bettmann et al., 2015; Forsman & Vinnerljung, 2012).

   Long-term membership of a peer group. Especially after age 2–3 and again in teenage years, being an accepted member of a long-term group of peers is important. A Danish review of international research since 1937 in kindergarten care concludes that small child groups (4–6 infants) and social-emotional interactions from stable caregivers improved long-term social-emotional competences, as well as improved IQ at age 16 (Christoffersen et al., 2014). Growing up in a long-term group of peers creates a protective adulthood network (Islam & Fulcher, 2016). Staying in foster care until age 23 instead of 18 and care leavers living in supervised peer groups after care show increased educational and employment success as opposed to living alone (Moelholt et al., 2012).
2. *Continued education and supervisor interactions with parents and caregivers*. The home or workplace satisfaction of parents and care-

givers – as well as their knowledge about how to meet disturbed child behavior – is paramount for their ability to form secure relations with children and youth. In reverse, the more the parents, foster families, or caregiver staff are isolated, the higher the frequency of caregiver burnout, abuse, and caregiver violence (Crockenberg et al., 2008). In studies of violence and aggression between children in South African orphanages, a clear link between violent caregiver culture and unsupervised staff groups was found (Hermenau et al., 2017). Other studies indicate that poverty problems in providing for children reduce parental ability to practice secure attachment behavior (Mills-Koonce et al., 2011).

3. *Agreement between those the child or youth is attached to and those who decide where the child belongs*. Marital conflicts and divorce have long-term consequences. A Danish longitudinal study of 52,000 children born in 1980 finds that rich and middle-class parents divorce later and much less frequently than low-income parents (Holm, 2014; Hornby & Collins, 1981). For both groups, the child's educational level at age 32 was doubled if parents stayed together. This development is a cause of concern, as global divorce rates increased by 281.8% from 1960 to 2017 (Nguyen, 2022). For children in out-of-home care, eight out of ten parents are divorced (Spijkers et al., 2012). Intergroup conflicts between parents, foster families and case managers, schools, etc., create paralyzing loyalty conflicts in the child, causing serial shifts in placements with negative mental health effects, poor school performance, and increased homelessness in care leavers. Negative child-in-care development is linked to frequent shifts in the child's social case manager (Rygaard, 2017).
4. *Adequate funding and legislation for government placement administration.* Close cooperation between NGO and government initiatives is paramount for efficient child-in-care management. In most countries, the author observed a severe lack of educated case managers, social workers, and mental health experts, creating harmful delays in child placement management.
5. *Standardized instruments for measuring child-in-care and caregiver development*. Collecting and retrieving reliable data from interventions is a costly challenge, and many instruments are culturally biased. Culturally adjusted methods, designed for non-educated or illiterate caregivers, are needed. Intruments should be easy to apply and register even in remote and low-income cultures, and allow for comparison of data with other instruments.

Conclusions from the Global Analysis

Summing up conclusions from the above analysis, a global intervention program to enhance high-risk children's attachments, resilience, and learning must provide an adequate response to the general challenges of organizations, families, and caregivers in their struggle to build new coping strategies, particularly in urban settings. It must reduce parent and caregiver stress by helping caregivers and children recover from personal and cultural trauma and prevent social isolation by regular dialogues in caregiver groups. It must focus on the lifespan from pre-birth through infancy and adulthood, in particular, during the first years of life where secure or insecure attachments are formed. It must include and activate the experience and knowledge of local recipients as cultural translators of general research recommendations. It must help participants merge traditional values and recommendations to enhance resilience and PTG in their new urban environment.

Some Theoretical and Practical Implications for FS Program Development

In many countries, caregiver's ability to provide secure care is compromised by childhood experiences of traumatic separations. In start-up seminars, students share their own experiences in a two-by-two interview and later use these as examples when asking caregiver groups to share their own. The interviews serve the double purpose of recovery by open sharing and help caregivers understand why avoidant, ambivalent, or disorganized behaviors are normal and healthy reactions to experiences of loss prior to placement. In later sessions, caregivers learn to share their own childhood narratives in dialogues with children about loss and resilience. Also, to promote psychological safety in non-parental caregiver groups, Bowlby's focus on mother/infant attachment is widened by the concept of "the Secure Caregiver Group," conceptualized as "*a group where all participants share and compare personal experiences of separation and loss in their own childhood, to better understand and respond empathically to the behavior and mental state of children in their care, who suffer from separations and trauma*" (Rygaard, 2017, p. 1379).

The following text describes how the basic educations and training session topics are researched and adapted in various partnerships with respect to local traditions, stressors, and trauma caused by colonization and urbanization, and posttraumatic indicators of growth. Variables described are: country child mortality, birth rates, traditional care practices, and social network support. Examples are from partnerships in three cultures: the former hunter-gatherer culture of Greenland, the following extended rural family cultures in Cambodia, Indonesia, and East Africa, and present urban family cultures in ten European Union [EU] partner countries.

Part 2: The Organization of Care in Three World Cultures

Programs in Greenland's Former Hunter-Gatherer Culture

In 2017, the two directors of Greenland Government's Social Board of Prevention visited FS and invited for a partnership in response to two challenges: (1) the lack of cooperation between parents, school teachers, school home, and group home staff, hosting young pupils who move from settlements to continue education in cities after 7th grade and (2) the lack of staff and municipal capacity to support and train foster families. It was agreed that both educations and trainings should be in Inuit and Danish language versions. Interviews and research provided the cultural background for program design.

Inuit Adaptations to the Arctic Environment

For 5000–10, 000 years, the hunter-gatherer culture prevailed. Tribes in small groups survived by following the wanderings of deer and fish. Over time, Arctic Inuit adapted epigenetically to harsh conditions by developing a relatively low height, a layer of isolating body fat, a metabolism adjusted to marine nutrition, and resistance to cold climates (Fumagalli et al., 2015). Originally, only few newborns survived, creating the need for many births per family due to high frequencies of neonatal and infant mortality. Numbers of surviving children in the group were determined by alternating periods of access to food and starvation.

Research in Traditional Inuit Care

Hunter-gatherer caregiver mindsets and practices are still prevalent across the Arctic circle (Alaska, Northern Territories, Greenland, Finland, Russia). Valuable care traditions were mapped in research. The danger of incest due to isolation is inherent in the Inuit creational myth: a brother desires his teenage sister, but she runs away and becomes the sun goddess, forever chased by her brother, the moon. To avoid fatal inbreeding in isolated settlements, visitors from other tribes were often invited to have intercourse with local women. Considerable expertise in midwifery was inherent in Inuit groups (Archibald et al., 1996). The cradle and the baby sling were probably developed in hunter-gatherer cultures, allowing mothers to work and migrate while providing physical stimulation and enhancing attachment at the same time (Cassella, 2022).

In this culture, there was and still is little distinction between "parents" and "children," rather a strong undifferentiated group identity, regardless of age. For intergenerational constancy, children were named after and perceived as reincarnations of their ancestors. Avoiding internal group conflicts was vital for survival in a hostile climate. Even today, open disagreement is not allowed – saying "no" or "I disagree" is absent in language and conversations. Children were not disciplined by scolding or made to feel guilty. Instead, parents referred to a host of evil spirits to guide behavior: "*If you go close the ice edge, the sea monster will grab you!*". Extreme caution and impulse control exercises were another feature in upbringing. Parents gently and repeatedly provoked their toddlers emotionally in order to install adult self-control in situations critical for survival. A wealth of combined play and work skill activities were developed in the long Arctic winters.

Stress and Traumatic Effects of Colonization and Urbanization

The combined effects of colonization's alien diseases, deportations, and recent urbanization decimated many indigenous populations and created a traumatizing conflict between traditional and modern care practices. Due to Greenland's need for centralized services, mothers in remote settlements no longer give birth in their local environment. Even though infant mortality decreased by a factor four from 1973 to 1996, Greenland still has the highest neonatal mortality among indigenous peoples in the Arctic (lower in the capital of Nuuk than in remote settlements) (Friborg et al., 2004). The rapid shift from marine animal to modern diets caused an epidemic of diabetes, increasing babies' risks of birth defects, stillbirth, and preterm birth (Centers for Disease Control and Prevention, 2018). The aftermath of cultural trauma also causes excessive maternal substance abuse: smoking, alcohol, and drug intake during pregnancy (Houd et al., 2022).

Likewise, mental responses to cultural trauma in this non-aggressive culture produce self-destructive responses. Suicide ratios are 7.5 higher than those in Denmark, adding to the ten percent of infants and children in alternative care (Grønlands Statistik, 2010), compared to Denmark's one percent.

Initial interviews and dialogues during startup seminars revealed how traumatic separations occur from birth to adulthood, caused by the combined effects of colonization and urbanization. For example, a Social Board staff member described her childhood experience: "*I grew up in a small settlement on the East Coast. When I was five, two Danish social workers visited my parents. On the same day, I was sent to live with a foster family in a small Danish village. I didn't know why I was sent, or the Danish language, and I was so unhappy that I later tried to commit suicide. After six years in care, I was suddenly returned to my settlement. I had lost my Inuit language, and I was rejected by my family and friends because I was "too Danish". That's why I work as a childcare consultant today*".

Designing a Cross-Professional Teacher and Caregiver Education

In this population of 56,000 people – vastly spread across Greenland – more than 250 primary school teacher positions are vacant, and many staff are uneducated. In general, substitute professionals from Denmark don't speak Inuit and only stay for short periods. Greenland government invests much in remote settlement schools, but for schooling after 7th grade, teenagers must leave their families and live in urban school homes. Many teenagers are torn between teachers urging them to be educated and parents urging them to drop school and return home to continue their traditional lifestyle. As a result, very few pass the 10th grade, and six out of ten 18- to 25-year-olds don't complete youth education (Grønlands Statistik, 2022). During research, FS interviewed a school home youth: *"It's very expensive to travel, so I haven't seen my family for two years. When we talk on the mobile, my father keeps telling me and my sister to come home to fish, hunt deer and have children...We are often very lonely here. Last year, three of my school home friends committed suicide, and none of the staff talked with us about it."*

In response, FS developed and implemented a cross-professional education and training sessions for 25 municipality teachers and caregivers. The program aims at promoting a joint understanding of how to build secure relations in open dialogues with school children and teenagers, how to introduce regular communications and online meetings with parents, how professional secure attachment behavior can be practiced in group homes and classroom management, and also how to provide special needs teaching for children who suffer from learning disabilities due to early deprivation and separation trauma. Participants developed a common mindset to understand how the provision of a secure base is a prerequisite for play, exploration, and learning ability and continue to train colleagues.

Designing a Foster Family Consultant Education

Positive program feedback inspired the second request from the Board. The five Greenland municipalities are overwhelmed by lack of capacity to supervise and train the many foster and kinship families of every tenth infant or child. A social worker is often responsible for managing more than 110 placement cases in foster, group home, or kinship care.

After a second research and travel phase, 20 staff (pedagogues, social workers, family center staff, and psychologists) were educated as foster family instructors, following modules from home while training local groups of foster and kinship families. Sessions focus on how to prepare family members to receive a stressed child in care, how to stimulate babies and infants physically, and how to practice secure attachment behavior with insecurely attached infants and children, share caregiver childhood experiences of loss and recovery with children, help children create a unified social identity in cooperation with biological parents, and guide teenagers to prepare them for leaving care.

Posttraumatic Growth in a Former Hunter-Gatherer Culture

In the long-term cultural merger after colonization, 27% of the Inuit genome is now of Scandinavian origin (Kløvgaard & Christensen, 2018). This, combined with better services and widespread obesity among pregnant mothers, accounts for increased average birth weights. The former stunting in girls and boys has been replaced by average heights similar to Danish children (Kløvgaard & Christensen, 2018). Tuberculosis and other diseases have been eradicated, and children have fewer medical consultations than Danish children. Psychologists and other professionals notice that children in Greenland appear to recover better from trauma and be more resilient compared to Danish children, calling for further study in resilience.

The young generation of indigenous peoples work to recover by forming national, Arctic, and international networks and build a new national identity. Danish government now finances the “First Thousand Days” program to support young parents (Social- og indenrigsministeriet et al., 2020) and invests in a major program to prevent child abuse in a remote community in Eastern Greenland. FS participated in meetings headed by former Social Minister Martha Abelsen to coordinate NGO and government initiatives and advised Danish and Greenland Ministries.

Lessons Learned in a Hunter-Gatherer Culture

In Greenland, the general shortage of government and educated municipality staff is still a major challenge for all initiatives, as well as program cancellations due to frequent shifts in workplace for leaders and staff. Interventions must focus on strengthening municipal services and professional educations for the country’s own inhabitants. Due to the lack of data on outcomes for all public and NGO interventions in Greenland, the FS, the Greenland Social Board, and Professor Ask Elklit of Southern Danish University developed an accredited Inuit language version of the Strength and Difficulties Questionnaire for Child Development [SDQ] (Youthinmind, 2015).

Lessons from Partnerships in Extended Family Cultures

From 2012 to present day, partnerships in Asia and Africa provided lessons from the next cultural and evolutionary step in the organization of care, as the extended family culture began to replace the hunter-gatherer culture some 10,000 years ago. Hunter-gatherer tribes settled as farmers in family clans, and agricultural villages prevailed.

Adapting to survival by farming, caregiver-child relations was now formed in myriads of small self-sustaining villages. Spurred by the division of labor, farming gradually created a differentiation of work domains and gender roles. Ownership of property and paternal family authority hierarchies emerged, often favoring the eldest son. The need for ownership of limited arable land and ensuing family clan feuds (for example, the Italian vendettas) made bloodline kinship and strategic marriages vital for family inclusion and care. Starvation and death due to failed harvests and epidemic diseases were now major causes of child mortality, making numerous offspring important to ensure the constancy of future generations. Infants and children are still raised by group norms rather than by focusing on the individual child, an important concern for future program designs.

Experiences from Partnerships in Asia

A Foster Family Program for Japan

In 2012, child psychiatry professor Kamikado Kazuhiro from Nagano University visited FS and later translated and published the group home and foster family programs in Japanese as an instrument for the transition from orphanage to foster family care. However, attempts to introduce foster care were terminated, as it is alien for extended Japanese families to include children who are not considered blood related. The low social status of foster children and lack of post-care support produced high care leaver suicide rates, and one in four placements was terminated (Ito, 2021), which is a valuable lesson for understanding how family clan structures affect the progress of foster care development in many Asian and African cultures.

Research for a Program in Cambodia

With the FS partner SOS Children's Villages Denmark (hence, SOSCVD), exploration travels in 2016 assessed the relevance of a foster family program in Khmer, in cooperation with other NGOs and government (Fairstart Foundation & SOS Children's Villages, 2016).

In Cambodia's traditional Buddhist childcare, a new child is highly valued. Birth and care customs included talking with the baby in the womb, long-term breastfeeding, fathers taking over household chores to relieve the mother after birth, assisted by grandparents and sisters. Infants are not punished or shamed. Behavioral and moral rules are taught, and favors and appreciations can be taken away (Covar, 2006; Vivodin & Klaus, 2014). Child obedience is an important traditional value, but as the "teen age" phase in life was formerly nonexistent, professionals in all fields today are very insecure about how to handle teenagers and refrain from exerting authority over young people. Instead, teens join unsupervised and sometimes criminal peer groups.

The Impacts of Rapid Urbanization in Cambodia

Compared to Cambodia, few countries have experienced such rapid acceleration in urbanization. International rice companies have indebted village farmers and bought their lands, causing extreme poverty and migration. From 2010 to 2017, the population of the capital Phnom Penh almost doubled from 1.3 to 2 million, expected to double again in 2030, overwhelming public administration and services. A quarter of the population is younger than nine, and the under-five mortality rate is Asia's highest. Stunting and compromised development are seen in one out of ten infants (World Food Programme, 2019).

Poor urbanized parents must find other means of survival, with severe consequences for the coherence of the family. A representative interview with a traumatized mother in Phnom Penh: "*I have left my two small children back home with their grandparents because I work three jobs. My husband left for Dubai to send us money, but I haven't heard from him in two years – I fear he is dead. My two sons dropped out of school in 4th* *grade with their friends. In Thailand they can earn ten times more than here.*" SOSCVD decided to postpone a foster family version until government and the organization were better prepared. This research raised the general question of how to help world parents and children stay together as families at all.

Posttraumatic growth has been slow. The Khmer Rouge genocide further added to transgenerational trauma and slow recovery (Burchert et al., 2017). In response to increasing numbers of Cambodian orphanages, government set the goal of transferring 3500 orphanage children to family reintegration by 2018. As in many other countries, obtaining this goal has been delayed by a lack of government financing and a major lack of support after child reintegration (Lizarazu, 2018).

A Partnership in Indonesia to Train Orphanage Staff

Although traditional village care is quite similar to that of Cambodia, caregiving traditions are much more diverse, due to centuries of international trade and isolated cultures in hundreds of islands (Febiyanti & Yulindrasari, 2021). Traditional care emphasizes lifelong devotion and respect for parents and ancestors. In some areas, being disrespectful is believed to cause the birth of a handicapped child in the next generation (Febiyanti & Yulindrasari, 2021). One cultural difference observed in Bali is the preservation of an extremely strong and inclusive village care tradition. For example, a group of schoolgirls were the only tsunami survivors from a small island who stranded in a rowboat near a mainland village. Within a week, the village community had built housing and started educating the girls to help them make a living. Local communities can be strategic partners in interventions.

In partnership with the NGO ReAct Indonesia (Fairstart Foundation, 2016) from 2012–2014, 350 Muslim, Christian, Buddhist, and Hindu orphanage leaders participated in jointly arranged FS training seminars. Twenty orphanage staff were further educated as instructors in Bali and Flores, training groups with FS sessions in the common Bahasa language.

Stressors in Indonesian Culture

This partnership revealed the challenges of public services: only 250 social workers were responsible for overseeing Indonesia's 8000 orphanages with 500,000 children, and nine out of ten are sent by poor parents unable to pay for school and education. Many children were trafficked or illegally adopted. The consequences of meager public monitoring are exemplified in a video interview with a young girl in an orphanage, working to educate herself while she and other girls were responsible for the daily care of all children (Fairstart Foundation, 2014). The orphanage was owned by an old man and financed by two daily buses of Australian tourists who paid him 50 dollars to see the children perform traditional dances, and to hug and photograph them.

In posttraumatic and economic growth, economic progress has reduced under-five mortality from 220 per 1000 to 10 in 2020 (The World Bank, n.d.). Many international and national interventions and initiatives occur. Since 2014, the Martin James Foundation, the NGO Harum Family Center, and Indonesian government cooperate to introduce foster care, family reunion, and community care programs (Cousins-Kamari, 2021).

Lessons Learned from Extended Family Cultures in East Africa

In 2017, FS and SOS Children's Villages Denmark (SOSCVD) agreed on a partnership for East Africa, in response to the 2009 UNICEF call to close world orphanages in favor of family reintegration and foster and community care (Hope and Homes for Children, 2020). The role of FS was to develop staff educations and group training programs for groups of SOS mothers and foster families, starting in Zanzibar, Tanzania, Kenya, and Rwanda. Since 1949, SOS Children's Villages International (SOSCVI) has built village homes for children worldwide, including high-quality internal schools. While four to six children in each village house benefited from lifelong relations to an educated SOS mother and the majority of children succeeded in education, they were also separated from parents and their culture. For many care leavers, the shift from close daily care in protected villages to independent living in a challenged society was traumatic, and SOS mothers were not allowed to have their own children.

In consequence, SOSCVD initiated the program "Quality in Alternative Care" to support local community strengthening, financed by SOSCVD and Danish government's foreign aid DANIDA department (Loilang'akaki & Birungi, 2019). This multi-dimensional strategy includes building local health care centers, microfinancing small businesses for groups of women, and SOS village mothers moving out to become local foster parents.

Countries first covered by FS for SOSCVD were Zanzibar, Tanzania, Rwanda, and Kenya with online classrooms in English and group training sessions for foster and kinship families in English, Swahili, and Kinyarwanda versions. Today, Ethiopia is included with an Amharic language version, and a version for Somaliland is planned. At present, 200 East African instructors have been educated and have trained the foster and kinship parents of some 35,000 children and youth in care. New student groups are included: Tanzanian government sends social workers from four districts in Dar Es Salaam working to support parents, and university and government staff from several countries participate.

Research in Traditional Sub-Saharan East African Childcare

Very small clusters of hunter-gatherer family cultures still exist in East Africa: Sabue, San, Hadza, and Sandawe tribes share their 20,000-year-old genetic origin and the click language Khoisan (Sexton, 2019). As a center of trade routes for millennia due to trade winds spanning from the Far East and Arabia, the East African region now hosts a rich variety of religions and cultures. Despite this diversity, the common organizations in agricultural villages were variants of extended family systems, still predominant in the common Muslim and Christian societies.

In traditional villages, numerous births are necessary to counter former mortality rates as high as 400 per 1000 (Thomas, 2020). At birth, delivery of the child is assisted by village women. The newborns are bathed and named after ancestors and start years of breastfeeding, carried in slings during early infanthood by their mothers. Infant care and the upbringing of girls belong to groups of village women (not solely to the mother), while men head the family and are responsible as family providers and guides for boys and young men (Wadende et al., 2016). Even today, a foster or kinship family must have a male member as its formal head.

Every step of intergenerational transmission for social inclusion and life skill learning is marked by fixed rituals, such as the Akamba community ceremony four days after birth, transforming the newborn from a spirit to a family member when named by its grandmother. For each step toward adulthood, care practices include specified tasks and social responsibilities, such as learning hygienic habits, social obligations in caring for younger siblings, and moral values. The shift from childhood to adulthood is short, marked by a ritual. Learning happens by active participation in synchronized social activities: infants participate in daily chores, traditional play, storytelling, and singing (Wadende et al., 2016). An observation is that women in coastal Zanzibar still plant and harvest weed along the coast by low tide. From early infanthood, girls accompany their mothers and learn this skill by heart.

Respecting parental authority is mandatory, and deviance from behavioral rules is often met with physical and mental disciplining, such as slapping and shaming the child. For example, at a startup seminar in Zanzibar, two dignified Muslim ladies were clearly sceptic during the program presentation. In a dialogue to understand, they unanimously stated that "*Our children are always obedient. They don't speak unless spoken to, and they do whatever we tell them to do. If we didn't shame them when they misbehave, we would deserve shame as parents ourselves. And if this program makes our children behave like Western children, we will have* *nothing of it!"*. A long plenum discussion ensued about the alternative of authority by secure care before participants considered and engaged enthusiastically in the program.

The importance of the family clan's ownership and heritage of arable land formed protective networks for all child relatives who are considered blood-related. For example, Muslim Kafala and Christian codes of conduct oblige any family to take in the children of deceased or poor relatives. An example from an interview with an elderly rural woman in Rwanda shows that she cares for three of her own children, three from her brother who was killed in the Hutu conflict, and three from a sister who died from AIDS. In spite of her profound exhaustion, she obliges to this code.

Stress and Traumatic Effects of Urbanization in East Africa

Due to the continued tradition of numerous births per family and lack of prevention, the population of Sub-Saharan East Africa (Burundi, Comoros, Djibouti, Ethiopia, Eritrea, Kenya, Rwanda, Seychelles, Somalia, South Sudan, Sudan, Tanzania, and Uganda) is growing almost exponentially. With a growth rate of 2.3% annually, UNFPA data show that Eastern Africa already in 2010 had a total population of 327 million, thus having advanced into the most populated region in Africa. UN projections predict the population in all sub-Saharan countries to be 2.5 billion by 2050. In some of the poorest countries, under-eighteens constitute over 50% of the population (Statista, 2022). Under-five mortality remains a major public health challenge, peaking in East Africa where estimates range from 51 to 92.2 per 1000 (Tesema et al., 2022).

Industrialization, climate change, and unfavorable world trade deals cause rural families to seek to the cities. East African cities are among the fastest growing in the world (Society for International Development, 2010), overwhelming public services and planned city development in general. In particular, due to the impact of HIV/AIDS, a large numbers of children have lost either one or both parents – 15.1 million according to a recent estimate. The consequences are obvious: a high vulnerability of many children, an enormous strain on extended families, and the exhaustion of conventional public or NGO child protection and care systems, especially in a region with very limited social services infrastructure. The COVID-19 epidemic accelerated these challenges: To FS, SOSCV reported a triple in numbers of street children and estimated that 160,000 girls more than normally became pregnant during school lockdowns.

Stress and Trauma in Families

For the ability of urbanized families to care for their infants and children, poverty and unemployment take a united toll on the cohesion of family networks. For large numbers of unemployed men (in one country up to 90%), it is still shameful to be unable to provide for the family and others have to work at long distances. Consequently, many go from divorce to societal exclusion, followed by social demise and substance abuse. They frequently form serial families and leave their partner when failing to provide, and one-third of children in Tanzania and Kenya grow up without their father (Posel & Devey, 2006). When also stressed by public shaming, many commit suicide – African men have the world's highest male suicide rate (Bataliack et al., 2022).

The urban disintegration of family relations and extended family networks is partly compensated by the extended family's flexibility. A third of children reside with an adult male who is not their father. In many African cultures the term for father, "Baba," still pertains to any male heading the household, as long as they are relatives or even second husbands (Morrell, 2006). In our interviews with East African fathers, their most common statements were the undermining of paternal authority and a lack of respect for elders and traditional social responsibilities. Fewer young men abide to tradition and often leave a pregnant woman, adding to numbers of women at risk.

Adding Training Sessions to Support Suburban Families

On the request from Tanzanian government to SOSCVD, social workers from four districts in Dar Es Salaam now participate in FS educations. Their daily job is to help suburban families stay together, counter the effects of poverty. For these professionals, a number of group training sessions for social workers in suburbs were added, such as Working with Street Children and Engaging Fathers in Care for Children and Youth. In several East African FS countries, government and university staff also participate in FS educational programs. As a result, elements of FS have been included in national programs.

Posttraumatic Growth in East Africa

African economies are growing, and the asset of a young and energetic population holds a future promise for families if governments are able to strengthen care for children and educate large numbers of school-age children. Regional governments revise family and child legislations, and cities form Pan-African networks to coordinate health services and interventions for families and children. In a four-year agreement with FS, SOSCVD plans the upscaling of FS to more African countries. Program development continues to help urbanized families adapt to city life.

Lessons Learned from Asian and African Extended Family Cultures

One important lesson from urbanized Asia and East Africa is the need to preserve the positive elements of traditional infant care also in urban life – strong protective family networks and kinship care, securing infants at risk. The practices of breastfeeding and carrying infants in a sling provide stimulation and enhance early secure attachment. The parenting practices of teaching life skills in daily activities prepare children for adult independence. Initiation rituals mark stages from pregnancy to adulthood, and provide a clear set of roles at each new stage of development. These early care qualities were core elements in the evolution of the attachment system, and they are clearly deteriorating in all urban cultures. FS training sessions aim to include these traditional practices.

Lessons Learned from Urban Family Cultures in Europe

Two European Pilot Programs

The present FS program was preceded by the author's work with partners in ten EU countries. Europe is where large-scale urbanization first happened and urban care cultures evolved, as families gradually have adapted to urban life since the Middle Ages.

From 2008 to 2012, the European Commission [EU] invested 762,000 Euro (660,000 USD) in two EU Lifelong Learning Fairstart projects, designed by the author and managed by the Danish School of Social and Health Care in Aarhus, Denmark. NGO and district government staff from Denmark, Germany, Italy, Greece, Poland, Romania, Bulgaria, Russia, Turkey, and Latvia met regularly in Denmark and also visited each other's countries. Participants received a handbook for instructors in group training. Videos of best care practices were recorded locally for a number of online group training sessions in local languages, conducted by instructors.

In the first project (2008–2010), an instructor education handbook and sessions focusing on infant care for orphanage staff groups were designed, implemented, and evaluated. Handouts with pre-and post-questionnaires for caregiver well-being and child development were distributed by instructor students. Valuable lessons were learned. On the positive side, group home caregiver mindsets and practices were transformed as intended. From being sole material providers, a new professional identity as attachment figures and relations builders provided a theoretical mindset and a new caregiver culture. Smaller groups were formed, uniforms were discarded, hammocks and cradles replaced hospital beds, physical stimulation and play activities were introduced. Care was organized in smaller groups, and a group session to revise staff workplans enhanced continuity in caregiver/child relations.

Due to requests from partners, a foster family version was developed in a subsequent project (2010–2013). Local foster parents benefited from guidance and dialogues in peer groups, and project managers and instructors exchanged experiences from their respective countries. On the challenging side, participant feedback reported high travel and accommodation expenses for recurring seminars. Retrieving data from translated paper questionnaires proved time-consuming and difficult to comprehend for many caregivers. Planning for future trainings by instructors was not part of the project, reducing the impact of the pilots. On the request of the EU Commission, recommendations for EU educational standards in Alternative Care were summarized in a report (Rygaard, 2013). Results were presented at the 2012 Istanbul Congress of the European Federation of Psychologist Associations [EFPA].

Effects of Urbanization in the European Union

The two EU Fairstart pilots focused on the third evolutionary step in social organization and childcare: the urban family. The European Continent was the first region where industrialization and mass production forced farmers into cities. In the century-long process of industrialization, millions of families have been uprooted and migrated to survive in this novel – and literally unfamiliar – environment. Today, Europe's population is the world's most urbanized, and projections suggest 90% by 2090 (Clark et al., 2018). Developments in Europe may thus serve to prepare for challenges in less-urbanized countries.

Traditional Care in the Transition to European Urbanization

In medieval Europe, investing in care for individual children was weighed against the risk of losing them: studies of medieval under-five mortality suggest that 25% may have died in their first year, 12.5% between age one and four, and 6% between five and nine (Orme, n.d.). The merciless struggle for survival was reflected in two medieval Danish proverbs: "*A child should be fed like a bird, have clothes like a newly shaved sheep, and be beaten with a stick like a donkey*" and "*The seven-year-old is fit for adult work.*"

From this era and forward, two growing stressors have killed millions of parents and children: from the escalation of local clan conflicts over farmland into wars among nations to recent international warfare. Second, the densely populated cities were – and still are – the ideal habitat for the spread of infections and viruses. Care for thousands of orphaned street children in Eastern Europe was first organized in the sixteenth-century Istanbul. The Osman sultan Süleyman and his Christian wife Roxane decreed that every mosque built should have a Madrasah, a school home hosting orphaned children – a task performed by nunneries in Catholic Western Europe. Later, families impoverished by industrialization in the eighteenth-century London made Thomas Coram establish the Foundling Hospital, London's first of many homes for babies abandoned by mothers. In cities, the former extended family upbringing and child labor now tended to be replaced by public and private orphanages and schools.

Contemporary Stressors for Europe's Urban Families and Caregivers

Particularly in Northern Europe – and in particular for women – urban life creates a threefold dilemma between the state's need for work force, women's rights as providers to equal education and income, and the task of parenting their children. Swedish and Danish parents have the longest combined European work hours (Skov, 2015) and the highest divorce rates. From 1965 to 2016, the EU marriage rate declined to half while the divorce rate doubled, most frequent in Northern Europe, and more divorces happened in families with infants. In Scandinavian Denmark, half of all marriages end in divorce, most frequently after five years, and a third of all Danish parents are single providers. Many studies indicate that the ensuing stress takes a heavy toll on family cohesion and child development. A Danish longitudinal study of 52,000 children born in 1980 finds that rich and middle-class parents divorce later and much less frequently than low-income parents. Compared to those divorced, the child's educational level at age 32 was doubled if parents stayed together until their children left home (Holm, 2014).

Mental Health, Early Separations, and Frequent Shifts in Children's Relations

How can the urban paradox of better physical and deteriorating parent and child mental health be understood? As one of Europe's most urbanized countries, Denmark illustrates a hallmark of urban life: the tendency toward separations between parents and infants, from pregnancy to adulthood. While mothers in labor once gave birth in the tribe or the village, industrialization requires centralized expertise. In consequence, only three percent of Danish babies are born at home (Sundhedsdatastyrelsen, n.d.). World Health Organization [WHO] now warns against the growing use of potentially risky artificial interventions such as caesarean section, practiced in one of four European births (WHO, 2021).

Looking at infanthood, the development of attachment in infanthood is at risk due to still earlier separations in the daytime, as both parents are away for education and work. Nine out of ten Danish infants of ages 1–3 years are looked after in daycare or kindergarten for 30 hours a week, and studies find elevated levels of the stress hormone cortisol in daycare infants younger than one year (Vermeer & van IJzendoorn, 2006). For caregivers, the average job length of pedagogues and teachers has fallen dramatically, and staff per child ratios are dropping. For immigrant refugees, daycare and kindergarten attendance is now mandatory, and mothers who traditionally would be at home with 3–6 children are forced to work and join education at the risk of losing subsidies. The lack of continuity in infant relations may account for long-term mental health effects in parents, youth, and children. A study from the Danish Board of Health based on 183,000 questionnaires describes a dramatic increase in poor mental health for the next generation of parents, the 16- to 24-year-old men and women (Sundhedsstyrelsen, 2021). A similar decrease in parental mental health in the EU is described by Eurofound (2022).

Posttraumatic Growth in Europe? A Mixed View

The long-term adaptation to the urban environment produces profound reorganizations in all areas of reproduction and family care mindsets, almost in reverse to former challenges and strategies. Physical health stressors have been eradicated, and under-five mortality has reduced from 12 to 3.8 per 1000 since 1990. European families enjoy a high and growing economic income equality (Filauro & Fischer, 2021). Life expectancy is growing, prolonging all phases of life: infancy, childhood, teenage years, parenthood, and old age. In the view of one in five children live in poverty, the EU parliament issued a child guarantee charter.

However, reproduction and fertility numbers present new challenges. The mean age of women at the birth of first child rose from 24 years in 1970 to now 29.5 years, ranging between Bulgaria's 26.4 to Italy's and Denmark's 31 years, adding to fertility problems in the gap between the biological and social best age spans for motherhood. In men, sperm quality presents a steady decline of 32.5% between 1965 and 2015, and 15% of Europe's adult population is infertile (Eurostat, 2022a) – in the author's view, yet another indicator of the gap between our evolutionary programming and the present environment for families.

The numerous childbirths in extended families are history. In 2021, half of all child family households in the EU were one-child households, 38.6 percent had two children, and only 12 percent had three or more children (Clark, 2022). In sum, since the 1970s, no EU country has been able to reproduce its population by the necessary birth rate of 2.1 child per family, now at 1.5 in 2020 (Eurostat, 2022b). A major concern for governments, as a well as a source of stress for future and present parents, is a 15% chance of infertility. Recently, the pressures from climate change and global crises have caused a split in the political unity of Europe's public infant and child policies, and also in EU mental health initiatives to enhance the peaceful inclusion of refugee families in urban life (Cullinan, 2022).

More Infants and Children Are at Extreme Risk in Europe

Once again, a pandemic and international and European war separate parents and children. In 2009, only one million or one in one hundred European children were in alternative care (Rygaard, 2021). By the end of 2021, the number of non-EU refugees in Europe was more than 7 million, an increase of 3 per cent from the previous year (UNCHR, n.d.). From March 2022, the war in Ukraine produced 2.5 million internally displaced children, and two million Ukrainian children were received in neighboring countries (UNICEF, 2022).

Summary and Key Points

Perspectives on Future Infant Mental Health Interventions

The global and local analyses underlying the FS programs pertain to urban risks, local strengths, and posttraumatic growth in the transition to urban living. One bias should be observed: The FS program targets infants and children in nonparental care and high-risk families, a fraction of the much healthier world population. Nevertheless, the urban environment presents a general discrepancy between the environments for early care where attachment evolved in evolution (the hunter-gatherer and extended families) and today's urban environments for infant care. Compared to the characteristics of best environments for early care in this chapter, urbanization tends to weaken caregiver-child relations continuity and coherence in social networks, to shorten the constancy of marriages, and to cause multiple stressful and traumatizing separations from parents and caregivers from birth to adulthood.

Decentralized Units – A Universal Goal for Future Interventions?

In the light of the overview presented, the global analysis and the local program implementations offer a general question for further studies: How can ECMHC interventions strengthen the social and professional networks for parents and daily caregivers in cities, enabling them to form small secure units and local groups for infants and children? Can the saying "it takes a village to raise a child" be replicated for secure groups in cities by creating social units across the lifespan, where continuity in relations is the key word? What comes to mind is district centers where parents-to-be, pregnant parents, young families, children, teenagers, and the elderly can profit from a cross-professional staff group. For example, many Danish kindergartens are now situated next to homes for the elderly, and both parties flourish in loving relations. As a member of the Psychology Coalition at the United Nations [PCUN] group for migrant children, the author follows work to cooperate with New York City Council in care for refugee families, a model to be replicated in other cities.

Goal Proposals Derived from Local Partnerships

The global and local analyses highlight the success of interventions to reduce under-five mortality rates to a record low across the world, also in developing countries. Rates are still a little higher in rural and settlement areas where all social services have been reduced after migration. Two goals may be derived from this: helping more mothers give birth in their local environment or at home, and initiatives to reduce the use of artificial birth aid procedures to a minimum. In the Netherlands, a third of births happen at home after decentralizing birth units across city districts, and the use of anesthetics is rare (van den Berg, 2022). The global and local analyses show that infant mortality is now higher in rural areas and remote settlements than in cities. A development calling for creative solutions for the dilemma of giving birth in familiar surroundings versus professional birth aids monitoring. One such initiative is the Finnish Tays for Life unit, where relatives participate during birth, are instructed in care by staff, and stay in a family hotel afterward (Tays, 2022).

The impact of reductions in under-five mortality is also very different, depending on culture (as described in Bloch's theory of uneven speed in the adaptation to city life). In upcoming cultures where extended family mindsets still prevail, the outcome is an exponential population growth that threatens the capacity of governments and NGOs combined. They now experience the same boomer generations that once emerged in postwar Europe, in China, Japan, and the USA (for an analysis of the USA, please see (Rygaard, 2020)). These countries are adapting gradually to urban life, but now face the challenge of fewer government resources for young parents and their social services due to budgets for an overwhelming number of retired work force.

Conclusions

In this short-term perspective presented, migration and the struggle to adapt in urbanization create many conflicts between past and present caregiver mindsets. Economic inequality, racism, and social disintegration challenge governments, and agreement on health care policies is often paralyzed by antagonistic family policies. In a long-term perspective, these examples of transitions offer the prospect of posttraumatic growth: peaceful intercultural cities, where parents and caregivers benefit from good physical and mental health, and children enjoy secure attachments across the lifespan.

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Part II

Infancy and Early Childhood Mental Health Assessment

10

Infancy and Early Childhood Mental Health Assessment: Overview

Miri Keren

As the first 5 years of life are a period of major developmental changes with quite a lot of individual variability in pace and course, a major challenge faced by clinicians is to decide what behaviors fall into the normal variability range and what are signs of early psychopathology. The cutoff point is not always easy to determine, especially when one considers cultural variations in defining normality and abnormality. It is still a major responsibility that we, IMH clinicians, have, to be able to determine whether and what type of intervention is needed for a young child and his/her caregivers.

Assessing mental health first requires a working definition of infant mental health. According to ZERO TO THREE Infant Mental Task Force, “Infant Mental Health” (IMH) is the developing capacity of the child from birth to 3 to experience, regulate (manage), and express emotions; form close and secure interpersonal relationships; and explore and master the environment and learn—all in the context of the caregiving environment (2023). The underlying general assumption is that external behaviors express the infant’s inner subjective experience (Lieberman, 1998). Assessing the infant’s capacities is an ongoing process that involves gathering data from parents, caregivers, teachers, as well as from observations of behaviors and interactions. Over many years, various tools have been developed to make these assessments more objective and reliable. In the early 2000s, a *Handbook of Infant, Toddler, and Preschool Mental Health Assessment* was published (DelCarmen-Wiggins & Carter, 2004), focusing on assessment tools and procedures aimed at early detection and prevention in different settings and cultural contexts. Assessing the very young child’s emotional, cognitive, social, linguistic, and motor strengths and weaknesses is necessary not only for early detection of problematic behaviors but also for determining the type of educational setting that is optimal for young children with significant developmental disabilities. Hence, observing the young child’s behaviors and interactions across home, office, and school settings is the only way to have an integrated and reliable picture of the young child’s emotional and developmental status. Contingently with the infant’s total dependence on caregivers, one cannot assess a young child without assessing the caregivers’ own strengths and weaknesses and the quality of the parent-infant relationship. The use of the multiaxial structure of the DC 0-5 classification system, which encompasses both the child’s behaviors and his/her relational and environmental context, enables to combine diagnoses and formulation (ZeroToThree, 2016). Diagnosis is the identification and classification of the infant’s symptoms, while formulation represents the

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understanding of the infant's symptoms in the context of both the infant's and the caregivers' risk and protective factors (biological, developmental, social, and scholastic). The need and the rationale for classifying various symptoms observed by clinicians in their daily practice with very young children and their parents led and still leads, to intense, sometimes even quite emotional discussions among IMH professionals about categorization in spite of the rapid developmental changes and stigmatization (von Klitzing, 2017). The debate about the pros and cons putting diagnostic categories versus dimensional approaches in the conceptualization of significant symptoms in infancy may remind us of the "nature/ nurture" debate. We probably need both dimensional and categorical frameworks in order to comprehend the complexity of development, behavioral problems, and psychopathology at any age, but especially in infancy where contextual factors have such a prominent impact on the infant's emotional, developmental, cognitive, and behavioral functioning. In a way, this is what the multi-axial structure of the DC0-5 five axes was meant to reflect: the first axis is categorical, the other four are dimensional. In addition, the multi-axial structure enables the clinician to create an integrative picture of the complex cases where psychological and/or medical risk factors in the infant's family and the environment interact and influence outcomes.

The chapters in this second part of Volume 2 embrace different aspects of the assessment of young children's mental health and functioning. In Chap. 11, Zeanah and Mirzoy present an overview of the background, the rationale for and the content of the DC: 0-5. They emphasize the underlying principle of having empirically grounded criteria for the various disorders as well as prioritizing those disorders that are clinically meaningful to clinicians in different parts of the world. They also describe the changes from the previous versions of the Diagnostic Classification, such as the insertion of the diagnosis of Relationship Disorder on Axis I. Though all of the axes are substantially revised, the most different change is to Axis II, the relational context axis. In addition to presenting a clearer dimensional approach to ratings of primary caregiving relationships, DC:0-5 also introduces ratings of the broader caregiving environment. Chapter 12 deals with assessment and screening tools. Puura and Nugent describe various tools for early detection and assessment of potentially problematic behaviors in infants, while considering cultural and contextual factors. The authors end with several important suggestions, including to expand early screening for relationship disorders, depression, and self-regulation problems; to train professionals in mental health, pediatrics, early childhood education, child welfare, and other related professions to recognize risk factors; to ensure that undergraduate, graduate, and continuing professional education include content on infant mental health; and to support Obstetrics and Pediatrics Departments to screen for at risk situations that may precipitate or exacerbate mental health conditions. Last but not least, they recommend to integrate infant mental health consultations into programs for parents, childcare, early education, well-child health services, and home-based services. In Chap. 13, Ross-Donaldson and colleagues address the importance of incorporating diversity-informed practice while assessing the parent/caregiver–infant relationship. They show how the Western-oriented assessment tools may be totally invalid for Indigenous people, and how much assessors may be dangerously biased. They highlight the impact of social, economic, cultural, historical, and political contexts on these relationships. Not less important, they discuss the role of the family-assessor relationship as well as the assessor's perception of the relationship. They suggest using both the DC 0-5 cultural formulation and the Irving Harris Foundation Diversity-Informed Tenets to increase the assessor's critical self-reflection and awareness of the cultural complexities. They end their chapter with the following recommendations for assessors: Be intentional and self-reflective in identifying your biases; know the power you hold when judgments are made based on personal preferences or the views of the dominant culture; identify tools that help you better understand yourself, your preferences, and your conscious and unconscious biases; and keep in conscious awareness that historically, dominant group norms are the norms by which subordinate groups have been judged. During consultation/supervision, discuss concepts of dominant and subordinate group dynamics and history, and remember that the assessor's tool is only one piece of the story in exploring the caregiver-child relationship and other considerations should be the companion for decision making. Chapter 14 focuses on the assessment of adverse childhood experiences. Morris and colleagues describe psychometrically strong and easy-to-use assessment tools of both early adverse and positive experiences for both the infant and his/her caregivers, which influence development and parenting. They discuss a selection of well-supported assessment tools for screening trauma and adversity among young children and their family system. They emphasize the need to have identifiable cutoff scores for interpretation that can inform next steps in further assessment to support treatment planning. They describe the ICARE model that provides a framework for examining both adverse and protective experiences, and can be used as a research tool as well. Finally, Wesner and colleagues, in Chap. 15, strongly advocate for ways of addressing equity by decreasing measurement disjuncture in Indigenous communities. They remind us that Indigenous communities have been assessing and promoting infant and early childhood mental health for centuries through relational practices and intergenerational systems of care. Western worldviews and priorities among assessors have resulted in measurement disjuncture. What existing measures tell us about young Indigenous children often cannot be trusted to be reliable or valid, and these measures often do not measure outcomes important to Indigenous families and communities. The authors propose a common language for measurement across a cultural continuum, with illustrative examples, and end with suggesting strategies to improve the field of measurement in Indigenous communities. Great emphasis is put on an ongoing respectful dialogue between the community and the assessors: looking for what is right and culturally acceptable for Indigenous caregivers, reducing the burden of measures, and finding more holistic ones.

While assessment and making diagnoses are at the core of clinicians' daily responsibility and mission, many other professionals in the field of infant mental health use assessments to understand and study more about individual differences in infant mental health and development. The clinical goals of infant mental health assessment and diagnosis include screening to identify children needing health and/or educational support, assessing the child's strengths to diagnose developmental delays or special needs and weaknesses, diagnosing psychopathology and planning for intervention, and assessing the quality of the parent-infant relationships. The field of IMH has developed based on Western-oriented theories, concepts, and measures, while these are probably irrelevant for non-Western and Indigenous families. Hence, the capacity for the assessor's self-reflection and awareness of potential cultural biases is essential, as well as the development of culturally fit measures. This is true for research as well as for clinical and educational teams. The authors of the five chapters in this section have indeed emphasized the issues of diversity, equity, and wide cultural variations in assessment, understanding development, and, for clinicians, diagnosing infants and parents and their relationship. An additional key point to keep in mind is to be aware of the need to assess both adversity that may affect development negatively and protective experiences in development is to be aware of the need to assess while assessing the infant and his/her caregivers.

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11

Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood, DC:0-5

Charles H. Zeanah and Silai Mirzoy

In 2013, ZERO TO THREE, a multi-disciplinary professional organization, with policy, education, and professional support missions, commissioned a task force to revise and update *DC:0-3R™ Diagnostic Classification of Mental Health and Developmental Disorders,* which had been published in 2005. The task force, with the backing of ZERO TO THREE leadership, determined that the revision should be substantial and should derive from considerable research on psychopathology in young children that had recently appeared. Five years later, *Diagnostic Classification of Mental Health and Developmental Disorders, DC:0-5™,* was published. In this chapter, we review the background and context that led to the creation of this nosology and provide an illustrative overview of its content.

Why a Nosology of Early Childhood Disorders?

Rationale

Although it is increasingly accepted that infants and young children may be developing on maladaptive developmental trajectories, we still may question whether deviant behaviors and expressions of emotion constitute psychiatric disorders that can be defined categorically. One may consider that a nosology of psychiatric disorders in young children allows clinicians, researchers and policy makers, in different parts of the world, to communicate with colleagues about patterns of painful or impairing behaviors they observe—their prevalence, course, response to treatments—as well as risk and protective factors that moderate impairment and outcomes. Autism, for example, has been defined in many different ways, at different times, and by different groups. Without an agreed upon definition of what we mean by the term, it is difficult to learn how best to meet the needs of affected children. A second concern is about stigmatizing individuals with diagnostic labels. In fact, although we assess individuals, we diagnose disorders. A child *has* but not *is* ADHD, much as the child has but not is diabetes. The purpose of providing a diagnosis to individuals is to allow for better access to care and support that is geared toward their unique experiences with the ultimate goal of alleviating distress in that moment and promote measures to prevent further difficulties or disorder in the future.

Why Diagnose Babies?

In addition to the concerns mentioned above, the notion of diagnosing babies is especially

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objectionable to some (von Klitzing, 2017; Zeanah et al., 2017). For many, thinking of a baby or toddler conjures up images that are hard to reconcile with mental illness. It is more palatable to think of young children as demonstrating risk factors rather than psychopathology. On the other hand, we now have decades of research demonstrating that infants and young children may display impairing symptomatology that causes distress and serious developmental risks (Zeanah, 2019). In fact, epidemiologic studies indicate the prevalence of psychiatric disorders in preschool children is almost as great as the prevalence of disorders in children, adolescents, and adults (Egger et al., 2006; Gleason et al., 2011). Given these findings, a nosology of disorders may be viewed as enhancing access to helpful interventions that can positively influence young children's developmental trajectories.

Others may note that given the rapidity of brain and behavioral development in the earliest years of life, perhaps young children are changing so rapidly that concerning behavior may be merely transient perturbations rather than true symptomatology. Nevertheless, we now have data indicating that the rate of persistence of symptoms and disorders from preschool to childhood is roughly equivalent to the rates of persistence of disorders from childhood to adolescence and adolescence to adulthood (Briggs-Gowan et al., 2003; Cohen et al., 1993; Meltzer et al., 2003).

Finally, some are more comfortable considering deviant behaviors in infants and young children to be risks for subsequent psychopathology rather than manifestations of already established psychopathology. This perspective, however, fails to account for demonstrations that infants and young children may experience painful and sometimes impairing symptoms, which is indicative of already existing psychopathology that warrants treatment. Further, symptoms in young children may reflect broader relational problems within the family. Failing to appreciate the distress and impairment of symptoms makes accessing effective treatments for young children more difficult.

Alternative Approaches

Even for adults, the usefulness of diagnoses is often questioned. The descriptive approach of contemporary psychiatric nosologies is far different from most medical diagnoses that derive from understanding etiologies and pathophysiology. Even with modest goals such as aiding in developing a treatment plan and predicting outcomes, psychiatric disorder categories fall short of most medical diagnoses.

Alternative approaches have been proposed. It is increasingly clear that most psychiatric symptoms are continuously distributed, meaning that any classification system, by necessity, imposes an arbitrary distinction between disorder and no disorder. The Hierarchical Taxonomy of Psychopathology (HiTOP) has been proposed by an international consortium of psychologists and psychiatrists as a new approach to diagnosing mental disorders (Kotov et al., 2018). To address comorbidity and symptom overlap, the HiTOP approach is to classify dimensions of psychopathology at multiple levels within a hierarchy. At lower levels of the hierarchy, single symptoms may be targeted, whereas at higher levels, treatment is more broad-based and comprehensive. However, dimensional values have limitations. Clinicians still must make categorical decisions—case or no case, for example, and treatment or no treatment.

Another approach, proposed by the National Institute of Mental Health, is the Research Domain Criteria (RDoC), which characterizes mental disorders by incorporating dimensions of behavior, thought patterns, neurobiological measures, and genetics (Insel et al., 2010). This is also a dimensional approach, but one that is explicitly tied to neuropsychological measures. The goal of the RDoC approach is to attempt to link neural substrates to psychopathology. Nevertheless, this system has not yet attained clinical utility.

Challenges remain before these alternative approaches are applicable in clinical practice and become more clinically useful than current categorical approaches. Therefore, the DC:0-5 Task

Force concluded that alternative approaches are still far from being better guides for treatment and better predictors of outcomes than extant diagnostic categories, especially for infants and young children.

History

The impetus for creating a nosology of early childhood disorders arose from frustration among infant mental health practitioners who found extant alternatives unhelpful in describing psychological symptomatology in young children. Though longitudinal research was limited, there was a strong belief at the time that early manifestations of maladaptation reflected both risk for subsequent disorders and current suffering and/or impairment.

DC:0-3

In 1987, ZERO TO THREE created a Diagnostic Classification Task Force led by Stanley Greenspan and Serena Weider. The Task Force was international and multi-disciplinary and drew upon published reports, primarily case reports, and the experiences of the members. Criteria for disorders were derived from expert consensus. In 1994, the *DC:0-3™ Diagnostic Classification of Mental Health and Developmental Disorders* was published (ZERO TO THREE, 1994). In keeping with the multi-axial approach of DSM-III-R (American Psychiatric Association, 1987), a 5-axis system of classification defined clinically relevant disorders for infants and young children. Axis I listed the primary diagnosis, Axis II a relationship disorder classification, Axis III included medical and developmental disorders, Axis IV listed psychosocial stressors, and Axis V described the young child's functional emotional developmental level. The disorders defined were all asserted to be evident in young children and not defined in any alternative nosologies.

RDC-PA

DC:0-3 sparked interest in investigators interested in studying early childhood psychopathology. Sponsored by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, a group of investigators formed a task force who developed research diagnostic criteria for disorders identified in children less than 6 years old. The rationale for this work was that well-operationalized diagnostic criteria could be reliably applied within standardized assessments across multiple samples. The group of investigators met in 2000–2002 and produced the Research Diagnostic Criteria-Preschool Age (RDC-PA), hoping to accelerate systematic research on psychiatric disorders in young children (Task Force on Research Diagnostic Criteria: Infancy and Preschool, 2003).

The group reviewed research and proposed criteria for attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, major depressive disorder, posttraumatic stress disorder, reactive attachment disorder, two types of sleep disorders, and 6 types of eating disorders. The investigators noted, "The field is now at a point where face validity of many disorders is no longer an issue, as it might have been just 10 years ago. The next step is a more systematic and large-scale effort to study psychiatric disorders in infants and preschool children" (p. 1510, Task Force on Research Diagnostic Criteria: Infancy and Preschool, 2003).

DC:0-3R

In 2003, ZERO TO THREE selected and appointed a Revision Task Force. The group was to draft a revised version of DC:0–3, providing needed specifications and clarifications of criteria to allow reliability among clinicians and to advance the evidence-based evolution of the system (ZERO TO THREE, 2005). For 2 years, the group reviewed research and clinical literature and other diagnostic systems. They also administered two surveys to DC:0–3 users worldwide, and they gathered draft language and comments from experts across disciplines.

The revised DC:0–3, published in 2005 as *DC:0-3R™ Diagnostic Classification of Mental Health and Developmental Disorders,* drew on empirical research and clinical practice that had occurred worldwide since the 1994 publication. The Task Force reviewed large data sets on clinical and community samples of young children, studied clinical literature and other diagnostic systems, developed and disseminated a satisfaction survey of DC:0–3R users worldwide, posted criteria for public comment, and gathered draft language and feedback from world-renowned experts who represented a variety of professional disciplines. The resulting product extended the depth and criteria of DC:0–3R, expanded the number of disorders defined but maintained the essential structure of the previous version.

Key Features of DC:0-5

Multi-axial Structure

Because of the special importance of context for infants' and young children's development, the multi-axial approach from DC:0–3 and DC:0–3R was retained, although most axes were extensively revised and updated. Axis I defines formal disorders categorically, but Axes II-V are dimensional, and each axis contributes to the clinical formulation and potentially aids decisions about prognosis and treatment by providing detailed ratings of the young child's relational context, medical status, psychosocial stressors, and developmental competence.

Significant Changes from Previous Versions

The first major change in DC:0-5 was an expanded age range from 3 to 5 years of age. This was in part, due to growing evidence indicating both continuity in symptoms from toddlers to preschoolers and that disorders in preschool age children were not well described by DSM or ICD. Another change was inclusivity, so that all disorders relevant for infants and young children were included in the nosology instead of only those not previously mentioned in other nosologies. To address concerns about pathologizing expected developmental perturbations, each diagnosis requires distress or functional impairment. To increase diagnostic reliability, a diagnostic algorithm was specified for each disorder. There was also a conscious emphasis on the cultural context of early childhood development. In DC:0-5, there is an effort to integrate culture throughout the text, and to include international perspectives and examples (Sarche et al., 2019). Finally, in keeping with efforts to align criteria and disorders as much as possible with other nosologies, DC:0-5 includes crosswalks to corresponding DSM-5 and ICD-10 codes.

Axis I Disorders of Infancy and Early Childhood

In DC:0-5, Axis I is a compendium of disorders of early childhood, the criteria used to define them and a diagnostic algorithm for each disorder. Additionally, it includes text about the diagnostic features, associated features supporting the diagnosis, developmental features, prevalence, course, risk and prognostic features, culture-related diagnostic issues, gender-related diagnostic issues, differential diagnosis, and comorbidity. Thus, in addition to summarizing what is known about these topics, DC:0-5 also highlights the gaps in our knowledge that should be addressed.

Disorders Defined Similarly to DSM-5: Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder

Neurodevelopmental disorders, as a group, have their onset in childhood, with a steady course that generally does not relapse or remit, and that feature delays or dysfunction related to the biological maturation of the central nervous system.

Two of the most common disorders that are well-studied within this section are autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD). Both are defined largely similarly in DC:0-5 and DSM-5.

Disorders Defined Differently in DC:0-5: Sensory Processing Disorders and Eating Disorders

Sensory processing disorders are diagnosed in infants and young children who demonstrate behaviors that may be reflective of dysfunction in regulating sensory input across one or more sensory domain, thus causing distress and impairment in everyday functioning. Infants and young children could experience clinically significant and impairing responses to sensory stimuli without experiencing other psychopathological or neurodevelopmental conditions. When infants or young children fail to respond to or process sensory information in a developmentally typical manner, this may cause impairment to them and their family. Sensory processing disorders may co-occur with other mental disorders, but in DC:0-5, they also are defined as distinct disorders.

In DC:0-5, sensory processing disorders are categorized as sensory over-responsivity disorder, sensory under-responsivity disorder, and other sensory processing disorder. This differs from DC:0-3 and DC:0-3R, which defines similar clinical presentations as "regulatory disorders." The diagnosis is supported by research indicating that abnormal sensory responses and accompanying impairment in functioning may occur in infants and toddlers independent of other disorders (e.g., autism spectrum disorder). Preliminary research in older children has identified neural differences that are associated with sensory processing sensitivities (Acevedo et al., 2017), highlighting a promising line of future research with young children. By including this disorder, additional support could also be provided to infants and young children and their families who may be significantly impacted by the effects of sensory processing dysfunction in their daily lives.

Eating Disorders of Infancy and Early Childhood were previously described as *Feeding Behavior Disorders* in DC:0-3R. The change from "feeding" to "eating" behaviors changes the focus from the caregiver's behavior to the infant's or young child's behavior. While DC:0-3 and DC:0-3R included six distinct feeding disorders, DSM-5 lumped many different disorders into a single diagnosis—avoidant/restrictive food intake disorder. DC:0-5 took an intermediate approach and defined three disorders: overeating disorders, undereating disorders, and atypical eating disorders, the latter including hoarding, pica, and rumination (see Keren, 2016). If any eating symptoms are evident with only one caregiver, then the diagnosis should be relationship-specific disorder of infancy and early childhood rather than an eating disorder.

Disorders Not Defined Previously

Early Presentation of Established Disorders: Early Atypical Autism Spectrum Disorder (EAASD) and Overactivity Disorder of Toddlerhood (OADT)

EASSD is characterized by severe social communication deficits and restricted and repetitive symptoms in infants and young children between 9 and 36 months of age, who have not yet met full criteria for autism spectrum disorder (ASD). The diagnostic threshold for EAASD requires two of the three social-communication symptoms and one of the four restrictive and repetitive behaviors, as well as evidence of functional impairment. EAASD was included in DC:0-5 as a new diagnosis in order to provide a way to identify a group of children who have not yet met full criteria for ASD but who are showing signs that are functionally impairing and likely to meet full criteria for a diagnosis of ASD in the future. Several studies have found early intervention in populations of children with ASD improved outcomes (see Soto et al., 2016). By identifying young children with EAASD, clinicians can implement early interventions.

OADT is characterized by the presence of pervasive, persistent, developmentally inappropriate hyperactivity and impulsivity in infants and young children between 24 and 36 months of age, that is, at an age at which a diagnosis of ADHD is not permitted (Gleason & Humphreys, 2016). Signs of hyperactivity and impulsivity must be considered developmentally inappropriate and must exist either in multiple settings or in multiple relationships (e.g., parents and teachers). To exclude transient perturbations, signs must be present for a minimum of 6 months. Although developmentally, this age group typically presents with more motor movement and impulsivity than older children, the population of young children who meet this criterion exhibit such extreme, persistent hyperactivity and impulsivity that it impacts their ability to participate in the activities that are important at this age, such as play, impairs their ability to form relationships, and can also pose safety concerns due to injury as a result of their impulsive behaviors.

Many longitudinal investigations of young children with signs of hyperactivity and impulsivity have found stability from toddlerhood through preschool years (see Gleason & Humphreys, 2016, for review). Most of these studies, however, observed rates of hyperactivity and impulsivity without assessing impairment; thus, the inclusion of a requirement for impairment in DC:0-5 protects against overidentification of merely active children. Identifying the population of highly hyperactivity and impulsive young children early on may be particularly helpful in directing clinicians and families to psychosocial interventions and mental health support such as various parent management training interventions.

Aggression as a Mood Disorder: Disorder of Dysregulated Anger and Aggression

Children with oppositional and defiant behavior have been clustered within disruptive behavior disorders in DSM-IV and DSM-5 despite anger and irritability being prominent mood symptoms. Nevertheless, oppositional defiant disorder (ODD) with severe temper tantrums has been shown to be more predictive of later anxiety and mood disorders than disruptive behavior disorders in middle childhood and adolescence. This is in contrast with older children, in whom ODD is more predictive of later ODD and conduct disorders. Therefore, DC:0-5 introduced disorder of dysregulated anger and aggression of early childhood (DDAA) to describe young children with chronic irritability and angry outbursts. Criteria for the disorder were derived from longitudinal research on emotional and behavioral dysregulation in young children.

In early childhood, developmentally salient goals include self-regulation, internalization of rules, and social problem-solving. Infants and young children with DDAA have difficulty with these central developmental tasks, experiencing problems with modulating irritability, leading to disruptive, dysregulated behavior, and resistance or insensitivity to social rules (Biedzio & Wakschlag, 2019). Because of the centrality of negative affect in these disorders in young children, disruptive behaviors are re-conceptualized as a mood disorder instead of disruptive behavior disorders in DC:0-5. Understanding the process as a core emotional dysregulation disorder related to anger and irritability allows clinicians to focus treatment on the young child's emotional experience. Young children older than 24 months may be diagnosed with DDAA if they experience pervasive problems of both mood and behavior, for at least 3 months, under the four clusters of symptoms—anger, non-compliance, reactive aggression, or proactive aggression.

The usual challenge in early childhood psychopathology of determining what is truly impairing symptomatic behavior as opposed to typical variations is especially pronounced in the case of DDAA. In fact, 3- to 5-year-old children have the highest rates of temper tantrums and aggressive behavior of any ages. Tantrums that are severe, prolonged, frequent, and/or include violent behavior are indicative of extremes (Belden et al., 2008).

Impairing Temperamental Extreme: Inhibition to Novelty Disorder

Inhibition to novelty disorder defines extremes of behavioral inhibition that impair an infant or young child's functioning. Infants and young children with this disorder show a generalized, pervasive difficulty approaching new situations, toys, activities, and persons with significant levels of fearful distress, restricting exploratory behavior and learning. Infants and young children who meet the diagnostic criteria for this disorder exhibit an aversion to novel experiences and items that is different from slow-to-warm temperament and behavioral disinhibition that is a normal variant. This new disorder in DC:0-5 highlights a group of infants and young children less than 24 months of age who may be at increased risk for later emerging anxiety disorders that become more clearly manifest after 2 or 3 years of age (Biederman et al., 2001). Management and treatment of inhibition to novelty disorder may be helpful in preventing future anxiety disorders, although more research regarding efficacy of such efforts is needed.

Relationship Disorder of Infancy and Early Childhood

One of the most radical features of DC:0-5 is the inclusion of a disorder that is defined by symptomatic behavior in the child that is limited to one relationship rather than across relationships. The long tradition in psychiatry and medicine is that disorders exist within individuals and that their symptoms are evident cross contextually. In contrast, a relationship-specific disorder means that the disorder exists between individuals, in this case, caregiver and young child.

This disorder was derived from compelling evidence in attachment research that young children construct qualitatively different attachment relationships with different caregivers, as well as from case reports of young children whose symptomatic behavior was evident only with one caregiver. Previous versions of DC:0-5 had defined a relationship disorder diagnosis, but there were significant limitations in the approaches. The advance in DC:0-5 is that the child's symptomatic behavior is not specified. The disorder requires impairing symptoms that are evident in one but not other caregiving relationships (see Zeanah & Lieberman, 2016, for review).

Axis II Relational Context

Infant mental health is an explicitly relational field, and the most experience-near context for infant development is the relationships with caregiving adults who provide for the infant during the earliest years of life. For this reason, DC:0-5, like its predecessors, devotes an entire axis to characterize the relational context of the infant young child. The rationale for a relationship axis is that infants and young children establish relationships with a small number of primary caregivers whom they identify as their attachment figures, and that the quality of these relationships profoundly affect infant development. Primary caregiving relationships can mediate or moderate the effects of environmental or intrinsic risks on young children. DC:0-5 expanded Axis II from previous iterations by including characterization of the network of caregiving relationships that envelops the developing young child and importantly affects the young child's experiences and behaviors. Independent ratings are made of the overall adaptation of each the infant/young child's primary caregiving relationships (Part A of Axis II) and a separate rating for the infant/young child's broader caregiving environment (Part B of Axis II).

Primary Caregiving Relationship and Infant/Young Child Adaptation

According to DC:0-5, good enough caregiving involves three essential features: (a) caregivers' knowing and valuing their child as a unique individual, (b) caregivers' being consistently emotionally available, and (c) caregivers being effectively and empathically in charge of caring for the child. When present, these characteristics allow the caregiver to promote healthy development and build the young child's trust in the caregiver's capacity to respond to their physical and psychological needs. Clinicians rate primary caregiving relationships based on observations of the caregiver–child interaction and on the dyad's subjective experience of one another. Because children may have different qualities of relationships with different caregivers, all the primary caregiver/young child relationships that are important should be assessed whenever feasible.

Because relationship disturbances may occur because of the child's or parent's behavior, two ratings are used to assess caregiver and child contributions to the overall relationship quality. A number of specific dimensions of caregiving are rated as strength, not a concern or concern, as

shown in Table 11.1. In addition, several child characteristics are rated as strength, not a concern or concern, as shown in Table 11.2. These ratings, and the entirety of information obtained in the assessment, are used to rate the overall adaptive quality of the caregiver/young child relationship at one of four levels. Each level represents a range of adaptation: Level I ranges from well-adapted to good enough, and Level II encompasses relationships that are strained to concerning. Level III is used for relationships that are deemed to be compromised to disturbed, and Level IV, the most worrisome rating, covers relationships that are disordered to dangerous. The treatment implications of these ratings are that Level I requires no intervention, Level II bears close watching but not necessarily intervention, Level III generally indicates that intervention is needed, and Level IV conveys urgency about an immediate need for intervention.

Table 11.1 Primary caregiving dimensions in DC:0-5

Providing for basic needs
Conveying psychological commitment to and emotional investment in the infant/young child
Recognizing and responding to the infant's/young child's emotional needs and signals
Ensuring physical safety
Establishing structure and routines
Providing comfort for distress
Teaching and social stimulation
Socializing
Disciplining
Engaging in play and enjoyable activities
Showing interest in the infant's/young child's individual experiences and perspectives
Demonstrating reflective capacity regarding the infant's/young child's developmental trajectory
Incorporating the infant's/young child's point of view in developmentally appropriate ways
Tolerating ambivalent feelings in the caregiver–infant/young child relationship

Table 11.2 Child characteristics contributing to caregiver/child relationships in DC:0-5

Temperamental dispositions
Sensory profile
Physical appearance
Physical health (from Axis III)
Developmental status (from Axes I and V)
Mental health (from Axis I)
Learning style

Because Axis I includes relationship-specific disorder of infancy and early childhood, it is important to note that Axis II is rated even in the absence of a relationship-specific disorder. If relationship-specific disorder is diagnosed, however, then the Axis II, Part A rating should be at Level III or IV.

Caregiving Environment and Infant/Young Child Adaptation

In keeping with the fact that infants and young children are raised in many different family structures and given that adult co-parenting relationships affect infants and young children's development in important ways, DC: 0-5 added a second component to the relational context Axis—the Caregiving Environment. This rating considers the coordination, integration, and compatibility among the different caregiving relationships within which the child is developing. In addition to adult caregiver's relationships with one another, sibling relationships also should inform this rating. Broader caregiving dimensions, listed in Table 11.3, are used to guide the clinician's assessment of the broader caregiving environment, with special attention to cultural values and practices.

As with Part A ratings of primary caregiving relationships, Part B ratings of the broader care-

Table 11.3 Caregiving environment dimensions in DC:0-5

Problem-solving
Conflict resolution
Caregiving role allocation
Caregiving communication: Instrumental
Caregiving communication: Emotional investmentBehavioral regulation and coordination
Sibling harmony

giving environment use the same four levels of well adapted to good enough, strained to concerning, compromised to disturbed, and disordered to dangerous, but this time, rating the broader caregiving environments. As with the Part A ratings, Part B ratings also are relevant for directing intervention efforts.

Axis III Physical Health Conditions and Considerations

The mental health needs of infants and young children are inextricably interwoven into their physical health. Studies of cumulative risk, for example, have demonstrated that adverse experiences in childhood lead to both physical and mental health disorders in adults (Felitti et al., 1998), presumably operating through common cellular and molecular pathways. Newer models have described specificity between types of experience (e.g., threat vs. deprivation) and atypical brain structure and function (McLaughlin et al., 2019).

Physical health includes wellness (absence of disease or dysfunction) and illness (presence of disease or dysfunction). These factors may have a detrimental impact on the infant, may promote resilience for the infant, or perhaps have no substantial impact whatsoever. Information about physical health and development should include the entire span of the infant or young child's life, including consideration of their prenatal environment. Clinicians should consider the ways in which these factors both directly influence the infant/young child's mental health (e.g., toxins/medications/drug exposure causing more irritability or sleep dysfunction, gastrointestinal dysfunction or anomalies causing inability to eat, and congenital anomalies or genetic conditions impacting infant's neurodevelopment and social/emotional functioning) and indirectly influence their mental health (e.g., medical condition causing prolonged hospitalization disrupting attachment, exposure to medical procedures causing anxiety and trauma, and chronic medical conditions impacting an infant/young child's developing perception of self). While an objective understanding of the infant/young child's health is very important, just as important is the parent's subjective perception and experience of their child's physical health and wellness. A thorough assessment includes seeking information from the young child's caregivers as well as from their primary care provider and/or medical records. Categories of health described in DC: 0-5 include prenatal medical conditions, chronic medical conditions, acute medical conditions, medical procedures, pain, physical indicators of caregiving environment problems, medications, and markers of health status.

Axis IV Psychosocial Stressors

Infants and young children are embedded within family and environmental contexts, which influence their mental health and impact the presentation, course, treatment, and prevention of mental health symptoms. DC:0-5 updated the psychosocial stressors in DC:0-3R and provides a reorganized, more comprehensive list of stressors that may impact the infant/young child's mental health. Stressors are grouped together in categories such as challenges within the family and primary support group, house challenges, economic and employment challenges, infant and young child health (which has some overlap with Axis III), as well as legal challenges within the environment. Through inclusion of Axis IV, DC:0-5 acknowledges the important psychosocial and environmental factors that impact the mental health of infants/young children both directly and indirectly, such as racism/discrimination, war, work-related stressors or dangers for a parent, disease-related epidemics, and disasters.

Extreme weather events related to climate change and the COVID-19 pandemic are especially salient examples of complex stressors that may have both direct and indirect effects on infant/young child well-being. DC:0-5 also includes an assessment of the age at which the stressor started, the duration of the stressor within the lifespan of the infant/young child, and the severity of impact that stressor had on the infant/young child.

Comprehensively assessing psychosocial and environmental stressors in young children is vital for clinicians who are trying to develop effective treatment plans. Accumulating risk factors indicate increasing probability of disorders and impaired functioning, but the clinician's task is to determine how various risks lead to deviations or delays in development and impairing symptomatology.

Axis V Developmental Competence

The final axis of DC:0-5 highlights the central role of development as a context for infants and young children. The mental health and well-being of infants and young children can only truly be understood by incorporating an understanding of their developmental competencies. Emotional, social-relational, language-social communication, cognitive, and movement/physical are interrelated domains of development that may be consistent with chronological age, delayed (e.g., first steps at 17 months), or deviant (e.g., echolalia). In DC:0-5, Axis V has been expanded to capture a broad range of developmental competencies and includes a detailed (though non-exhaustive) table of developmental milestones in an appendix of that lists milestones at 3-month intervals from 3 to 24 months and then annually at 36, 48, and 60 months of age. To identify expected competencies through the first 5 years across multiple domains of development, ratings of "fully present," "inconsistently present or emerging," or "absent" are used to understand a child's developmental status within and across domains of development.

Summary and Key Points

DC:0-5 is the most comprehensive and research informed nosology of disorders of early childhood published to date. It builds upon and significantly expands on previous efforts and benefits from the growing body of systematic research on disorders of early childhood and population-based studies of problem behaviors that have appeared in the past 10–15 years. It also benefits from input from surveys of infant mental health clinicians, from solicited input during presentations at national and internationals forums, including WAIMH Congresses, and from the clinical experiences of Task Force members.

The result is retention of some disorders, reconceptualization of other disorders, and introduction of disorders not previously described. Notably, DC:0-5 extends the age range covered from infancy to 5 years, with a conscious effort to include criteria that covered the first year of life when justified by available data. It attempts to provide criteria for all of the relevant disorders in young children in a single volume and provides a detailed algorithm to determine diagnostic thresholds. To avoid over-pathologizing developmental perturbations, it requires distress or functional impairment as a criterion for every disorder. Finally, it clearly acknowledges the comorbidity that frequently occurs with mental health disorders.

The most important continuity between DC:0-5 and its predecessors is the multi-axial system, which contrasts with both the DSM–5 (American Psychiatric Association, 2013) and the *International Classification of Diseases* (11th ed.; ICD–11; World Health Organization, 2019). This multi-axial framework is necessary to highlight the importance of context, especially the developmental, relational, cultural, and medical contexts for understanding young children's behavioral and emotional symptomatology.

Though all of the axes are substantially revised, the most profoundly different change is to Axis II, the relational context axis. In addition to presenting a clearer dimensional approach to ratings of primary caregiving relationships, DC:0-5 also introduces ratings of the broader caregiving environment. This necessarily provides a fuller appreciation of the relational context of young children's development.

Of course, much remains to be learned. A forthcoming casebook provides detailed examples of application of this manual to detailed descriptions of the clinical presentation of young children with impairing symptomatology (Mulrooney et al., in press). The hope is that the putative advancements in DC:0-5 will facilitate careful research to determine the usefulness of the criteria and disorders, especially those not previously described, and to enhance our understanding of ways to promote the healthy developmental trajectories of young children. And as with its predecessors, as we learn more, subsequent revisions will bring us closer to this goal.

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12

Assessment and Screening for Early Detection

J. Kevin Nugent and Kaija Puura

Why Do We Need Early Screening and Assessment?

Child well-being is globally defined as the multidimensional nature of health that is enhanced when physical, cognitive, and social–emotional–spiritual development is nurtured in developmentally appropriate ways (The Alliance for Child Protection in Humanitarian Action, 2021). There is widespread agreement that the early years of life are crucial to a child's well-being because of the rapid changes in brain connectivity and skill acquisition occurring during this time. Children who are nurtured, protected, and supported in the first years of life tend to have better individual outcomes and are more likely to grow up to become healthy, productive adults (Sameroff, 2000; Shonkoff, 2014; Sroufe, 2021; Stern, 1995).

But, not all children have an equitable start in life, so these early years are also a time of developmental vulnerability when infants are at risk for environmental adversity, the enduring effects of family disruption, trauma, and violence (Lyons-Ruth et al., 2017; Osofsky & Lieberman, 2011). Children who have experienced environmental adversity—such as abuse, neglect, or poverty—are at a markedly elevated risk for developing psychopathology. Children with disabilities or developmental delays are also more likely than are other children to develop social, emotional, and behavioral difficulties (Ghosh-Ippen et al., 2014). Moreover, racial and ethnic disparities in well-being emerge even before birth, and inequities by additional sociodemographic factors (e.g., family income, home language, and maternal education) across domains of development become evident during the first year of life and grow larger as infants become toddlers (Davis et al., 2022; Machel, 2017; Lu et al., 2010; Wilkinson et al., 2021).

The Need for Validated Screening and Diagnostic Measures

Because mental health problems are a major public health challenge during the first 3 years, the search for validated measures of screening and diagnosis has become critical in efforts to develop intervention techniques designed to improve overall child well-being. Effective prevention and intervention depend on the availability of feasible and validated measures of screening and intervention. Early identification, accurate diagnosis,

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and effective treatment of emotional or behavioral disturbances in infants and young children can alleviate immeasurable suffering for young people and their families dealing with behavioral health challenges. Identifying developmental processes that are disrupted by adverse early environments is the key to developing better intervention strategies for children who have experienced adversity (Osofsky & Osofsky, 2021; Salo & Paul, 2007).

The lack of widespread acknowledgment of disorders of infancy is still a major challenge for practitioners in the field of infant mental health (IMH), as it is well recognized that mental disorders occurring among infants often go unnoticed and undetected (Lyons-Ruth et al., 2017). Although this may be due to a pervasive impression that children of that age do not experience serious emotional difficulties or develop mental health problems (Osofsky & Lieberman, 2011), it may also be because of the paucity of valid instruments to assess and diagnose children so young. There is therefore a critical need to examine and, where necessary, to refine and expand early screening for infants and toddlers to detect mental health issues, such as relationship disorders, depression, and self-regulation problems. There is a clear case for prioritizing earlier identification of need and provision of appropriate support for children in their families during this phase of life (Barlow & Schrader McMillan, 2010; Brandt, 2014; Lieberman & Van Horn, 2008; Luoma et al., 2001).

There is also a growing consensus that the assessment of a young infant's emotional, behavioral, relational, and developmental capacities must involve a multifaceted, multilayered, and multidisciplinary framework. The process of assessment should be based on an integrated developmental model and should integrate information from multiple sources, in terms of both formal and informal information-gathering techniques. An integrated approach is important for the most vulnerable families suffering from multiple risk factors and needing a range of different support (Costa & Noroña, 2019; Hutchon et al., 2019; Zeanah Jr. & Zeanah, 2009).

What Do We Mean by Screening and Early Assessment?

Effective assessment and intervention depend on feasible and validated measures of screening and assessment. Screening can detect signs that indicate whether a young child may be delayed in aspects of development, such as regulation, communication, autonomy, affect, and interaction with people, while an assessment is a more comprehensive process that uses a series of different tests or instruments to help make a diagnosis in terms of the infant's social–emotional development. Screening, assessment, and intervention should be regarded as an integrated seamless process, as screening and assessment provide a starting point for discussing the difficulties of the infant or family risk factors together with parents or caregivers.

Screening

Screening is a brief, simple procedure used to identify infants and young children who may be at risk of potential health, developmental, or social–emotional problems. Developmental screening, using valid, reliable screening methods, enables professionals to detect children who may be at risk for developmental and social–emotional concerns, accurately and cost-effectively. These screening tools are typically based on caregiver report and take the form of a series of questions or checklists used to track children's development relative to milestones achieved by a larger group of children of the same age. Most screening measures are concerned with developmental problems, screening for children's socio-emotional and behavioral problems and family psychosocial problems, e.g., parental mental health problems, substance use issues, parental stress, or parent–child relationship problems.

Holistic screening in infant mental health settings may include screening measures that assess social and emotional risk and resilience factors in the mother, father, and infant's wider social network, which form the context within which the child is developing. Standardized screening measures can be administered by medical or mental health professionals in the context of medical, early care, or home settings, thus providing ample opportunities for universal approaches to IMH screening and intervention. The process of screening is not intended to serve as a diagnosis for a child—but rather to carefully and accurately inform about the need for meaningful next steps, such as more in-depth social-emotional assessment. In short, screening can be thought of a snapshot of a child's capacities and family situation and can help determine whether the child is meeting the appropriate milestones for their age or is in need for support.

Several screening tools are available to screen for developmental issues and social–emotional concerns in children and connect them to helpful interventions. What tools are feasible depends also on the setting and resources of health-care services in each country or culture. An example of a very brief and simple screening tool for primary care settings in developing countries is the Basic Infant Mental Health Scale (BIMHS) (Puura et al., 2018). The BIMHS has only six items that cover possible parental worry about the child, general well-being of the parent, growth of the infant, two items on socio-emotional development (eye contact and shared pleasure in interaction), and finally the professional's possible worry about the infant. In case any of the items raise concern, the measure gives suggestions on how to further investigate the issue with the parent. The Ages and Stages Questionnaire, Third Edition (ASQ-3) is an example of a slightly longer screening instrument for detecting problems in the social–emotional development of a child. It asks parents or other caregivers to answer a series of simple questions regarding their child's social–emotional development, and those whose social–emotional development appears to fall significantly below that of their peers are flagged for further attention. An example of a screen for risk factors is the Adverse Childhood Experiences (ACEs) questionnaire, which is a 10-question instrument used to screen for childhood adversity. Another widely used screening instrument for perinatal mood and anxiety disorders is the Edinburgh Postnatal Depression Scale (EPDS). Screening tools such as these are used to indicate only the need (or lack thereof) for further assessment and do not constitute a thorough assessment in and of themselves.

Assessments

While screening is used to identify children who may be at risk for certain mental health issues, an assessment consists of different methods and instruments to help make a diagnosis in terms of the infant's social–emotional development. The assessment of children, age 0–3 years, aims to discover how a child is responding to their environment, how they are developing, what kinds of problems they may be experiencing, and how supportive their caregiving relationships are.

It must be recognized that infant developmental assessments are not the same as a thorough infant mental health assessment. While a developmental assessment can identify developmental delays in cognitive areas, it should never be the only source of information. An infant mental health approach to assessment incorporates a developmental, relational, and biological perspective on the presenting symptoms and includes data collected from interviews, observations of dyadic or triadic interactions, and scores on validated screening tools. An assessment is the start and not the end of the process, and its results can be used to determine the best level of care, provide the right services, and help point to the needs of the child.

How and Where Are Assessments Carried Out?

Infant mental health assessments rely much more heavily on observations and interactions and frame mental health issues in the context of the development and relationships of the young child. In practice, this means providing an opportunity for the practitioner and family to observe the baby's behavior together and see the world through the eyes of the child, thus enhancing the caregiver–infant relationship. This can take place in hospital, clinic, or home settings and can be done in person or online. Clinicians can make use of unstructured naturalistic observations or use one of the many structured procedures for observing the infant, like the Alarm Distress Baby Scale (ADBB; Guedeney & Fermanian, 2001), caregiver–infant interactions, such as the emotional availability (EA) scales (Biringen et al., 2000), or the Parent-Child Early Relational Assessment (PCERA; Clark, 1999), which will be described later in this chapter.

Clinicians face some age-specific challenges while assessing infants and toddlers. For young children, both context and relationships are influential and the variation in their behavior across settings is highly informative. Due to all these factors, infants and toddlers cannot be effectively assessed in one meeting. The assessment of an infant or young child is usually easiest to start with a clinical interview with the parents or caregivers about the concerns of the parents and possible symptoms of the infant. Parental reports and views on the infant's characteristics and temperament, on the caregiver–infant relationship, and on the risk factors affecting the family are also important.

In practice, most infant mental health assessments will involve several sessions. For example, four to six sessions are recommended by ZERO TO THREE, The National Center for Infants, Toddlers, and Families (Zero to Three, 2016). For diagnostic assessment with the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC 0-3 or DC 0-5), it is recommended that the assessment should be carried out over the course of several weeks and involve the primary caregiver or caregivers and should include multiple contexts over time. Assessments should include at least one home visit and also visits to the child's childcare setting if applicable. Children need to be seen in their own environments, as this is where they should be the most comfortable. However, clinic or office visits may also be included to look at differences in their behaviors and interactions in unfamiliar settings.

Infant mental health assessments can add value to a child, family, and mental health service if only they contribute to our understanding of the child's needs and ultimately to treatment planning and an improved quality of life. Infant mental health assessments are often conducted by teams and, hence, infant mental health practitioners may come from a variety of disciplines—social workers, psychologists, nurses, nurse practitioners, psychiatrists, occupational therapists, pediatricians, speech-language pathologists, or early intervention specialists. For example, a speech therapist may conduct a speech evaluation, an occupational therapist may evaluate the child's skills and abilities, and a psychiatric nurse practitioner or a psychologist may evaluate the child's emotional, social, and family functioning. Collaborative skills are critical for an effective infant mental health assessment. Increasingly, early interventionists are adopting an infant mental health approach to assessment and intervention—searching for family strengths, listening to parents, helping the family identify stressors, and helping the family to keep the baby in mind. They also develop healthy professional relationships with the family while assisting in meeting the outcomes identified by the family. Parents and primary caregivers should have access to effective support systems to ensure successful transitions to the new roles as parents, mitigating potential distress and isolation of the parents and nurturing the healthy mental and emotional development of the child. This may also include connections to community-based services to meet health-related social needs that are required to treat depression and anxiety, such as financial counseling services or housing support.

Where and When: Specific Prenatal, Neonatal, and Later Infancy Measures

The Prenatal Period

Unfortunately, large numbers of women across the world receive little or no care during or before pregnancy. Addressing this issue in low- and middle-income countries (LMICs) where minimal essential care is generally available is critical for improving maternal and neonatal health status and decreasing the associated morbidity and vulnerability to anxiety and depression. Maternal undernutrition, alcohol and drug use, and infections and chronic diseases carry a high risk for poor maternal and neonatal health, while anxiety and depression symptoms are common among pregnant women worldwide. Regular antenatal checkups with improved screening can save many maternal and neonatal lives and pregnancies; as the transition to parenthood is a period of critical vulnerability, there is a need for interventions to improve the health of women and their newborns and to make their pregnancy safe (Barlow & Schrader McMillan, 2010).

In recent years, there has been increased awareness of the importance of screening in the preconception period and during pregnancy to increase awareness and promote health right from the time of conception onward. Early pregnancy and prenatal appointments and checkups provide practitioners with an opportunity to assess social and emotional risk and resilience factors in mothers, fathers, and their wider social network. The purpose of antenatal screens is to evaluate any significant risk factors in the mother's life. These include mental health problems, domestic violence, drug and alcohol abuse, as well as risks to the fetus, including substance abuse, smoking and significant levels of antenatal anxiety or depression. Prevention, screening, and treatment can be effective in lessening the symptoms of these disorders and the resulting impact on families. Resilience factors may include evidence of coping, supportive family relationships, especially with one's partner and mother, and other support.

Perinatal Mood and Anxiety Disorders

Recent focus on perinatal anxiety and mood disorders has drawn attention to the mental health needs of perinatal women and their partners and the effects of these untreated conditions on mothers, partners, infants, and children. The consequences of delayed care for pregnant mothers can be of long term and life-threatening and may lead to severe emotional problems and general medical problems in mothers, fathers, and children if early appropriate treatment is not received. For almost all parents, the perinatal period can bring increased anxiety and uncertainty as parents experience dramatic psychological, behavioral, and neurobiological adjustments, as the foundations of parenting are established and both parents are experiencing the stress of a major life change including job strain and depressive or anxiety symptoms. Women who give birth to preterm infants or infants with congenital anomalies or who experience a traumatic birth, especially from an emergency cesarean section, also have an increased incidence of perinatal depression. While perinatal depression can affect individuals of all backgrounds, low socioeconomic status, poor access to education and healthcare, adolescent age, and recent immigrant status are thought to lead to postpartum depression in this population demographic (Ceballos et al., 2017; McCoy et al., 2016).

An example of a screening tool for perinatal depression or anxiety is the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 2014), which is widely used in several countries. The EPDS is a set of 10 screening questions, which can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. It can be completed by the mother or provider in any health-care setting and reviewed by the provider for immediate follow-up. The mother checks off one of four possible answers that is closest to how she felt during the past week. The EPDS is not intended to provide a diagnosis but is designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period. The authors point out that the EPDS score should not override clinical judgment and that a careful clinical assessment should be carried out to confirm the diagnosis. Discussing the EPDS with the parent promotes the use of open discovery questions, listening, reflecting, and goal setting to enable them to reflect on their particular priorities and to support them in finding their own solutions to the challenges they face.

After screening and assessment, intervention with expectant parents can be carried out by pediatric or obstetric residents, nurses, social workers, early intervention specialists, and paraprofessionals in obstetrics offices taking on the educational role to provide it, by links to community groups who provide it, and by novel approaches using the Internet and digital health platforms to teach it (with the necessary attention to access issues for marginalized and less literate populations).

The Neonatal Period

Neonatal neurobehavioral assessment has become a standardized component of clinical care provided to newborn infants, guiding neonatal clinical care and subsequent access to early interventions and services. The most widely practiced assessments used to provide an objective quantification of newborn behavior observed during clinician–infant interactions are as follows:

- The Neonatal Behavioral Assessment Scale (NBAS) (Brazelton & Nugent, 2011)
- The Assessment of Preterm Infants' Behavior (APIB) (Als et al., 1982)
- The NICU Network Neurobehavioral Scale (NNNS) (Lester & Tronick, 2004)
- The General Movements Assessment (GMA) (Prechtl, 2001)
- The Hammersmith Neonatal Neurological Examination (HNNE) (Dubowitz et al., 2005).

The Neonatal Behavioral Assessment Scale (NBAS), developed by Berry Brazelton, is a neurobehavioral assessment scale designed to describe the newborns' responses to their extrauterine environment and to examine the effects of a wide range of pre- and perinatal risk factors, such as prematurity, low birth weight, undernutrition, the effects of prenatal substance exposure, and exposure to environmental toxins, and is used to document the contribution of the newborn infant to the development of the emerging parent–child relationship. The NBAS consists of 28 behavioral items, which measure the infant's behavioral capacities, and 16 reflex items, which measure the infant's neurological status, and is suitable for examining newborns and infants up to 2 months old. The NBAS can also be used to demonstrate the newborn infant's behavioral capacities toward parents, thereby strengthening the relationship between the parent and child and supporting family adjustment (Bruschweiler-Stern, 2009; Nugent & Brazelton, 1989).

The Assessment of Premature Infant Behavior (APIB) (Als et al., 1982) is a neurodevelopmental diagnostic instrument designed to assess preterm, at-risk, and full-term newborns from birth to 1 month after expected due date. The APIB can be used by newborn intensive care, healthy newborn nursery, and follow-up clinic staff professionals. Inspired by the NBAS, the main objective of the APIB is the assessment of infant individuality and competence, based on the observation of the behavioral subsystems in interaction with each other and with the environment. These subsystems include the autonomic (respiration, digestion, and color), motor (tone, movement, and postures), state organization (range, robustness, and transition patterns), attention (robustness and transitions), and self-regulation (effort and success) systems as well as the degree of facilitation required. The APIB has well-established inter-rater reliability and concurrent and construct validity and is clinically relevant to behavioral intervention and individually appropriate and supportive care.

The NICU Network Neurobehavioral Scale (NNNS) (Lester & Tronick, 2004) is an assessment of infant neurobehavior designed to provide a comprehensive assessment of both neurological integrity and behavioral function of infants exposed to high-risk conditions such as drugs and/or prematurity. The NNNS assessment includes three parts: (1) classic neurological items that assess active and passive tone, primitive reflexes, and central nervous system (CNS) integrity; (2) behavioral items, including state, sensory, and interactive responses; and (3) stress/

abstinence items that document the range of withdrawal and stress behaviors likely to be observed in substance-exposed or high-risk infants. Infants can be assessed in the preterm period once they are medically stable.

The General Movements Assessment (GMA) (Prechtl, 2001) is a nonintrusive observational technique used to identify neurological issues, which may lead to cerebral palsy (CP) and other developmental disabilities. General movements are associated with neural development, and, so, the GMA is used to identify absent or abnormal general movements. This assessment describes the repertoire of complex, highly variable, spontaneous whole-body movements, which emerge in the fetus and continue until the first 4–5 months of life. The GMA allows for motor function–based diagnosis without the need to apply stimuli. Infants whose general movements are absent or abnormal on the GMA are at a higher risk of motor dysfunction, especially cerebral palsy.

The Hammersmith Neonatal Neurological Examination (HNNE) and the Hammersmith Infant Neurological Examination (HINE) were initially developed by Lily and Victor Dubowitz in 1981 and revised in 1999 (Dubowitz et al., 2005). The HNNE includes 34 items subdivided into six categories (tone, tone patterns, reflexes, movements, abnormal signs, and behavior). The HINE consists of 26 items and can be used for infants aged between 3 and 24 months of age to assist in the early detection of motor impairments and in the diagnosis and prognosis of cerebral palsy (CP) in infants born both preterm and at term. It has the advantage of being quick, practical, easy to perform, and easy to record even by nonexperts using a recording sheet (proforma) that includes diagrams and definitions.

Supporting the Parent–Infant Relationship in the Neonatal Period

Due to the recent rise of family-centered approaches in neonatal care, an additional objective included in some assessment approaches concerns the evaluation of the infant in the context of the parent–infant dyad in order to promote infant health and the caregiving relationship. Family-centered neonatal interventions, such as the Newborn Behavioral Observations (NBO) system, the Newborn Individualized Developmental Care and Assessment Program (NIDCAP), and the Facilitating Attuned Interactions (FAN), are used to help parents transition to the caregiving role and promote parenting efficacy.

The Newborn Behavioral Observations (NBO) system (Nugent et al., 2007) is an interactive relationship-building tool used to strengthen the relationship between infants and parents and to improve the goodness of fit in parent–infant dyads and, in turn, support the development of emotion regulation, at a time when the very bases for parental functioning are being established. Inspired by the Neonatal Behavioral Assessment Scale, the NBO consists of 18 neurobehavioral observations and is designed to show that newborns possess a wide range of visual, auditory, and perceptual abilities that allow them to explore the world around them and to engage in face to-face, eye-to-eye mutual exchange. Over the course of serial observations, the NBO yields an individualized profile of the infant's behavior so that the clinician and parents can discuss the implications of the baby's responses for the management of sleep, feeding, and crying in addition to identifying the kind of interaction that is best suited to the infant's behavioral threshold and style. In a number of randomized control studies, the NBO was associated with enhanced mother–infant engagement, a reduction in postpartum depressive symptomatology, and anxiety levels and was effective in helping parents be more responsive to their infant's communication cues (Kristensen et al., 2020; McManus et al., 2020; Nicolson et al., 2022; Nugent et al., 2014, 2017).

The Newborn Individualized Developmental Care and Assessment Program (NIDCAP) (Als, 2009) is research-evidenced system, designed to assess and support the individual strengths of prematurely born infants and other high-medical-risk infants while they are still in hospital. It conducts detailed behavioral observations of the infant's communication to form the basis for decision-making, planning, and care. The NIDCAP model gives the infant a voice and an active role together with the family and embraces a caregiving approach that focuses on each infant's unique behavioral communications system. It supports family competence and confidence on their path to increased independence, and so that NIDCAP is based on deep respect and care for the dignity, comfort, and well-being of infants and their families. NIDCAP is associated with enhanced brain structure development and improved behavior outcome in infancy and childhood and adulthood (Als et al., 2012). NIDCAP training is appropriate for clinicians, developmental professionals, and consultants in the newborn intensive care; healthy newborn nursery; and follow-up clinic setting.

The Fussy Baby Network® (FBN) and the FAN (Facilitating Attuned Interactions): The Fussy Baby Network (Gilkerson et al., 2012) is a family-centered program supporting families struggling with infant crying and related concerns. High levels of infant crying place families at risk for disrupted relationships, parenting stress, and even child maltreatment, and, so, the Fussy Baby Network is designed to assess the infant, support parents, and reduce family stress. The FAN (Facilitating Attuned Interactions) approach is an extension of this work and is used to train practitioners to engage parents around their urgent concerns about their baby's crying, sleeping, or feeding in a way that builds their longer-term capacity as parents. It helps practitioners improve their ability to read parents' cues and respond with interventions that match what parents most need from moment to moment.

When and Where in Later Infancy

Infant mental health emphasizes the importance of caregiving relationships as having major effects on a young child's social and emotional experience. Just as negative life events in early childhood can affect the brain structure, positive experiences can repair the damage done to the brain and form new neural pathways that set the child onto a better developmental trajectory. The first years of life provide an opportunity to parents and families, supported by infant mental health practitioners, communities, and policymakers, to create healthy and stimulating environments that support the caregiver–infant relationship and promote the ability of infants to reach their full potential.

In practice, IMH assessments enable us to look simultaneously at what the caregiver(s) bring(s) to the setting AND what the baby brings to the setting as well as how the child and caregiver work together in both calm and stressful times. Infant–caregiver relationships should be the centerpiece of assessment in infant mental health. A child's behaviors, competencies, and problems are identified, as well as how that child can regulate their behavior and emotions with and without their caregiver's support. Healthy caregiving relationships, which are embedded within multiple social and cultural contexts, promote social competence in young children, which, in turn, is associated with adaptive behavioral emotional and cognitive outcomes.

Ideally, the setting for infant screening and assessment in the early years should include multiple contexts over time—home visits, clinic visits, the child's childcare setting if applicable—and should occur over the course of several weeks and involve the primary caregiver. The following are some instruments used in infant mental health settings:

The Brief Infant Mental Health Scale (BIMHS, Puura et al., 2018) is a simple screening measure developed particularly for countries where infant mental health services may be scarce or are just beginning to develop. The BIMHS has only six items that cover possible parental worry about the child, general well-being of the parent, growth of the infant, two items on socio-emotional development (eye contact and shared pleasure in interaction), and, finally, the professional's possible worry about the infant. In case any of the items raise concern, the measure can be adapted to local context to provide suggestions on how to further investigate the concern raised and what services could be available for the infant or parents.

The Bayley Scales of Infant Development (BSID) (Bayley, 2006) is a norm-referenced developmental assessment tool for diagnosing developmental delays in infants and toddlers. BSID IV, the current version of the scale, was published in 2019 and has greater clinical sensitivity and accuracy when compared to BSD I, II, or III. BSID IV assesses development from 16 days to 42 months in five domains: cognition, motor, language, socio-emotional, and adaptive behavior. The BSID helps in detecting developmental delay early and also in initiating early developmental intervention by individualizing the management of the young child's developmental and learning needs.

The Battelle Developmental Inventory, Third Edition (BDI-3) (Glascoe & Byrne, 1993) is widely used as a screening tool from birth up to 7 years. The Battelle measures a child's progress in the following areas: adaptive, social–emotional, communication, motor, and cognitive. It has robust psychometric properties, although its ability to discriminate effectively among various degrees of functioning in the early months has been questioned (Alfonso et al., 2010). The most common target population of the Battelle is children with autism spectrum disorders.

Ages and Stages Questionnaire (ASQ-3, Third Edition) (Squires et al., 2009) consists of a series of 21 parent/caregiver-completed questionnaires. It is designed to screen the developmental and social–emotional performance of children in the areas of communication, gross motor skills, fine motor skills, problem solving, and personal–social skills. The target population is children between 1 and 66 months of age, and it is used to identify those children who would benefit from in-depth evaluation for developmental delays. Validity and reliability have been demonstrated through a number of psychometric studies. The ASQ-3 has been translated into and validated in multiple languages, and studies have shown both the disadvantages and effectiveness of the measure when translated and culturally adapted for use in various countries.

The Infant-Toddler Social and Emotional Assessment – Revised (ITSEA) (Carter et al., 2003) and the Brief Infant-Toddler Social and Emotional Assessment (BITSEA) (Briggs-Gowan et al., 2004) were both developed to assess social–emotional and behavior problems as well as delays or deficits in the acquisition of competencies that may arise between the ages of 12 and 36 months. The BITSEA is based on the longer ITSEA, and the authors suggest that positive screens on the BITSEA should be followed by the ITSEA. BITSEA scores have been found to be highly correlated with the longer ITSEA. Both assessments include parent and childcare provider forms that can be completed independently as a questionnaire or administered verbatim as an interview.

Finally, the Adverse Childhood Experiences (ACEs) scores (Felitti & Anda, 2010) can be used by infant mental health clinicians to screen for childhood adversities. ACEs are defined as stressful experiences occurring during childhood that directly harm a child or affect the environment in which they live and represent a variety of negative experiences, such as physical and sexual abuse, neglect, growing up in a house with a harmful family environment as a result of domestic violence or substance abuse, etc. Exposure to these experiences has been linked to a range of negative health conditions, including poor mental health, substance use disorder, adverse health behaviors, chronic physical disease, and shortened life span. As a screening tool, the ACEs score approach has the advantages—and limitations—of simplicity: its simplicity facilitates wide-ranging applications in public policy and public health and clinical settings but risks oversimplistic communication of risk/causality, determinism, and stigma. Other ways of measuring adversity—examining single adversities or using theoretically or empirically driven methods—might have advantages over ACE scores.

Observation Methods in Later Infancy

The Alarm Distress Baby Scale (ADBB) is meant for infants between 2 and 24 months of age and measures sustained withdrawal behavior in infancy, which is an important alarm signal to draw attention to both organic and relationship disorders. The scale has good criterion validity as a screening procedure for detecting the developmental risk of the infant. The cutoff score of 5 with a sensitivity of 0.82 and a specificity of 0.78 has been determined to be optimal for screening purposes in several countries (Guedeney et al., 2013). The scale can be used in different clinical settings, provided a sufficient level of social stimulation is given to the infant in a relatively brief period of time. The scale can be used by nurses and psychologists or by medical doctors after a short period of training (Puura et al., 2010).

The Emotional Availability Scale (EAS; Biringen et al., 2000) is a method of assessing dyadic interaction for the emotional availability of the parent to child and child to the parent. It is a global measure of the overall interactional style in each partner and requires clinical judgment and awareness of the contextual factors. There is extensive research to show that it is highly associated with the infant's later attachment behavior. Two versions of the four EA scales are available for different ages of the child, whereas "The Infancy to Early Childhood Version" can be used for children of ages 0–4 years. The recommended method for coding the EA scales is to video record and later analyze at least 20 min of interaction. Training is required to reach reliability on the scales.

The CARE Index (Crittenden, 1979–2004) is based on a brief (3–4 min of "playing and talking") video clip of the caregiver and infant or toddler (range: 2 months to 4 years). It is used in a number of infant mental health settings both for initial assessment and outcomes evaluation. This tool demands extensive training to reach reliability. It is often used in and recommended for child protection evaluations. Further information is available at http://www.patcrittenden.com/.

The Parent-Child Interaction (PCI) Feeding and Teaching Scales, developed as part of the Nursing Child Assessment Satellite Training (NCAST) program by Kathryn Barnard and colleagues, consist of a series of observable behaviors that describe caregiver/parent child interaction in either a feeding or teaching situation (Barnard, 1994). There is an extensive body of research across disciplines supporting their validity and reliability and have been used across disciplines to guide interventions.

The Parent-Child Early Relational Assessment (PCERA) (Clark, 1999) is an observational coding system designed to measure the affective and behavioral quality of parent–child interactions at an evaluation during three 5-min situations: (1) meal time, (2) a structured task (e.g., parent attempting to get the infant interested in a toy), and (3) free play. The original assessment, which targeted psychiatrically ill mothers and their 2- to 48-month-olds, has been revised and modified for use with a broader age range (i.e., 0–5 years), fathers, and other high-risk groups (e.g., prematurely born infants).

What Do We Do After Diagnosis and Treatment Planning?

Today, the prevailing diagnostic classification system for infant mental health is the one developed by ZERO TO THREE (https://www.zerotothree.org/): the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Wieder, 1994; Zero to Three, 2016). In order to be able to assess and diagnose infants and toddlers, clinicians need to be familiar with this *Diagnostic Classification System* (Emde, 2016). This classification system frames mental health issues in the best interests of the child and what can be done to support the child. *It* is a diagnostic system specifically designed to evaluate and diagnose children from birth through age 3 years. It is developmentally based and was created to support clinicians in diagnosing and treating mental health problems in the earliest years. The DC 0-3 classification is organized into five descriptive axes to provide clinicians with a comprehensive diagnostic profile, while the revised DC:0-5 (2016) was expanded to include children from birth to 5 years.

The updated DC:0-5, Version 2.0, which was published in 2021, enhances the professional's ability to diagnose and treat mental health problems in the earliest years by identifying and describing disorders not addressed in other classification systems and by pointing the way to effective intervention approaches. The purpose of the DC is not to label young children with a mental health diagnosis but to identify and classify disorders in order to provide effective early intervention. Specifically, it is designed to enable mental health practitioners to:

- Recognize mental health and developmental challenges in young children
- Understand how relationships and environmental factors contribute to mental health and developmental disorders
- Use diagnostic criteria effectively for classification and intervention
- Work more effectively with parents and other professionals to develop effective treatment plans

A diagnosis is not just "labeling" but is a way of knowing and of understanding, as Campbell Paul points out, when he writes that "classification of mental health problems allow us to communicate about how we understand the problems that a very young child might be having, the problems they are having in relationships and development, and communicating this to colleagues, parents, and sometimes government agencies who need to act to protect the welfare of young children" (Paul, 2022). The infant mental health diagnostic system frames mental health issues in the context of the development and relationships of the young child. In practice, it means providing the opportunity for practitioner and family to observe the baby's behavior together and to "make meaning of" or interpret the baby's behavior. Establishing a relationship of respect and trust between the practitioner and caregiver is at the heart of the infant mental approach to assessment and diagnosis.

In sum**,** the goals of infant mental health assessment and diagnosis include the following:

- Screening to identify children needing further assessment to determine the need for health and other special services or support
- Assessing the child's strengths to diagnose developmental delays or special needs
- Diagnosing infant mental health disorders
- Determining eligibility for early intervention or further support
- Planning a support program and monitoring a child's progress

Beyond Formal Assessment

Screening and assessment can also open up the possibility for a shared discussion between the caregiver and clinician about the child and the family. Practitioners need to be ready to engage caregivers as partners in the assessment process. This will enable the practitioner to become aware of the emotional, social, and health needs of the whole family because these form the context within which the young child is developing. Above all, practitioners need to develop trusting relationships with families as part of the process. A strengths-based nonjudgmental approach means inviting the parent's perspectives into the conversation, in order to move forward with equitable, shared decision-making and treatment planning (Nugent et al., 2007; Zeanah Jr. & Zeanah, 2009). There are many strengths-based programs that exemplify an equitable relationship-based approach to treatment planning and intervention in later infancy and beyond, such as the Minding the Baby® Home Visiting (MTB-HV) program (Slade et al., 2020), Parent-Infant Psychotherapy (Fonagy et al., 2016), the Touchpoints approach (Singer & Hornstein, 2010), HealthySteps (Davis et al., 2022), the Circle of Security (Cooper et al., 2009; Marvin et al., 2002), Infant Massage (Field, 2019), and the Nurse Family Partnership (Olds et al., 2019).

Theory, Assessment, Diagnosis, and Culture

But, how do we interpret what we see in infant mental health assessment in order to reach a diagnosis and plan appropriate support and intervention? When we are observing a caregiver–infant interaction, for example, we find ourselves linking what we have found with what other people (theorists) have found. We may find that our observations fit with theories. We may find that they do not. Each of us has theories about infant and early development that have been built up through our own experiences as children, our experiences with children, the theories of those with whom we have had contact, and the theories we have studied. All these theories in one way or another are used to help us understand the meaning of the dynamic interactions between the child and the adult caregiver, which, in turn, can inform us about the impact of impaired relationships on the child's development. We use these theories to help us structure and interpret the meaning of the behaviors we have observed in the assessment setting.

The classic "grand" theories of Freud, Piaget, Erikson, Vygotsky, Bowlby, Winnicott, Fraiberg, Bronfenbrenner, Trevarthen, Brazelton, Lebovici, Greenspan, Stern, Emde, Fonagy, and the more recent brain models, for example, each have played a role in shaping the theoretical framework for infant mental health practitioners. Damasio (2010) has argued convincingly that adequate assessment of the child's developmental functioning must also be referenced to the neuroanatomical brain structures on which those functions depend. When it comes to understanding the difficulties that infants experience, we believe that possessing the clearest possible understanding of the brain's contribution to "what is wrong?" and "why?" gives us a more in-depth picture of how to work toward overcoming the obstacles they face. It is the integration across domains—brain, development, and context—that characterizes the practice of assessment and diagnosis in infant mental health. Understanding the neural basis of emotion—the "feeling," or social brain—is thus critical if we want to understand how children develop (Feldman, 2021; Nelson & Bosquet, 2000)

But, theories emerge in particular places at particular times and are therefore subjected to cultural assumptions and values. It is now acknowledged that that the majority of existing research on infant development and parenting—and our infant assessment techniques—spring from what has been referred to as a WEIRD (Western, educated, industrialized, rich, and democratic) cultural database, describing developmental constructs and processes in accordance with Western ideals (Henrich, 2020). From a postmodern perspective, the dangers inherent in assuming that theories are ahistorical and value-free require that all theories be viewed as partial, context-specific, and potentially normative in their applicability. The sociocultural context influences every aspect of human development, including how infant and early childhood mental health is understood, the expression of young children's development and attachment, adults' goals and expectations for young children's behavior and developmental milestones, and child-rearing practices used by parents and caregivers (Greenfield, 2018; Rogoff, 2003; Sarche et al., 2019).

The core of postmodernist thinking argues that rules, customs, beliefs, values, and ideas must be subjected to reanalysis and that greater awareness must be placed on their context-dependent, subjective nature. This perspective begs the question which theories might be the best to guide our assessment in infant mental health. It simply challenges us to reflect on the classic theories in the light of our own practical experience so that we can decide how applicable each of them is to the children we work with and our own individual work contexts. However, we also need to see the extent to which theories are supported by research evidence. It behooves us to explore the reasons underpinning our practice so that we become aware of our own assumptions, ideas, or theories and we can enhance them by reexamining the "grand theories." Practitioners can accept, adapt, or reject any one "grand theory" in question and use a range of theories while recognizing their limitations.

From a social justice and critical social science perspective, the importance of developing group- or culture-specific assessments and questionnaires is a critical challenge facing infant mental health practice. To understand the importance of culture, practitioners need to increase their awareness and understanding of the ways in which it is intertwined with power/oppression/exploitation and locate those processes within historical/social/political contexts. It is therefore critical in terms of our selection and use of conventional infant assessment tools to take account of the context-dependent nature of children's understandings. The Diagnostic and Statistical Manual of Mental Illnesses (DSM-5) has added a new Cultural Formulation Interview to guide the clinician in gathering information from an individual or family member about the impact of culture on the clinical presentation and treatment needs of the client.

The creation of the World Health Organization (WHO)-led Global Scales for Early Development (GSED) constitutes a promising leap forward in the development of a scale for use with children from 0 to 3 years across diverse cultural, demographic, social, and language contexts (McCray et al., 2023). Two measures have been created to provide a population- and programmatic-level measure of early childhood development for 0–3 years, which are valid and reliable and have psychometrically stable performance across geographical, cultural, and language contexts. These are the GSED Short Form (GSED-SF), which us a caregiver reported measure for population-evaluation that can be self-administered with no training required, and the GSED Long Form (GSED-LF) which is a directly administered or observed measure for programmatic evaluation that is administered by a trained professional. State-of-the-art quantitative and qualitative procedures are used to select theoretically relevant and globally feasible items representing child development for children aged 0–3 years. The measures include items with adequate psychometric properties derived from 18 instruments used across 32 countries, which were curated through consensus by subject matter experts. The versions of the GSED-SF and GSED-LF will be piloted and validated in children across multiple countries, both lower income, middle income and higher income families, to ensure validity across diverse demographic, social, and language contexts for future use.

In sum, a postmodernist approach to assessment seeks to provide clinicians with a set of analytical tools (something like a theoretical toolbox) that they can use to view practices from different perspectives, providing alternative ways of seeing and understanding the same situation while also assisting them in conceptualizing what other practices might be possible. DC:0-5 embeds clinical diagnosis within the context of Diversity-Informed Tenets for Work with Infants, Children, and Families. These Diversity-Informed Tenets are a set of 10 guiding principles that raise awareness of the inequities embedded in society by empowering practitioners, organizations, and systems of care to identify, confront, and dismantle the systems of oppression intricately intertwined with all work with and on behalf of infants, children, and families (Noroña et al., 2021).

Summary and Key Points

The goal of mental health assessment is to make sense of a child's mental health symptoms and the associated factors that include the parent–child relationship, the environmental context, the child's physical and developmental status, acute and chronic stressors, and biological features. Understanding the interplay among these factors may begin with another logical framework, but the domain of classification must be integrated with within-person, relationship-based, and environmental (including family, neighborhood, culture) approaches to understanding the risk, emergence, and persistence of impairing emotional, behavioral, and developmental symptoms in disorders of early childhood (Egger & Emde, 2011). An infant mental health approach to assessment incorporates a developmental, relational, and biological perspective on the presenting symptoms and includes data collected from interviews, observations of dyadic or triadic interactions, and scores on validated screening tools. An assessment is the start and not the end of the process, and its results can be used to determine the best level of care, provide the right services, and help point to the needs of the child.

In sum, IMH assessment and intervention should occur within a relational framework in which the IMH clinician establishes an open, trusting relationship with the caregiver and infant

(Zeanah et al., 2016). Developing a partnership with family members is therefore an essential element in the assessment–diagnosis process, given that infants and toddlers are unable to provide information of their own difficulties. The development of these relationships begins with the clinician's reflective stance: a stance of curiosity, openness, willingness to listen, and acceptance of differences and uncertainty.

As we look toward the future, we need to

- Expand early screening for infants and toddlers to detect mental health issues, such as relationship disorders, depression, and self-regulation problems.
- Train professionals in mental health, pediatrics, early childhood education, child welfare and other related professions to recognize risk factors and ensure that undergraduate, graduate, and continuing professional education include content on infant mental health.
- Support obstetrics and pediatrics departments to screen for health-related social needs, such as financial insecurity or intimate partner violence, to identify the risk factors that may precipitate or exacerbate mental health conditions.
- Develop group- or culture-specific assessments and questionnaires.
- Incorporate infant mental health consultations into programs for parents, childcare, early education, well-child health services, and home-based services.

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13

Diversity-Informed Practice for Parent/Caregiver Relationship Assessment

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Children are born into a world in which everything has an influence on them. As infants, they are shaped by what they are fed, how they are held and cared for, who communicates with them, and how communication occurs. Young children take in the sensations and emotions of their environments, and, based on sociocultural values and norms, caregivers help translate these experiences, providing meaning to the children's sense of self. Children who live in violence and chaos (e.g., families affected by war, genocide, displacement, etc.) can grow up fearful and constantly anxious or become distant. Or, they can have one or more emotionally attuned caregivers who do their best to shield them from the negative aspects of their environment and provide them with care, which encourages a healthier sense of self, thus helping the child to thrive. Caregivers come with their own histories, not just of their experience of being parented but also how they are impacted by their larger context. Therefore, contextual factors can either protect and support families or wound them. Hence, to learn about and understand a young child, one must look at those relationships in the context of the ecology surrounding the family.

Understanding Children in the Context of Relationships

Any assessment of a caregiver–child relationship should include awareness of the larger caregiving context, including where the child resides and with whom, what is going on inside the child's home and in the neighborhood and city, within local and national politics, and how this impacts both the child and the caregiver. The number of caregivers for any child varies and can be socioculturally influenced. In certain families and contexts, children are raised in multigenerational homes with relatives having assigned caregiving roles. In other contexts, children are raised communally, and community members play important roles in the nurturance of each child. Children are deeply impacted by their caregivers' well-being and they take cues from their caregivers to interpret their environment. Any infant mental health (IMH) clinician tasked with understanding a child will need to observe and assess the "web

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of caregiving relationships" (ZERO TO THREE, 2016, p. 145) and learn about the family's current and past contextual factors to understand the impact of each relationship on a child's life. Children have unique relationships with each caregiver and to understand only one relationship in any child's life will not provide the full picture in understanding the child. Similarly, the quality of relationships among caregivers influences the child; thus, observing the child with a caregiving unit is necessary to understand the full dynamics impacting the relationships.

It is important to attempt to understand how each caregiver sees the child and ask questions such as: What is happening in the caregiver's world that impacts the caregiver's view of the child? Does the caregiver enjoy this child, or is the caregiver experiencing multiple stressors that make it hard to have the energy to focus on the positive moments in parenting? Is the caregiver aware of the child's unique developmental needs, and does the caregiver's current emotional functioning enable them to handle raising this specific child? Was the child born from an adverse circumstance, which has left the caregiver distraught or conflicted about the child's existence? The assessor also asks how the dyad's sociocultural context has impacted the interaction. The assessor may question if and how structural circumstances and inequities have taxed the caregiver's and child's emotional and physical resources, impacting the caregiver's capacity to read their child's cues, attune to and enjoy their child, or provide protection to their child. How have these circumstances impacted the child's capacity to enjoy, communicate with, and find safety with their caregiver?

An evaluation of a young child is incomplete if the caregiving relationship context has not been assessed. The knowledge and skills to complete these assessments are needed for treating children on an outpatient basis, providing valuable input for a custody evaluation, and understanding what needs to be addressed in child protection matters for reunification with the parent and for those engaging in research on young children. Additionally, the assessor brings personal history, professional values and beliefs, and biases when understanding the dyad and interpreting what is presented during the assessment.

The Importance of Understanding Social Location

Every aspect of IMH assessment is shaped by sociocultural influences and other aspects of identity and social location in the family and in the assessor. Social location refers to the social position that a person or group holds within the society (who one is and who one is not) (Noroña et al., 2021) based on their identities, including race, ethnicity, social class, education, nationality, immigration status, gender identity, sexual orientation, ability, religion, and others. Individuals and groups can be positioned in contradictory ways because they hold multiple identities, and they may also navigate different sociocultural contexts at different moments in their lives (Hernández & McDowell, 2010; van Mens-Verhulst & Radtke, 2008). Social location deeply affects who a person becomes, their self-perception, access to opportunities, experiences with inequity and oppression, and interactions with others. It follows that a family's or caregiver's recognition and understanding of symptoms in a young child, their values and perspectives on help seeking, child rearing, caregiver–child relationships, and treatment options are all are integrally connected to their past and present social location and sociocultural contexts. An assessor who draws a conclusion from a Eurocentric lens may negatively view/interpret a caregiver's response to their toddler throwing a tantrum, while a caregiver coming from a different sociocultural context may not share the assessor's concerns. An assessor's perceptions, interpretations, and recommendations related to caregiver–child interactions, young children's symptoms, and the interactions of the assessor with the child's family are shaped by the assessor's identities (including their professional training, sociocultural context, and social location) and the values and beliefs inherent to these identities (Noroña et al., 2021). Therefore, building the assessor's capacity for self-awareness constitutes a necessary commitment to growth as IMH assessors, diagnosticians, and "experts." Assessors must understand and take responsibility for the impact of the paradigms used and imposed on the most vulnerable of families. They must question how they can be instruments of liberation or oppression and then make decisions about how they are going to use their power and privilege in the course of their work.

When Relationship-Based Assessments Can Be Harmful

Relationship-based assessments provide the assessor an in-the-moment view of the relationship between the child and caregiver. Because a hypothesis is often formed based on one or two interviews and interactions, assessors must be intentional in reflecting on their biases, power, privilege, purpose, and how assessments can be either helpful or harmful to families.

The IMH field has procedures for assessing several aspects of the caregiver–child relationship as reflected in the interactions between caregivers and their infants (Crowell & Feldman, 1988, 1989; Heller et al., 1998). However, it is necessary to also consider how assessors regularly assess for their own biases that might color their interpretations. Assessor biases are defined as assumptions made about families based on race, other markers (e.g., immigration status, sexual orientation, parenting views, literacy, language), and stereotypes. These assumptions can have a direct impact on how an assessor interacts, observes, interprets, and makes recommendations. An assessors' attitudes and biases, implicit and explicit, unconscious and often unexplored, contribute to disparities in mental health services and systems. This is particularly true in the treatment of Black, Indigenous, and People of Color (BIPOC). Stigmatization of families based on providers' and systems' views regarding socioeconomic status, education, and access to resources contributes to differences in how services are provided to BIPOC. An assessor needs to explore the messages received about diverse races, ethnicities, languages, and sociocultural groups from their childhoods, from their professional training, and how having or not having access to reflective supervision and knowledge about various people has impacted their assumptions, perceptions, and biases about other communities (Singh & Chun, 2010; Noroña et al., 2021).

The impact of stereotypes about BIPOC has to be acknowledged by the assessor, as ignoring this can result in harm to the family. Different cultures respond, attach, and interact differently in relationships. What is considered inappropriate parenting behavior in the dominant culture may serve as protection in an oppressive or unsafe environment. Keller (2018) warned against negatively judging parenting practices that are inconsistent with Western middle-class ways of describing sensitivity and responsivity. For example, not following an infant's lead, not expressing emotions openly, not talking about an infant's internal states, and using nonverbal communication may be labeled as intrusive, unresponsive, emotionally distant, neglectful, or showing a lack of mentalization. Stern et al. (2022) note that, based on current measures, African American families score lower on maternal sensitivity and secure attachment than do other groups and that this difference is accounted for by socioeconomic factors (Malda & Mesman, 2017). They call for research on caregiving behaviors that promote secure attachment and positive outcomes, specifically among Black children who are navigating attachment in a racist society.

Another area of potential harm occurs with families whose primary language is not English. These inequities may involve: (1) use of poorly translated instruments or consent forms, (2) use of instruments that have not been normed with the targeted population, (3) lack of assessors who have been vetted as bilingual/polyglot (knowing several languages) and who can understand, translate, and describe the nuances of caregiver–child relationships and their sociocultural context, and (4) lack of resources for training, collaboration, and support for interpreters. Serious consequences can result for families based on linguistic biases and barriers such as the collection of inaccurate data, which can lead to misidentification of strengths and needs, misdiagnosis, and the family forsaking services and becoming more isolated because of a of lack of trust in the provider or agency (The Workgroup on Adapting Latino Services, 2008; Perez-Foster, 1998). Not implementing, enforcing, or minimizing the importance of language-responsive services are manifestations of individual and organizational racism, which usually collude with policies that are harmful to young children (e.g., immigration enforcement policies) (Liu et al., 2019).

History of Harm on Power Base in Relationship-Based Assessments

Assessments begin with the knowledge that the assessor holds the power to use a tool and make a judgment based on analysis of information gathered and that information may be shared with another party. This power dynamic becomes particularly evident in child welfare when decisions on child removal or reunification are based on assessment results and the assessor wields formidable power.

Given the high-stake situations in which assessments are used, scholars have warned against shortcuts or misinterpretations in relationship-based assessments. This warning is specifically related to the misuse of attachment theory to make decisions regarding placement for children in child welfare, a system which, in Western societies, is fraught with racial bias and disparities (Cénat et al., 2021). A 2017 review authored by 43 prominent attachment researchers, primarily from North America and Europe, noted the troubling misuse of attachment measures as definitive assessments in child welfare along with the false assumption that all children who display disorganized attachment behaviors have been maltreated (Granqvist et al., 2017). While disorganized attachment has been associated with maltreatment, it is also associated with withdrawn, frightening, or frightened parental behavior, extreme deprivation, socioeconomic risk (Cyr et al., 2010; Stern et al., 2022), and the intersection of historical and intergenerational trauma (Lewis et al., 2013; Lewis, 2019). Given that attachment theory is a theory of safety and security, it is necessary to consider that frightened parental behavior may be an adaptive response when racial violence or other forms of oppression are present. Cyr et al. (2010) found that children who were exposed to five or more socioeconomic risk factors, including low income, low education, adolescent motherhood, single motherhood, and ethnic minority status, were at a similar risk of disorganized attachment as were children who had been found to be maltreated. Granqvist et al. (2017) describe the misunderstanding and misuse of attachment assessment for placement decisions as harmful for families with multiple socioeconomic risk factors, discriminating against BIPOC, and violating human rights. In focusing on a child's behavior in the context of the relationship rather than the larger context, the caregiver is blamed, punished, or, at best, the target of intervention, when, in fact, the focus should be to understand the impact of structural factors on the relationship.

The Importance of Contextualizing Relationship-Based Assessments

When looking through the lens of the relationship with BIPOC, immigrant communities, and other marginalized groups, considerations about the impact of historical trauma, ethno-racial trauma, and the ways in which these communities protect their children, heal, and thrive via nondominant ways of knowing and being need to be explored, understood, or included.

The importance of understanding, assessing, and treating children in context is not a new idea. It is foundational to the IMH field. The field's pioneers observed children impacted by war, hospitalization, and institutionalization (Bakwin, 1942; Burlingham & Freud, 1942; Spitz 1949). As the field matured, it integrated multiple theoretical perspectives, including transactional systems theory (Sameroff, 1975, 2010) and ecological systems theory (Bronfenbrenner, 1979), which highlight the interconnected nature of the child, caregiver, and multiple levels of the environment. The addition of a diversity-informed framework (St. John et al., 2012) demonstrated the growth of the field in accounting for sociocultural, political, and historical influences of power, privilege, and oppression on children, caregivers, child/caregiver relationships, IMH providers, and provider/family relationships.

Core Components of Child/Caregiver Relationship-Based Assessments

The necessity of a relationship-based assessment in understanding infants' and young children's mental health has been codified as best practice in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (ZERO TO THREE, 1994, 2005, 2016). DC:0–5™ Axis II operationalizes the core components of relationship assessments and a review of selected chapters on relationship-based assessments reveals general agreement on these core components (Clark et al., 2019; Frankel et al., 2019; Larrieu et al., 2019). Although DC:0–5™ is considered an internationally accepted diagnostic system and the chapters reviewed all address issues related to cultural sensitivity, the chapters were written in English from a Eurocentric lens. The core components described below include diversity-informed practice as operationalized through Diversity-Informed Tenets for Work with Infants, Children, and Families (Irving Harris Foundation, 2020), which defines diversity-informed practice as

> a dynamic system of beliefs and values that shapes interactions between individuals, organizations, and systems of care. Diversity-informed practice recognizes the historic and contemporary salience of racism, classism, sexism, ableism, homophobia, xenophobia, [transphobia], race, ethnicity, class, gender, sexuality, age, able-ism, xenophobia, homophobia, and other systems of oppression and strives for the highest possible standard of inclusivity in all spheres of practice: teaching and training, research and writing, policy and advocacy, as well as direct service. (p. 1)

Relationship-Based Assessment Attends to the Family–Assessor Relationship

An assessor must be an authentic, open, and intentional listener who knows when and how to probe and what words to use for further explanation of what is being observed without offending or disrupting the interaction. From the very first contact, the assessor meets the caregiver where they are. This may require greater attention depending on the referral source, for example, if the caregiver is mandated to complete this assessment versus if the caregiver is voluntarily seeking services. At the onset, assessors note the caregiver's pace, level of understanding, reason for seeking services, and implications of the family's identities (race, ethnicity, sociocultural and linguistic background, etc.) for the family's social location, and contextual factors during the assessment process. Assessors mention their identities and social location when they introduce themselves to families as a way to create a port of entry to have honest and difficult conversations about racism and other systems of oppression. The steps for an assessor's initial meeting may look like this (Table 13.1).

Here is where the assessor starts to establish a relationship, creating an environment to foster trust so that families will feel comfortable showing and sharing their authentic selves in the child–caregiver relationship. As the fostering of trust unfolds, understanding the families' responses and behaviors within their sociocultural context becomes paramount. It is imperative for the assessor to ask the caregiver whether they feel comfortable sharing their culture, beliefs, and behaviors. This authentic acknowledgment of the assessor's interest can often strengthen the trusting relationship. Everything that the assessor

Table 13.1 The steps for the assessor's initial meeting

Introduce yourself using social location and explore the purpose of the meeting as understood by both parties
Ask the caregiver to introduce themselves and ensure that there is time for a more detailed exploration of both the assessor and the family so that the family members feel heard and accepted
Explore what information the caregiver has about you and/or your agency and the reasons why they were referred to you/your agency
Provide information, free of jargon, about your agency/practice, training background, role in the context of the referral, and your relationship with the referral source (e.g., the referral source will expect a report from you) if the request for services did not come from the family
Collaborate with the child's caregiver(s) to identify a time, a date, and a modality (telehealth, in person) for an initial informational session
Describe what will occur in the assessment process. Highlight the collaborative nature of the process
Open space to answer any questions the caregiver has about what the assessment process will entail. Recognize that the caregiver may not feel comfortable questioning an assessor who holds power in this relationship and will need extra encouragement that the assessor truly wants input from the caregiver throughout this process
Explain how and with whom the information will be shared and what that means in terms of confidentiality
Explain how the assessment findings will be shared with the family
Acknowledge that there may be times when you ask questions to clarify your understanding of what you have observed and how you have interpreted an observation. Encourage the family members to also ask questions throughout the process
Explain that you and the caregivers will meet at the end of the evaluation to discuss their thoughts and the results of the assessment

does sets the stage for how the family feels about the evaluation and how and if the family will work with the assessor moving forward.

Perceptions of power and authority impact the engagement of the family. The caregiver knows that the results of the assessment may influence decision-making for their child. The power differential is always present even when the assessor is of the same sociocultural background, race, and gender as the caregiver. However, the power differential becomes more complicated when the assessor is from a different cultural background, race, or gender and the caregiver's experiences with the assessor's culture group have been complex. It is the assessor's responsibility to understand the family and how history and experiences of power, powerlessness, and oppression might hinder the family member's ability to initially engage in a relationship with the assessor. If this is not considered, then the family member may present as quiet, not engaged, or perceived as uncooperative. When engagement does not occur, the assessment will likely not show the true relationship with the child due to fear and mistrust. The assessor must also be aware that silence in some cultures is a way of processing before communicating and avoiding eye contact in some cultures is a sign of respect. IMH assessors understand that while there is an initial formal assessment period, the assessor continuously learns about the family as the relationship between the assessor and the family deepens.

The family–assessor relationship is paramount. Healthy psychotherapy relationships contribute to positive outcomes across all therapies and settings (Laska et al., 2014; Norcross & Wampold, 2011). The assessor must be authentic, present, and empathic—a listener from the beginning and throughout the therapeutic process. Each family member must be seen as an individual with unique concerns. These concerns, which have been brought into the system, should not be judged nor should assessors assign blame. The concerns must be evaluated objectively as actions impacting the family's life. Withholding bias and prejudice and seeing families through these lenses allow assessors to work from a place of awareness and facilitate the ability to empathize with the family member's feelings while maintaining perspective. This empathy can be felt just as unspoken judgment can be perceived by the caregiver, and it sets the tone for whether the family can begin to build trust and feel safe in the assessor–family relationship or whether family members need to remain guarded. Society, social environment, and experiences must be understood to understand the family.

Carl Rogers (1942) said:

> The relationships which are helpful are characterized by a sort of transparency in which real feelings are evident; by an acceptance of the other person as a separate person with values in his own right; and by a deep empathic understanding which

> enables me to see his private world through his eyes. When these conditions are achieved, I become a companion to my client, accompanying him in the frightening search for himself, which he now feels free to undertake. (p. 34)

Linguistic Responsiveness Is a Right

A central aspect to the implementation of relational assessments is linguistic responsiveness. It can be defined as the provision of "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (National Alliance of Mental Illness, 2014, p. 12) in families served.

Tenets 6 and 7 of the Diversity-Informed Tenets underscore that language (verbal and nonverbal) has the power to heal or hurt, praise and honor, or blame and shame. They also remind the assessor that offering IMH assessment in the family's native language is not only congruent with socially equitable practices but that it is also a right that families have (St. John et al., 2012). The National Standards for Culturally and Linguistically Appropriate Service (CLAS) Standards were developed in 2000 by the US Department of Health and Human Services (HHS) Office of Minority Health and were updated in 2013 to encourage organizations and practitioners to implement strategies to abide by this right.

Organizations should develop strategies for hiring, recruiting, training, and promoting providers who are polyglots to conduct assessments. If the caregiver and child communicate in different languages, the assessment should be conducted in both languages, and the assessor should serve as a bridge between the caregivers and child. If the assessor is unable to communicate in the family's language, an interpreter trained in mental health should be used, and if an interpreter is not available, cultural brokers (e.g., *promotoras*) can also be trained to support interpretation and help build bridges with the targeted communities (Perez-Foster, 1998).

Materials should be developed in the languages of the target populations or they should be translated from English using best practices available like a qualified translator service or by a committee that includes bilingual speakers/polyglots who are part of the target population or who have experience working with them and are also familiar with the terminology and content area. The Workgroup on Adapting Latino Services (2008) recommends

- Translations should always be reviewed by a translation review committee and followed by a consumer feedback process.
- Assessors and organizations should only use translated measures of the highest quality.
- Translated instruments must have achieved reliability and validity in the language of the target population and be sensitive to the language needs of the target population.
- Non-translated procedures and instruments should be translated using a forward and backward translation process followed by a translation review committee and consumer feedback processes.

Organizations should also have interpreters available and allocate resources to adequately train, supervise, and support this workforce. A relational model should be used where assessors work with interpreters as a team. Time is devoted for the interpreter and assessor to meet before and after the assessment to clarify the purpose of the session and each partner's role and also to discuss any information that was unclear or missing. Interpreters should not be expected to facilitate structured tasks or play with children during relational assessments but stay within their professional role (Miller et al., 2019.

To the Degree Possible, the Assessment Is Conducted Across Time and Settings

Assessors develop hypotheses about caregiver–child relationships based on a finite amount of data, and the conclusions are limited based on the data available. Each piece of information adds to the picture, which will change over time as the assessor–family relationship progresses. The information obtained is influenced by the state of the caregiver and child at a particular time and in a particular setting (e.g., in the home, at childcare facility, in the office), with a particular assessor, and based on the tools used to assess. The assessor should ensure that the assessment of the dyad, triad, or other configurations of the child and their caregivers is conducted when the caregivers and the child are at their optimal functioning, for example, not conducting a formal assessment during the child's naptime, just after a doctor's visit when the child received shots, when the caregiver or child is ill, or when the caregiver or child is actively in need of food or shelter.

Multiple Methods of Assessment Are Used for a Full Understanding of the Relationship

Different methods of assessment, including observations, interviews, and paper-and-pencil measures, allow for information to be conveyed and received across multiple modalities, providing opportunities for caregivers to share their thoughts and feelings and for assessors to observe the in-the-moment interactions between caregivers and child. Each of these modalities may be formal or informal and standardized or unstandardized, and they each provide unique information. Hearing or reading how a caregiver thinks and feels about the child is often different from observing the dyad together. Caregivers may positively describe the child but then show minimal connection when they are in a room together. For example, a caregiver may not visibly respond to the child's cues or may be triggered by the child playing independently, crying, or not smiling. Conversely, a caregiver may have few words to share about the child and present a limited picture of their relationship during an interview, but then the caregiver and child may be observed to engage comfortably in each other's presence. By gathering information across multiple modalities, the assessor gathers clues to understand the dynamics impacting the child through relationships.

The Following Domains of Child/Caregiver Relationships Are Assessed

Background Information on Caregiver(s), Child, and Caregiving Environment Assessors generally begin a relationship-based evaluation with the caregiver(s) completing a background interview without the child present so that the caregiver may speak freely about concerns and events that are potentially contributing to the current situation. Assessors may also request collateral information from other sources (e.g., the child's medical records, including pre- and perinatal history, reports from the child's school, previous caregiver or child evaluations, and court documents if there is child welfare or family court involvement). During a background interview, the assessor obtains information about the child's and caregivers' histories, including each individual's trauma histories (inclusive of racial and immigration trauma), information about environmental stressors and resources, information about family routines and traditions across generations, and information about sources of joy, positive early experiences, and cultural healing practices. A standard interview also includes prenatal, medical, and mental health issues of the child and caregiver, developmental (cognitive, motor, social, and emotional) attainment, educational and legal system involvement, family composition, transitions and losses, and any other relevant background information (Costa & Noroña, 2019). in addition to a clinical interview, standardized paper-and-pencil measures may be used to assess symptoms and adaptive features in the caregiver that impact the relationship, symptoms and adaptive features in the child that impact the relationship, risk and protective factors in the environment, and the child's development.

DC:0–5™ supports understanding the caregiving environment through a sociocultural lens by the inclusion of a Cultural Formulation for Use with Infants and Young Children (Sarche et al., 2019) and offers a table with guidelines on incorporating cultural perspectives across all areas of infant/young child assessment. Guidelines include (1) obtaining information about the caregivers' and child's cultural identities including multiculturalism and acculturation, (2) understanding cultural explanations for problems including whether the caregiver perceives a problem or if someone else perceived a problem and referred for an assessment, (3) obtaining information about the child's psychosocial and caregiving environment including the child's life space in the home and in the community, the child's caregiving network, and the caregivers' beliefs about parenting and child development.

Consideration of Subjective Experiences Caregiver–child relationships, specifically attachment relationships, are intergenerationally influenced and mediated, in part, by the caregiver's internal working model (Bowlby, 1969), defined as a subjective, cognitive-affective framework that shapes how individuals understand themselves, others, and the world. Internal working models influence what the caregiver expects from their child and, therefore, impact how a caregiver interacts with a particular child. This interaction, along with other factors from the child's sociocultural context, in turn, influences that child's internal working model of how others will treat them and how they perceive themselves and the world. Caregivers' subjective experiences may be gleaned from behavioral observation and interviews, whereas the child's subjective experience is inferred based on behavioral observation (Dickson & Bekman, 2019; Larrieu et al., 2019).

Standardized interviews to understand the caregiver's subjective experiences of their child and of parenting include the Working Model Interview of the Child (Zeanah et al., 1996), the Parent Development Interview (Slade et al., 2004), and the Adult Attachment Interview (George et al., 1996). Paper-and-pencil measures, such as the Parenting Stress Index™, Fourth Edition (Abidin, 2012), assess the caregiver's level of stress, including stress based on how difficult the caregiver perceives the child to be. Unstructured interviews may also be used to assess how a caregiver views the child, including projections, attributions, and expectations. During interviews, the assessor listens for cues from the caregiver in several areas: recognition of the child's unique needs, acknowledgment of the child's perspective, evidence of parentification, evidence of flexibility in their belief system, openness to new perceptions as the child grows and changes, and a balanced understanding of the child that is developmentally appropriate and within the bounds of cultural expectations of parenting and children's behavior. As always, consideration of the sociocultural context is necessary to understand a caregiver's responses when asked about parenting and expectations for children. Keller (2018) specifically warned that judgment based on consideration of an infant's internal states does not account for cultural variations of parenting. It is important to consider that the internal working model and associated constructs such as reflective functioning are based on theoretic constructs developed from a Eurocentric lens and to consider the lenses of the family.

Caregiver–Child Behavioral Interactions Are Observed A relationship-based observation is not complete without the assessor's observation of the caregiver(s) and the child. Because of the limited expressive language capacities of young children, the observation component of the assessment is where the child is able to provide information about the relationship from the child's perspective as seen through the child's behavior.

Structured observational assessments measure different aspects of the caregiving relationship. For example, the Crowell Parent-Child Interaction Procedure (Crowell & Feldman, 1988) includes free play, cleanup, increasingly challenging structured tasks, separation, and reunion; the NCAST Parent-Child Interaction Feeding Scale allows for observation of a feeding interaction (Sumner & Spietz, 1995), and the Lausanne Triadic Play (Corboz-Warnery et al., 1993) paradigm includes observation of a triad (two caregivers and a child). Unstructured observation may also be used if the assessor has a firm knowledge base of infant mental health, including diversity-informed practice and knowledge of multiple domains of development, attachment, and the impact of trauma/chronic stress on caregivers and young children.

While the assessor must not overgeneralize based on a single observation without putting it into context with other collected data, the observation can also be described as a snapshot of the entire history of the relationship, and the child is the one who tells the story. Both caregivers' and children's behaviors will likely be influenced by being observed. However, because they understand the impact of an assessment, because of the power dynamics at play, and because of the impact of social desirability, adults' behaviors are more likely to diverge from usual. The caregiver's feelings during the evaluation impact their behavior. For example, a caregiver who is at risk of losing custody of their child may display anger or anxiety. A child who is not used to the caregiver's mode of interaction during the observation may look at the caregiver with surprise or be unsure how to engage with this version of the caregiver who is unfamiliar. A caregiver who is acting sweet to the child during the assessment will not erase the child's memory of being abused by this caregiver, and the child may still not approach the caregiver for fear of being hit. The assessor's ability to set the stage for the evaluation in an open and supportive manner will help the caregiver engage with the least amount of stress, though removing all impacts of being observed is unlikely. It is useful to ask the caregiver at the end of the evaluation if the interaction was similar to interactions at home or if it was markedly different.

Infants/Young Children's Relationships with Each Caregiver Are Assessed Separately

A child's relationship with each caregiver is unique, and to have a comprehensive understanding of a child in a relational context, it is helpful to observe the child with each caregiver who serves in a primary caregiving role. Tenet #5 of the Diversity-Informed Tenets reminds assessors to honor diverse family structures (St. John et al., 2012). When deciding which caregivers to observe with the child, it is important to ask, rather than assume, who the child's primary caregivers are.

Each relationship is based on the individual's experiences and characteristics and how each individual responds to the other. DC:0–5™ Axis II, Table 2 lists infant's/young child's contributions to the relationship, including temperamental disposition, sensory profile, physical appearance, physical health, developmental status, mental health, and learning style. However, the relationship is defined not solely by what either the child or caregiver brings but by what happens between the child and caregiver within the particular sociocultural context, the history of the interactions, and who else is present.

DC:0–5™ describes three overarching characteristics of adequate caregiving: (1) the caregiver is consistently emotionally available, (2) the caregiver knows and values the infant/young child as a unique individual, and (3) the caregiver is comfortably and completely in charge of raising the infant/young child. DC:0–5™ further lists 14 dimensions of caregiving for which the assessor rates its contribution to relationship quality as a strength, not as a concern, or as a concern. The domains include ensuring physical safety, providing for basic needs, conveying psychological commitment and investment, establishing structure and routines, recognizing and responding to emotional needs and signals, providing comfort during distress, teaching and social stimulation, socializing, disciplining, engaging in play and enjoyable activities, showing interest in individual experiences and perspectives, demonstrating reflective capacity regarding developmental trajectory, incorporating the infant's/young child's point of view in developmentally appropriate ways, and tolerating ambivalent feelings in the relationship. While listing specific dimensions of caregiving, DC:0–5™ notes the culturally bound nature of child/caregiver relational behavior and exhorts that the assessor "think carefully about family cultural values and practices that define the infant's/young child's characteristics and which parenting practices are endorsed or proscribed"

(ZERO TO THREE, 2016, p. 143). This is consistent with Diversity-Informed Tenet 4, which reminds assessors to recognize and respect nondominant bodies of knowledge, inclusive of parenting, communication styles, and expression of emotion, and focus on the individual vs. the collective (St. John et al., 2012).

In addition to observing caregiving behavior, it is also necessary to observe the reciprocal nature of the interaction between the caregiver and child, including how both the child and the caregiver elicit interaction from one another and how they each respond to those bids for interaction. Observing the child's reactions to the caregiver supports the assessor in understanding the unique relationship and goodness of fit (Chess & Thomas, 2013) between the caregiver and child. For example, if a caregiver appears to tease a child during an interaction, the observer should note whether the child responds with fear, anger, neutrality, or delight. Heller et al. (2019) summarize child behavioral and affective domains as emotional regulation; security, trust, and self-esteem; vigilance, self-protection, safety, and comfort seeking; learning, curiosity, and mastery; play imagination; self-control, cooperation, and self-regulation; and predictability. It is critical to also assess how the dynamics shift when the child is with more than one caregiver.

Historically, assessors watch for referencing and proximity seeking between the dyad, which, from an attachment theory perspective, are viewed as observable indicators of security, safety, and trust. It is important to acknowledge that indicators of a child's sense of safety with the caregiver varies by family and are culturally bound. When observing these behaviors, sociocultural values associated with independence and interdependence should be considered as Westernized cultures prize independence, while other cultures may not. The assessor may note if the child explores the room freely or if the child stays close to the caregiver, if the child checks back with the caregiver once they venture out to play, and how the child locates themselves in relation to the caregiver. Does the child reference the caregiver or turn to them if scared? Does the child keep a vigilant eye on their caregiver's movements, staying out of reach? These are all observable behaviors that can only be interpreted within a larger context of awareness of the child's and the caregiver's personal histories and their current environment. A child may not feel safe leaving the caregiver's side and explore the toys as they have been taught that it is not safe to stray from their source of safety in the environment in which they live. A child may not visually reference a caregiver due to the family's belief that looking an elder in the eye is disrespectful. A child may feel safe and secure with a caregiver but may not show this in an unfamiliar environment, which causes stress and anxiety given their history with prior unfamiliar environments.

Ainsworth's development of the strange situation procedure (Ainsworth & Wittig, 1969) is widely used to classify attachment security by observing how a child responds to a separation and a reunion sequence. A child's body may visibly relax once the caregiver leaves the room, while another child may show signs of distress by crying, ceasing all play, looking repeatedly to the door, or calling out in an anxious tone for their caregiver. How a child reacts to the separation may be a function of the level of preparation by the caregiver (Crowell & Feldman, 1988), the history of the relationship, and the developmental age of the child. It can also be due to what happened that week in the family's life and the emotions that are being brought to the current assessment. Children used to separating daily to attend preschool or childcare may function with less distress when alone in the room, particularly if the caregiver was calm and explained that the caregiver would be right back. Caregivers who are very anxious when they leave the child can cause distress in their children who read these cues as a sign that something is amiss. It is important to note that children have been shown to be distressed by measuring their heart rate and skin conductance levels even if they do not visibly show this distress with their affect. During these assessments, the assessor watches the reunion to see if the caregiver can read the child's cues regarding the levels of need for comfort and if the dyad can resume a reciprocal positive interaction that is emotionally supportive with the caregiver assisting in regulating the child's emotions. All this requires significant clinical interpretation and a greater understanding of how comfort is provided in each family and the cultural variations around separations and reunions.

Historically, assessors are interested in what happens during play between the caregiver and child to see if certain variables are present. These variables are connected to Westernized values of positive parenting involving learning, encouraging curiosity in the world, supporting imagination in the play, and then mastery of various tasks. Westernized assessors have also looked at caregiver discipline, setting limits on unsafe behavior, and the child's level of self-control, including the child's frustration tolerance, level of cooperation in the play, and the ability to regulate independently or with the caregiver's assistance. This can all be seen in observing the dyad and triad during free play, structured tasks, or their daily routines. The assessor may note the physical orientation and distance between the caregiver and child, the amount and way the caregiver and child communicate, the emotional tone, and the reciprocity between the caregiver and child. In a multistep evaluation, the assessor may note how the child handles transitions or stressful tasks and how the caregiver reacts to the child. It is helpful to note the areas in which caregivers and children engage most positively. Some child/caregiver dyads and triads have more positive interactions while playing with toys, singing, or dancing, while others have positive interactions during daily routines (e.g., dressing, diapering, feeding, cleaning) or when teaching/learning. How individuals play and the expectation that adults engage in play with children vary across sociocultural contexts and that strengths and areas of growth in relationships may be determined by the caregiver's experiences of being parented as well as the sociocultural context.

Microprotections Are Understood Liu and colleagues (2019) have further elaborated on the concept of "microprotections" (2019), which refer to the caregiving behaviors that parents of color/BIPOC use to buffer their children against racial aggressions, discrimination, and trauma. These might include preparing their children to expect racial bias and violence, restricting their exploratory behavior to ensure safety, setting particular expectations about comportment at a young age to avoid microaggressions, and others. These dimensions of caregiving should be included in evaluations of child–caregiver relationships. Moreover, assessors and clinicians who have an understanding of racism and its purposes can play a significant role in combating negative views about these parental practices and actually in uplifting and promoting them. These forms of microprotections can involve dimensions such as (1) cultural socialization (ethnic pride, awareness of cultural history), (2) preparation for social bias, and (3) parental warmth and acceptance of the child's experience.

The Caregiving Environment Is Assessed Predominant models of relationship-based assessment have focused on children's dyadic relationships. However, young children function within families and communities, and they are directly and indirectly influenced by the relationships between members of their caregiving environment. Recognizing that assessing the web of relationships surrounding the child is required for a complete understanding of a child's experience, DC:0–5™ added ratings for the caregiving environment, which necessitates attention to caregivers' interactions and observation of the child with multiple caregivers at once. DC:0–5™ Axis II, Table 3 lists eight caregiving dimensions, including problem solving, conflict resolution, role allocation, instrumental communication, emotional communication, emotional investment, behavioral regulation and coordination, and sibling harmony. While listing specific dimensions, DC:0–5™ notes that the caregiving environment is likely to be defined and understood differently by different cultures and encourages clinicians to "strike a balance between understanding and accepting cultural variations and intervening with limits that support the infant's/young child's development" (ZERO TO THREE, 2016, p. 146). Assessors obtain information through structured and/or unstructured interviews/questionnaires with various caregivers and through direct observation of the child with multiple caregivers. The assessor notes the child's behavior and affect as they navigate relationships with different caregivers and how the relationships among caregivers impact the caregiver's ability to support the child.

The Assessor Engages in Reflective Practice and Reflective Supervision/Consultation Given that the expression of emotions and behaviors is socioculturally bound, diversity-informed reflective practice is essential for assessing these domains. What does the assessor feel while watching the child with their caregivers? Is this based on a personal experience/bias or does this use of self (Heffron et al., 2005) provide information about how the caregiver and/or child may feel? Assessors must recognize that assessments are layers of information. Using skills like metacognition can support an assessor's awareness of thoughts, biases, and triggers and contribute to the process of critical self-reflection. Metacognition refers to "thinking about thinking," a concept described by John Flavell who said that metacognition is the knowledge you have of your own cognitive processes (1979). Metacognition skills allow for higher-level thinking with the ability to think about and regulate one's own thoughts, to process and evaluate those thoughts, and to change those thoughts if necessary. Examining oneself is paramount in being able to examine how the assessor differs from the family being assessed.

Cultivating Critical Self-Reflection, Self-Awareness, and Diversity-Informed Reflective Supervision to Prevent the Reproduction of Systems of Oppression

The ability to think critically and examine the impact of the assessor's identities, experiences, and assumptions as well as what the assessor might represent for the families served (based on the assessor's history, identities, experiences, and assumptions), in the assessor–family relationship, is central to clinical practice. Tenet #1, *Self-Awareness Leads to Better Services for Families*, of the Diversity-Informed Tenets for Work with Infants, Children, and Families (Thomas et al., 2018) reminds us that "working with infants, children, and families requires all individuals, organizations, and systems of care to reflect on our own culture, values and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, [transphobia], and other systems of oppression have had on our lives in order to provide diversity-informed, culturally attuned services" (p. 40). Self-awareness, critical self-reflection, and diversity-informed reflective supervision/consultation are essential interconnected processes in the journey toward dismantling oppressive and inequitable systems and cultivating practice change in providers.

Self-Awareness

Self-awareness is the capacity to intentionally reflect on the influence that our history (personal, family, community), identities (race, class, gender identity, sexual orientation, immigration status), social location, professional culture, and other dimensions of "who we are" have had on the assessors' values, beliefs, perceptions of others and ourselves, and practice. It requires truthful examination and accountability of whether or not assessors are providing diversity-informed, anti-racist services to the families they serve and identifying areas for growth or whether the assessors' actions are performative. Cultivating self-awareness is an ongoing journey that is linked to critical consciousness and critical self-reflection.

Critical Self-Reflection

Critical self-reflection is a process in which "individuals seek to identify the assumptions influencing their actions, reveal the historical, political, and cultural origin of these assumptions, question their meaning (Stein, 2000) and purpose, take responsibility for the manifestation of their ancestral history and their impact on others, and engage in the construction of new awareness and ways of being (Fook & Gardner 2007; Rankine, 2018; Noroña, 2020; Noroña & Raskin, 2020).” It can offer practitioners resources to develop new perspectives when working with families and colleagues while addressing power relations, social and racial justice in relationships, and systems of care in society. Given that systems of oppression operate in invisible ways in individuals, their work, and in systems of care, and that implicit biases are unconscious, practitioners need access to reflective supervision/consultation that is grounded in social and racial justice is central to the provision of equitable and anti-racist services (Thomas et al., 2018; Noroña et al., 2021).

Diversity-Informed Supervision and Consultation

Diversity-informed supervision and consultation refers to the co-creation of a relational “…yet critical space for mutual challenge and collaboration in which supervisors/consultants and supervisees/consultees have the possibility of openly raising questions, challenging perspectives, confronting opinions, expressing ideas and feelings, and articulating concerns related (but not limited) to issues of racism, power, privilege, and other systems of oppression, and location of self (Norona et al., 2021, p. 64). This relationship is used to explore which dimensions of diversity (race, age, gender identity, etc.) the assessor is struggling with and to explore how to self-challenge regarding areas of discomfort, prejudice, and biases. Other areas explored include how often and under what circumstances the assessor initiates conversations about the dimensions of diversity and systems of oppression with families and what dimensions are more or less difficult to discuss (Hardy & Bobes, 2016).

The following vignette is presented as an opportunity to practice self-awareness and critical self-reflection based on information from a caregiver–child relationship-based assessment. Read the vignette and observe the thoughts, feelings, and somatic sensations that come up for you.

Vignette (Observation of a Caregiver and a Child)

A child and her grandmother, who is her current guardian, are completing a play observation in a clinic playroom. The child is well groomed with her hair nicely styled. The grandmother is in her late 50 s to early 60 s. She chooses to sit in a rocking chair and silently watches the child play with the provided toys. When the child deviates from the bucket of toys provided and goes to the shelf of toys, the grandmother calls out abruptly and tells the child not to touch anything. The child stills and stands with her back to her grandmother, looking at the toys. Throughout the play, the child does not ask her grandmother questions and does not bring her any toys to share in the play. The grandmother remains focused on watching the child.

When asked to clean up, the child resists initially, and the grandmother gives a firm directive to place the toys in the bucket now. The child complies and then looks to the grandmother. The grandmother moves the bucket to the side and takes out the tasks one by one. For each task, she tells her grandchild what to do but does not physically assist her. The grandmother gives commands from her seat. She does not specifically praise the child, but will say “OK” with finality if the child is able to complete the task. The grandmother’s affect is neutral throughout the observation as is the child’s.

At the time of the planned separation, the grandmother gives the child several toys and tells her to stay in the room and play. She leaves the room, saying she will be right back. The child is quiet. She looks at the toys and the door but does not engage in sustained play.

As an assessor for this dyad, what emotions and somatic sensations are you noticing? What are you thinking, and what are your assumptions? Who did you imagine in the dyad? What race and nationality was the grandmother? What race and nationality was the child? What language were they speaking? What were their levels of acculturation to the community? As you think about their identities, what are your thoughts about their social location? How might this social location have protected or oppressed this dyad? Would you describe this child and grandmother as connected or disconnected? Are you wondering about the level of warmth/comfort between the two? How would you describe the child's sense of safety and trust with this caregiver? What do believe to be positive in their relationship? What are the perceived challenges? How would you describe this dyad to others? What are your initial wonderings or hypotheses that you would want to explore with a colleague or reflective supervisor/consultant? What are you taking away to work on clinically to best support the dyad or areas where you feel you need more information?

In the vignette, how did you imagine the assessor introduced themselves to the grandmother and child? What aspects of their social location did they share? How did you imagine the assessor explained the rationale for watching the dyad without being in the room with them? How may this grandmother feel as she is being observed? What may have happened to the grandmother and child that day prior to the assessment or that week that may have impacted how they showed up in the room? When the grandmother looks at the assessor, what is she thinking? How can the assessor address the metacognitions and interaction to set up the assessment to be more supportive and to enhance the assessor's perspective to truly grasp the relationship between the grandmother and child in all its complexities and to communicate to the grandmother that the assessor is there to learn how to best support this relationship? How might it feel if the grandmother does not initially trust the assessor? How would you understand this? As the assessor, did you have any strong feelings in reading this vignette? Did you make some decisions about this dyad based on the way you were raised and the dyads you are used to observing? How would you challenge your thought process to ensure that you are considering your impact on the family and that you are looking at all angles of what this dyad brings into the room, both challenges and strengths??

Vignette (Interview with the Caregiver)

During the initial interview, the grandmother explained that she had raised her five children and did not plan on being a full-time caregiver to this young child and her two siblings. The grandmother is still working to best support her grandchildren and has been called many times to leave work to address the behaviors of her grandchildren. The grandmother conveyed her frustration and anger at her daughter who she describes as prioritizing her drug use over her children, and she feels she raised her daughter better. Initially, the grandmother expresses frustration with having to complete this assessment on top of all the other demands on her time. The assessor genuinely listens and asks if the grandmother has received any financial assistance. When the grandmother discusses not taking charity, the assessor conveys her admiration for the grandmother taking on this major task and empathizes with the incredible changes that the grandmother has had to make. The assessor halts the information gathering and shares that the assessor has worked with many families and fictive kin and asks if it would be OK to share the many resources that exist in their community to help keep these families together. With the grandmother's permission, the assessor calls to link the grandmother to a case manager to explore options for supports (e.g., TANF, kinship care dollars). The grandmother agrees to return the next week to discuss her granddaughter when she is off of work.

During her interview about her granddaughter the following week, the grandmother attempts to give a factual accounting of her granddaughter's behaviors. The grandmother shares that she was raised in an era when children listened, were not loud, and feared misbehaving. However, this no-nonsense demeanor shifts as the grandmother is asked to describe her granddaughter's personality and then to talk about their relationship. The grandmother begins to smile and becomes more animated as she cites the positive qualities of this young child who has experienced such adversity. The grandmother begins to reflect on all that her granddaughter has experienced in her young life and to explore why she may be engaging in some challenging behaviors but is also showing signs of trying to please her grandmother. It is clear that this is the first time the grandmother is taking dedicated space to think about her granddaughter's experiences and her needs. It is also clear that though the grandmother is stressed by her responsibilities, she loves her granddaughter and is fighting to protect her.

Holding these important questions in mind, what has changed in your view of the dyad? Did you notice the microprotections in the caregiver–child interaction? What do you personally bring to this assessment in your mindset and beliefs based on how you were trained, reared, and shaped and the current environment in which you reside and work? What are the wonderings or hypotheses that you would want to explore with a colleague or reflective supervisor/consultant?

Vignette (Observation of the Caregiver and Child Continued)

When the grandmother returns after a brief separation sequence, she opens the door and the child looks up, smiles, runs to her grandmother, and hugs her around her knees. The grandmother makes a small smile, hugs her granddaughter, holds her hand as they go back to the rocker and tells her she has been a good girl to wait for grandmother. The child then engages her grandmother in a conversation about the toys.

As you read this portion of the caregiver–child observational assessment, what emotions and somatic sensations are you noticing? What are you thinking now? Who did you imagine in the dyad? Did who you imagine change? Did your view of the level of connection between the child and grandmother change based on observing this reunion? How would you describe the level of comfort between the two? How would you describe the child's sense of safety and trust with this caregiver? What do you believe to be positive in their relationship? What are the perceived challenges? How would you describe this dyad to others? What are you taking away to work on clinically to best support the dyad or areas where you feel you need more information?

If your responses to any of the questions changed, why may this be so? How do you understand the interaction during the first portion of the assessment? How do you understand this subsequent interaction? Why may this caregiver have been quieter in the initial portion of the assessment? What is the context behind the grandmother's commands for the child not to touch the items in the room? What do you know about the grandmother, and what do you need to know about her to understand her caregiving choices? How will you wrap up this interaction to support the development of a positive working relationship?

Summary and Key Points

Understanding any young child involves an exploration of the child's caregiving environment that assists the child in understanding the world around them while providing the child with a sense of self. IMH assessors seek this understanding through observations, interviews, and various measures of the child's and caregivers' functioning. This information is only as good as the assessor evaluating it. Understanding how the family may perceive the assessor based on the caregiver's history of oppression, historical racism, and prior experiences with authority figures is critical. Preparing for any assessment, assessors should reflect on their social location, history of privilege, and how they may be perceived by their families. When conducting a diversity-informed, caregiver–child relationship-based assessment, the assessor conveys openness to the caregiver's thoughts and experiences, communicates in the caregiver's native language or uses an interpreter, conveys a willingness to learn about the family from the family's perspective, shows respect by communicating why they are gathering information in a certain manner, listens with an open mind, and conducts themselves from a supportive versus judgmental stance. The assessor ensures that the lens includes the relationship in context, factoring in historical trauma, and a wider sociocultural lens brings much greater understanding of a child in the caregiving context.

The manner of assessing a family either provides a foundation for a supportive therapeutic relationship to continue work with the family or leads to a caregiver becoming defensive, ceasing the evaluation and decreasing the likelihood that the caregiver will return for assistance in the future.

Being a competent assessor of young children requires critical self-reflection and a greater understanding of one's own biases, history, power, privilege, training, and assumptions that may be biased and be harmful in interacting with families. This chapter is an urgent call to the field about the need to question the current methods of relational assessment that reproduce and perpetuate inequities for the most vulnerable of families and proposes strategies for assessment that attend to the root causes of factors affecting caregiver–child assessment.

Actions for Practice

1. Be intentional and self-reflective in identifying your biases.
2. Know the power you hold when judgments are made based on personal preferences or the views of the dominant culture.
3. Identify tools that help you better understand yourself, your preferences, and your conscious and unconscious biases.
4. Keep in conscious awareness that historically dominant group norms are the norms by which subordinate groups have been judged. Dominant groups are those with systemic power, privileges, and social status, and subordinated groups are those that have been historically oppressed, excluded, or disadvantaged in society.
5. During consultation/supervision, discuss the concepts of dominant and subordinate group dynamics and history.
6. Be the advocate that provides clarification that the assessor's tool is only one piece of the story in exploring the caregiver–child relationship and other considerations should be the companion for decision-making.

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14

Infant Mental Health and the Assessment of Adverse and Protective Childhood Experiences

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Infant mental health theory and practice place early development firmly in the context of the caregiver–child relationship. Babies are born wired to connect, and brain development occurs within the social context and through social interactions (Belsky & Pluess, 2009; Child and Adolescent Health and Development, 2004; Hari et al., 2015). Having a comprehensive understanding of children's early contextual experiences, including both adverse and protective experiences, is essential for research and practice. The purpose of this chapter is to provide an overview of the methods for assessing the range of positive and negative experiences in infants and young children, as well as the influence on the caregiver experiences.

The history of infant and early childhood mental health is grounded in the importance of the early relational experiences of parents and other caregivers. These early relationships form the foundation for their own ability to provide nurturing care and supportive environments for infants and young children (Fitzgerald et al., 2011; Fraiberg et al., 1975, 2018; Lieberman et al., 2005). Following the publication of the adverse childhood experience (ACE) study (Felitti et al., 1998), and a large global epidemiological study investigating associated health risks (Anda et al., 2006), studies have also documented the enduring negative effects of cumulative adversity in childhood. The original ACE study provided evidence from thousands of adult patients to support what developmental and clinical psychologists had witnessed for decades in smaller studies and clinical practice; early childhood experiences set the foundation for later development in social, cognitive, physical, and mental health functioning. Indeed, the ACE study found that ACEs were common and co-occurred and that the effects were cumulative as shown in recent reviews (Anda et al., 2006; Felitti et al., 1998; Hays-Grudo & Morris, 2020).

The original ACE study developed the 10-item Adverse Childhood Experiences Study Questionnaire (ACE-SQ, described below), which included 5 items that assessed family dysfunction (household member incarcerated, mentally ill, and/or abused drugs or alcohol; parental divorce or separation; and domestic violence) and 5 items that assessed child abuse and neglect (physical, verbal, and sexual abuse and/or emotional and/or physical neglect). Respondents answered whether or not these experiences occurred prior to age 18.

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The effects of the original ACE study were astounding to the investigators and the field, indicating that having four or more ACE items increased depression 4.6-fold and suicide attempts 12.2-fold (Felitti et al., 1998), as well as anger control difficulties 4.0-fold and committing intimate partner violence 8.8-fold (Anda et al., 2006). The risk of unintended pregnancy was also doubled (Dietz et al., 1999). Since the original study, hundreds of other studies have found similar results among US adults (Giano et al., 2020) and children (Clarkson Freeman, 2014; Flaherty et al., 2013). ACEs are also common across countries and cultures, with adults living in African (46%; Oladeji et al., 2010), European (47%; Bellis et al., 2014), and Asian (74%; Ho et al., 2019) countries having reported experiencing at least one ACE. Studies have also expanded the original ACE measure to include other adverse experiences such as discrimination, war, corporal punishment, and refugee status (Cronholm et al., 2015; Solberg & Peters, 2020) and have found similar deleterious effects on development and functioning, which will be described below (Davis et al., 2018; Wade Jr. et al., 2016).

Importantly, studies have also found that protective early childhood experiences can buffer the effects of early adversity and promote resilience in both parents and children (Hays-Grudo et al., 2021; Morris et al., 2021; Narayan et al., 2018; Osofsky et al., 2021). Decades of developmental and clinical theory and research illustrate the importance of nurturing relationships for social, emotional, and brain development in infancy and early childhood (Howe, 2011; Vandell et al., 2010). Caregivers' reports of remembered benevolent childhood experiences (BCEs) in infancy and early childhood (Narayan et al., 2020) and working models of attachment predict adult functioning and parenting in the next generation (Cooke et al., 2019; De Wolff & van Ijzendoorn, 1997; Sher-Censor et al., 2013), thus underscoring the importance of assessing childhood protective factors as well as adversity to understand developmental trajectories and outcomes.

Life Span Perspective on Adversity and Resilience

Adversity affects the body, brain, and immune system, primarily through the body's response to stress. An altered stress response that is either over- or underactive due to the chronic experience of adversity inhibits a child's ability to learn, the body's capacity to heal, and the mind's ability to cope (for detailed reviews, see Hays-Grudo and Morris (2020), Shonkoff et al. (2012), and Teicher and Samson (2016)). Excessive childhood stress can become biologically embedded by systematically changing children's physiology (see Fig. 14.1), which is adaptive for survival in the moment but results in lasting differences in physical health, mental health, learning, and behavior (Berens et al., 2017; Hays-Grudo et al., 2021; Miller et al., 2011; Nelson, 2013). Adversity can be transmitted intergenerationally through biological adaptations, e.g., epigenetic and neurobiological stress responses (Anacker et al., 2014), through insecure attachments to abusive or neglecting caregivers (Lomanowska et al., 2017) and through deficits in socioemotional development (Briggs-Gowan et al., 2012; Lomanowska et al., 2017) resulting from childhood adverse experiences. Consequently, young children are at an increased risk of experiencing mental health concerns, social–emotional–cognitive delays, and physical health problems when they have a history of ACEs (Cprek et al., 2020; Liming & Grube, 2018).

The Intergenerational and Cumulative Adverse and Resilience Experiences (ICARE; see Fig. 14.1) model expands upon past models of adaptation to stress by incorporating both positive and negative adaptations to stress and adding prevention targets to negate potential maladaptive outcomes (Hays-Grudo & Morris, 2020). While acknowledging the neurobiological adaptations of adversity for survival, the ICARE model incorporates both biological effects of positive social relationships and developmental supports that promote pathways to resilience. The first panel in the model includes protective and adverse early life expe-

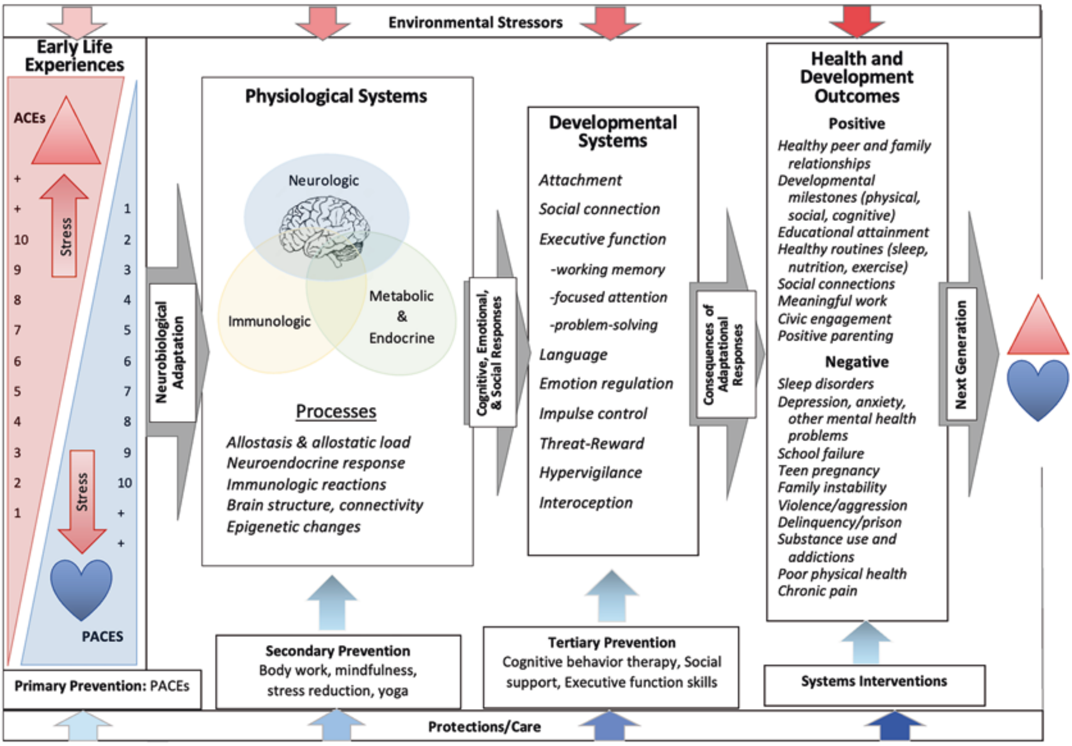

Fig. 14.1 The Intergenerational and Cumulative Adverse and Resilience Experiences (ICARE) model. (Reprinted with permissions from Hays-Grudo and Morris (2020))

riences, discussed in more detail in the subsequent sections of this chapter. From these childhood experiences, physiological systems adapt to promote immediate survival. Primarily, the neuroendocrine response and the immunological and metabolic systems are affected by allostatic load, which is the cumulative cost of stress on the brain and body after extended or repeated attacks on the crisis-response system (McEwen, 1998; Danese & McEwen, 2012). Research shows that environments void of necessary support – caregiver affection, language, and nutrition – can hinder neurogenesis, such that new neuronal connections are not as easily formed. Similarly, early chronic stress can also lead to overactive neuronal responses and decrease activation of brain receptors that return the body to homeostasis after activation (Anda et al., 2006; Slopen et al., 2013; Tyrka et al., 2016). Following these biological changes, further developmental adaptations occur regarding socialization, emotion regulation, and cognitive advancements such as language acquisition, impulse control, and executive function. When developmental systems have a typical trajectory, positive healthy outcomes are more likely. However, developmental systems that have atypical trajectories are more likely to lead to negative outcomes such as internalizing symptoms, aggressive or violent behaviors, and even poor physical health and chronic pain (Barch et al., 2018; Kelly-Irving et al., 2013; Masten & Cicchetti, 2010; Sachs-Ericsson et al., 2017). Finally, as seen in the last panel of the model, an individual's cumulative experiences are handed down to the next generation by passing on genetic and epigenetic variations as well as through social interactions and neighborhood and socioeconomic conditions (Metzler et al., 2017).

Assessing Adversity

There is growing interest in preventing the impact of ACEs and mitigating the intergenerational transmission of trauma (Bowers & Yehuda, 2016; Merrick & Narayan, 2020; Narayan et al., 2021). As such, it is imperative that treatment providers and researchers use psychometrically strong assessment tools to identify risks and symptomology among infants, toddlers, and young children. However, the risks associated with young children cannot be separated from the risks present in their caregiving environment (Narayan et al., 2021). This is especially true for infants, toddlers, and preschool-aged children (Nelson et al., 2020). Efforts over the past three decades have focused on identifying parents and caregivers with a history of ACEs and understanding how their experiences may directly or indirectly impact their child, such as their psychopathology and parenting practices (Narayan et al., 2020, 2021) or the environmental conditions in which they and their children are living (McKelvey et al., 2017a; McKelvey et al., 2017b). Thus, it is important that treatment providers and researchers take a holistic, relationship-based, and developmentally appropriate approach when assessing risk and adversity among young children, including their family and respondents from other social systems, such as other primary caregivers and teachers.

Assessment is necessary for screening, eligibility determination, and, ultimately, prevention intervention and treatment planning. This section discusses a selection of well-supported assessment tools for screening trauma and adversity among young children and their family system. According to best practices in trauma-informed screening, it is recommended that screeners have identifiable cutoff scores for interpretation that can inform the next steps in further assessment to support treatment planning (Substance Abuse and Mental Health Services Administration, 2014). At the end of this section, we provide the rationale for using gold-standard mental health assessment measures in early childhood and discuss the strengths and implications of these assessments as they should accompany screenings and assessments of adversity. Notably, assessing exposure to adverse conditions or experiences is not the same as assessing the type and extent of trauma experienced by children or their caregivers (Danese & Lewis, 2022). For the purposes of this discussion, assessment of adversity will refer to the former.

Adverse Childhood Experiences Study Questionnaire (ACE-SQ) The hallmark Adverse Childhood Experience (ACE) study was a collaboration between the Centers of Disease Control (CDC) and Kaiser Permanente (CDC, 2022) in which the study investigators created the Adverse Childhood Experiences Study Questionnaire (ACE-SQ) from a broad array of questions. The final 10-item survey asks adult respondents to reply either "yes" or "no" to a set of adverse experiences prior to their 18th birthday (described previously; CDC, 2022; Felitti et al., 1998). A total ACE score was calculated by summing all "yes" categories (some questions include multiple options), with higher scores being interpreted as having more ACEs (Felitti et al., 1998). According to medical treatment providers, asking parents about their own and their children's ACEs can be a brief and effective method to learn more about their patients, facilitate empathy and openness, and provide an opportunity to support them in treatment planning (Flanagan et al., 2018; Gillespie & Folger, 2017; Hardcastle & Bellis, 2019). Rather than having respondents provide a yes or no response for each question, they may be asked to provide a total score or the number of ACEs experienced, without identifying questions, to facilitate honest and confidential responses. Additionally, parents may be more receptive to receiving resources and referrals by treatment providers if they only report a total score (Flanagan et al., 2018; Folger et al., 2018; Hardcastle & Bellis, 2019).

The ACE-SQ has strong psychometric properties, including acceptable internal consistency ($\alpha = 0.74$) and test–retest reliability ($r = 0.79$; Karatekin & Hill, 2019). It also demonstrates strong convergent validity with other measures of adversity and trauma (Karatekin & Hill, 2019).

Although the ACE-SQ is one of the most researched and utilized screeners for early adverse childhood experiences, there are notable limitations regarding its interpretation. The most relevant concern is that the measure was developed for use in large-scale epidemiological studies and was not intended or validated for individual predictions of risk (Anda et al., 2020). A related issue is the determination of cutoff scores for the ACE-SQ. While some researchers suggest that any score greater than one should be considered clinically significant, others have argued that a score greater than four is a more appropriate clinical cutoff (Corvini et al., 2018). Additionally, the ACE-SQ does not ask respondents to indicate the intensity or chronicity of the adversity or age(s) at which the experience occurred (Felitti et al., 1998). As such, a positive screen on the ACE-SQ, irrespective of the cutoff score, only provides evidence that assessment and further evaluation is necessary (Substance Abuse and Mental Health Services Administration, 2014). The ACE-SQ also does not include adverse experiences that often occur in low- and middle-income countries such as refugee status and exposure to war. (The ACES-IQ (Adverse Childhood Experiences-International Questionnaire) is discussed in more depth later in this chapter).

Maltreatment and Abuse Chronology of Exposure (MACE) Scale The MACE scale addresses some of the issues related to the ACE-SQ questionnaire. It includes 52 items categorized into 10 types of maltreatments, including (1) emotional neglect, (2) nonverbal emotional abuse, (3) parental physical maltreatment, (4) parental verbal abuse, (5) peer emotional abuse, (6) peer physical bullying, (7) physical neglect, (8) sexual abuse, (9) witnessing interparental violence, and (10) witnessing violence to siblings (Teicher & Parigger, 2015). Respondents are asked to indicate whether they did or did not experience the type of adversity and, if so, at what age(s) the experience(s) occurred and the severity of the experience (Teicher & Parigger, 2015). The MACE scale can be interpreted using the overall severity score (ranging from 0 to 100), the severity sum of all individual maltreatment items, or the multiplicity score (ranging from 0 to 10), which is the total number of maltreatments indicated. Higher severity scores and multiplicity scores are interpreted as clinically elevated severity and total number of adverse experiences, respectively. The MACE scale has several strengths, as it was developed to address the limitations of the ACE-SQ and provides a more robust screening measure for the retrospective assessment of trauma and adversity during an adult's upbringing (Teicher & Parigger, 2015). The MACE scale expands on the abuse/neglect and household dysfunction classifications of adverse experiences by adding items for peer victimization and witnessing violence toward parents/caregivers and siblings (Teicher & Parigger, 2015). At the time of the MACE scale development, the Child Trauma Questionnaire (CTQ; Bernstein et al., 1997) was the gold-standard screening parent report measure for reporting child maltreatment history and severity of adverse experiences. However, the CTQ did not account for unique developmental trajectories and the child report version was only suitable for children of ages 8 years and older (Bernstein et al., 1997). Like the CTQ, the MACE scale was created to assess the severity and age of exposure across the developmental life span (Teicher & Parigger, 2015). Finally, the MACE scale has strong test–retest reliability ($r = 0.91$ for severity and $r = 0.88$ for multiplicity) and convergent validity with the ACE-SQ and CTQ (Teicher & Parigger, 2015).

The Family Map The Family Map is a comprehensive, strength-based, structured and semi-structured clinical interview and observational measure that gathers data about the quality of the family system and parenting environment and child outcomes and includes an assessment of both adverse and protective factors (Kyzer et al., 2016; McKelvey et al., 2017a; McKelvey et al., 2017b; Whiteside-Mansell et al., 2007, 2022). The Family Map assessment goes beyond screening and informs eligibility determination and treatment planning. The creators of the Family Map used community participatory action research guidelines to develop the measure with families and schools connected to Head Start programs (Whiteside-Mansell et al., 2007). The Family Map includes three primary areas of assessment: (1) physical and social conditions, (2) family climate and context, and (3) parental characteristics. The physical and social conditions domain assesses what the child experiences directly and the extent to which the child has opportunities for certain social conditions that promote optimal development (Bradley & Corwyn, 2002). For physical conditions, this includes assuring survival (i.e., by providing adequate nutrients, shelter, and healthcare), maintaining the physical health of the child, especially if they have chronic health conditions, and surveillance of the child through monitoring and childcare. For social conditions, this includes the extent to which parents promote school readiness, provide emotional support, have structured and nurturing routines, and integrate their young child into social contexts. The family climate and context component assesses the degree of cohesion and conflict in the family as well as exposure to violence, including both domestic and neighborhood violence. The parental characteristics domain assesses parents' personality characteristics, mental health, and substance use history (Whiteside-Mansell et al., 2007).

The Family Map has several strengths and some limitations. Not only does the assessment identify comprehensive and detailed information about parenting, health, and safety concerns but the information can be used to inform family goals and provide targeted intervention and service referrals (Whiteside-Mansell et al., 2007). As such, the Family Map can be a valuable tool for monitoring symptoms and assessing a family's response to intervention (Whiteside-Mansell et al., 2007). The Family Map has appropriate psychometric properties, including adequate test–retest reliability and interpretation cutoff points for assessing risks at the item level and three primary area cluster levels. Lastly, a breadth of treatment providers can be trained to administer the Family Map, as the training materials are free and have open access. The relative cost of the Family Map is time, as the assessment and observational component takes approximately 60–90 minutes to administer. However, the breadth and depth of the information collected by the Family Map is unmatched by other measures of children's developmental contexts.

Other Assessments of Trauma and Adversity It is beyond the scope of this chapter to include a discussion of all assessments of adversity. We have chosen instead to focus on the most commonly used assessments that are relevant to infant and early childhood mental health. There are additional assessments that have been used in the field for both parents or caregivers of young children to assess trauma and adversity, including the Assessment of Parent and Child Adversity (King et al., 2022), Pediatric Emotional Distress Scale (PEDS, Saylor et al., 1999), Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR; Choi et al., 2019), and the Child Stress Disorders Checklist (Saxe & Bosquet, 2004).

It is important to acknowledge and differentiate between adversity and trauma in order to understand what is being assessed and, consequently, what might require intervention. Adversity covers a wide range of negative and stressful experiences, including those indicated on the ACE-SQ and MACE scale. However, although they can be, not all adverse experiences are traumas for children. Trauma is often associated and indicated with posttraumatic stress disorder (PTSD), a psychiatric diagnosis found in the *Diagnostic Classification 0–5* (DC:0–5), and includes the expression of traumatic stress symptoms (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5)). A diagnosis of PTSD includes classifications of symptoms, including being directly impacted or exposed to a traumatic and adverse event, and a constellation of symptoms spanning 4 weeks after the adverse event, including reexperiencing, avoidance, and negative alternations in cognition, mood, and behavior (DSM-5). As such, the gold-standard, psychometrically strong and standardized diagnostic assessment tool for PTSD and other psychiatric disorders among young children of ages 2 years and older is the Preschool Age Psychiatric Assessment (PAPA; DelCarmen-

Wiggins & Carter, 2004; Egger et al., 2006). The PAPA includes psychiatric diagnoses derived from the *Diagnostic and Statistical Manual for Mental Disorders* (Fifth edition; DSM-V-TR; American Psychiatric Association, 2022), the *Diagnostic Classification: 0–5* (DC:0–5; ZERO TO THREE, 2021), and empirically supported symptoms and behaviors that are not captured in both diagnostic systems (DelCarmen-Wiggins & Carter, 2004). Importantly, not all young children who experience adversity develop traumatic stress reactions and, consequently, PTSD and, in fact, often have resilience and protective factors that can mitigate trauma (Narayan et al., 2021).

Assessing Protective Experiences

A wealth of research on resilience has revealed the role of protective experiences in mitigating the negative consequences associated with early life adversity (Hays-Grudo & Morris, 2020; Luthar, 2015; Masten, 2014a; Zeanah Jr., 2009). Research has suggested that protective experiences are dose-responsive, like ACEs, such that the more protective experiences one has in early life the better their overall health will likely be across their life span (Bethell et al., 2019; Morris et al., 2021). Decades of research on early adversity and resilience has resulted in the development of several frameworks and strategies for assessing protective experiences that can buffer children from the deleterious effects of ACEs as well as aid individuals with a history of ACEs in reestablishing healthy developmental trajectories (Hays-Grudo & Morris, 2020). Although the development of resilience-based assessments has gained notable momentum recently, a number of these approaches have been established and include instruments for assessing resilience in the context of early development. Four of these leading approaches will be outlined in the following sections.

Protective and Compensatory Experiences (PACEs) Scale The Protective and Compensatory Experiences (PACEs) framework is one approach for examining protective experiences across the life span (Morris et al., 2014; Hays-Grudo et al., 2021). A total of 10 PACEs were identified from the literature on resilience as experiences that mitigate the effects of early adversity through relationships and resources (Hays-Grudo & Morris, 2020). The PACEs scale was developed for assessing the protective and compensatory experiences in early childhood (0–5), childhood and adolescence (6–18), and adulthood (see Table 14.1). PACEs can be operationalized into two primary categories: relationships and resources. The relationship factors of the 10 PACEs include (1) love – being loved and cared for unconditionally; (2) guidance – positive relationships with adults outside of the immediate family; (3) friendship/peer relations – spending time with a best friend or peer; (4) affiliation – group interaction, membership in a group, club, team, or network for personal or professional support; and (5) benevolence – observing and practicing empathy and taking part in volunteer groups or activities. The resource factors include (6) stability – structure and routines; (7) comfort – a living space that is clean, safe, and uncluttered; (8) learning – resources to increase knowledge and skills to grow as an individual; (9) movement – time and opportunities to be physically active; and (10) recreational – opportunities for play and to cultivate engaging or relaxing interests and hobbies. The 10 PACEs come from decades of developmental and clinical research on resilience and include experiences and environmental resources that can serve as research-based protective factors and provide a blueprint from which everyday life can be built (Hays-Grudo & Morris, 2020) or "the conditions in which the 'ordinary magic' of resilience can flourish" (Masten, 2014b, p. 227).

There are a number of PACEs assessments (https://www.acesandpaces.com/) that can be used for research alone or in combination with assessments of adversity. The original PACEs scale was designed to be administered in combination with the ACE-SQ and includes 10 experiences that occurred prior to age 18 using "Yes" or "No" response options (see Hays-Grudo and Morris (2020)). In the last year, newer versions of the PACEs scale were developed to assess current

Table 14.1 PACEs across developmental stages

Birth to 5 years	Middle childhood	Adolescence	Adulthood
Love			
Nurturing and responsive care from parent or caregiver	Love from parent or caregiver not used as reward or punishment	Strong, positive relationships with parents, allowing more independence	Being loved and cared for by partner or close friend
Guidance			
Time spent with nurturing adults outside of immediate family	Supportive teachers or other caring adults	Opportunities for guidance from trusted adults	Positive relationships with older, wiser adults
Friendship			
One-on-one play with peers and siblings	Spending time with one or two best friends from school, family, neighborhood	Continuation of childhood friendships and addition of new ones as interests change	Keeping cherished friends and making new friends at each stage of life
Affiliation			
Group play and interactions with adult supervision	Social groups and clubs through school, interests, neighborhood	Expanded network of associations based on interests, aspirations	Membership in groups for personal and professional support and benefit
Benevolence			
Observing and practicing empathy and caring for others	Being helpful at home, school, neighborhood	Taking part in volunteer groups and activities	Being actively engaged in community volunteering and altruistic actions
Stability			
Regular, predictable schedule for meeting physical and emotional needs	Consistent times, routines, and rituals to accomplish daily tasks pleasantly	Reasonable changes in routines to allow more self-regulation	Structured but flexible routines and rituals that support goals and values
Comfort			
Food, clothing, hygiene, and a safe and uncluttered home	Involvement and cooperation in chores to keep a healthy home	Increased responsibility for ensuring healthy living conditions	Intentional actions to ensure safe, healthy, and orderly household
Learning			
Opportunities to learn through talking, reading, unstructured play, and being outdoors	Schools and other settings that provide resources for cognitive and social–emotional development	Educational resources to identify and develop skills and abilities needed for adult life	Resources to increase knowledge and skills, and grow as a person, partner, parent, member of society
Movement			
Regular active and outdoor play	Instruction and time to develop physical skills and sporting interests	Time and opportunity to be physically active individually or in organized groups	Regular physical activity to stay healthy and strong throughout adulthood
Recreation			
Resources readily available to play creatively	Opportunities and materials to develop creative or other talents and interests	Time and resources for self-motivated development of creative hobbies	Opportunities to cultivate engaging and relaxing hobbies and pastimes

PACEs using a Likert scale, with 1 being "Never" and 5 being "Very Often." The original scale demonstrates reliability as indicated by internally consistent responses across different demographic groups and concurrent validity, as it is associated with fewer ACEs, less depressive symptoms, and parenting attitudes and behaviors in expected directions (Hays-Grudo & Morris, 2020; Morris et al., 2021).

PACE scales for adults and early childhood are included in the Appendix. Because it can be difficult to objectively reflect on one's childhood, especially when attempting to get at the earliest years of life (Hardt & Rutter, 2004), the Baby PACEs (ages 0–5 years) can be collected from parents and caregivers on behalf of their child, whereas the Adult PACEs (ages 18+ years) can be collected on behalf of the reporting individual. See the Baby PACEs and Adult PACEs measures in the Appendix.

Benevolent Childhood Experiences Scale Another scale that has received attention in the early resilience literature is the Benevolent Childhood Experiences (BCEs) scale (Merrick & Narayan, 2020; Merrick et al., 2019; Narayan et al., 2018). The BCEs scale was developed by Narayan et al. (2018) specifically to assess early influences on the parent–infant relationship, highlighting positive early experiences of caregivers with the potential to mitigate or counteract the negative effects of early adversity. Like ACEs and PACEs, the BCEs scale includes 10 items administered retrospectively. It focuses on favorable early experiences around topics, such as perceived support and security and positive and consistent life qualities (Narayan et al., 2018). Items are structured with a "yes or no" response format, with items such as "Did you have at least one caregiver with whom you felt safe?" and "Did you have a predictable home routine, like regular meals and regular bedtime?" (Narayan et al., 2018). The BCEs scale has been found to possess high test–retest reliability ($r = 0.80$, $p < 0.01$, and an internal consistency coefficient of $\alpha = 0.61$) (Narayan et al., 2018; Oge et al., 2020). This scale was developed with the intention of being administrable for cross-cultural and multilingual use with careful consideration of the inclusion of items that would not be linked to higher socioeconomic status (SES) or individuals from more developed regions of the world.

Positive Childhood Experiences (PCEs) Scale The Positive Childhood Experiences (PCEs) scale was similarly developed to measure positive interpersonal experiences or opportunities that could potentially reduce the risk for adverse mental and relational health outcomes associated with exposure to early life adversity (Bethell et al., 2019). Items developed for this measure revolve largely around themes of family and community safety, support, belonging, and involvement. The PCEs composite score is calculated from seven items concerning an individual's experiences as a child, including: (1) felt able to talk to their family about their feelings; (2) felt their family stood by them during difficult times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled); (5) felt supported by friends; (6) had at least two non-adult parents who took a genuine interest in them; and (7) felt safe and protected by an adult in their home. Bethell et al. (2019) found the PCEs scale to possess an internal consistency of $\alpha = 0.77$. Items are framed within "childhood" rather than within a specified age range and are assessed using a two-point scale, with the first option including "never, rarely, or sometimes" responses and the second option including "very often or often" responses. Items were designed to be culturally sensitive and have been supported by associations with measures of resilience (Bethell et al., 2019; Ungar, 2008).

Positive Parenting Practices (PPPs) The six Positive Parenting Practices (PPPs) are assessed in the context of family environment, with a particular focus on parenting (Yamaoka & Bard, 2019). The Positive Parenting Practices approach targets the parent and child together, as parenting practices are considered to be one of the more readily modifiable aspects of a child's experience (Bethell et al., 2016; Traub & Boynton-Jarrett, 2017). These six practices include (1) eating family meals together; (2) getting out of the house together as a family (e.g., taking a walk, going to a park, doing yard work together, etc.); (3) singing together; (4) playing with peers and connecting with other children; (5) reading books and telling stories; and (6) setting limits on the use of technology and screen time. Each PPP is assessed by caregivers reporting how many days in the past week they engaged with their child in each of the mentioned activities as well as the number of hours their child spent on screen. From these responses, a PPP binary indicator is produced for each activity and operationalized as positive when the frequency of a PPP is greater than or equal to 3 (i.e., 3 days a week) and when the screen time is lower than 2 (i.e., hours per day). From this initial assessment, each of the six binary PPP indicators are summed to produce a count variable similar to an ACE score (Yamaoka & Bard, 2019). In their original study assessing the presence of PPPs for children between the ages of 0 and 5 years, the authors found that the PPPs were not only significant protective factors for early adverse experiences but also their absence had a similar negative developmental effect on children as adding "four or more ACE score units" (Yamaoka & Bard, 2019, p. 534). Reliability and validity data are not yet available for PPPs; however, this measure is more of a checklist of positive parenting behaviors than it is a focused index seeking to measure one construct of resilience.

Additional Assessments of Protective Experiences Additional resilience assessments that measure protective factors in adults and caregivers include the Flourishing Scale, an eight-item measure designed to capture self-perceived aptitudes in social and emotional areas, including self-esteem, optimism, and building and sustaining relationships (Diener et al., 2010). Summing scale items produces a composite score indicative of psychological well-being. The Child and Youth Resilience Measure (Ungar & Liebenberg, 2011), a self-report measure of social–ecological resilience, consisting of 28 items, serves as a screening tool for assessing the cultural, communal, relational, and individual resources individuals possess that may enhance their resilience (Ungar & Liebenberg, 2011). Another assessment of positive experiences, the Scale of Protective Factors (SPF), was developed by Ponce-Garcia et al. (2015) as a comprehensive resilience measure, particularly with individuals who have experienced severe or violent trauma. This 24-item scale emphasizes the protective or buffering factors that contribute to resilience, including social-interpersonal and cognitive-individual factors (Ponce-Garcia et al., 2015).

Example of Using These Assessments

Jayden is a 2-year-old Native American assigned female at birth (pronouns: she/her/hers). She presented with her biological parents at her annual well-child visit for routine screening and checkup. Jayden's mother was asked to complete several screening assessments so that her primary care provider (PCP) could understand Jayden and her mother's exposure to adversity and protective factors. Jayden's mother completed the self-report ACE-SQ (CDC, 2022), the parent report MACE scale (Teicher & Parigger, 2015), and the Current Adult and Baby PACEs (Morris et al., 2014; see Appendix). Jayden appeared well-adjusted and was meeting her developmental milestones in a timely and appropriate manner.

Jayden's PCP provided psychoeducation on screening for ACEs and PACEs and led a thoughtful discussion on the findings. Jayden's mother reported a total ACE score of 3 and a total PACE score of 8. As per her mother's report, Jayden had a total MACE score of 1 and a total PACE score of 7. Jayden's PCP used a trauma-informed approach and asked her mother to share her experience of adversity and protection at the level she felt comfortable. Jayden's mother shared that she experienced postpartum depression following Jayden's birth and has a chronic history of depressive episodes for which she has been treated with antidepressant medication. Jayden's mother reported a desire to "do the best for Jayden." Her PCP thanked her mother for sharing, validated her desire to provide unconditional love and support to Jayden, and offered her resources to mitigate the impact of adversity and also promote both of their PACES. Jayden's PCP gave her mother a referral for outpatient psychotherapy and new-mother social support networks within her community. Jayden's PCP created goals with her mother for capitalizing on Jayden's PACEs and supported her by adding a new PACE, including giving Jayden opportunities to be physically active.

Jayden's vignette demonstrates the utility of integrating screening tools for both adversity and stress and protective factors for young children and their families in the context of medical settings. Notably, Jayden's case can be generalized across treatment settings where initial screening and assessment procedures are often performed. As implied in the vignette, screening can be a brief and effective method to understand cultural context, promote provider–patient rapport, and provide prevention–intervention resources to families. Screening also serves to inform treatment using strength-based recommendations. For example, Jayden may have required a higher level of care had she reported higher MACEs and lower PACEs. As such, Jayden could have been referred to more intensive treatment or a comprehensive evaluation to determine treatment planning.

International and Cultural Perspectives

An international perspective on the contemporary approaches to the assessment of adverse and protective childhood experiences acknowledges and accounts for the unique and differential impacts of culture and context. An infant's rearing environment is one of the primary contexts in which they develop their sense of self, sense of others, and the world (Fitzgerald et al., 2021). Although all infants and toddlers are exposed to adverse and protective experiences within their rearing environment, to some extent, these experiences are context-dependent and are contextualized differently across cultures (Fitzgerald et al., 2021; Ungar, 2008). In other words, what might be considered an adverse experience that is associated with maladaptive health outcomes in one culture may not be considered a normal experience (Ungar, 2008) in a different culture (Del Giudice, 2014). Alternatively, experiences may be contextualized as protective and adaptative across cultures but with varying degrees of importance or salience (Ungar, 2008). Thus, it is imperative to be sensitive to how risk and resilience are defined across cultures and contexts by understanding these constructs across family and community systems and culture traditions and values (Fitzgerald et al., 2021; Ungar, 2008).

Although there is robust literature on understanding and preventing adverse and protective childhood experiences, there is limited research on the construct of risk and resilience in non-Westernized or industrialized cultures (Ungar, 2005). The lack of empirical literature is problematic because Westernized views and values of risk and resilience, and consequent health outcomes, do not translate globally (Ungar, 2008). For example, Westernized views of protective childhood experiences emphasize the importance of secure attachment between the child and caregiver, educational opportunities, and accessing resources and social support as a means of adaptive coping (Ungar, 2008). These protective childhood experiences cannot be assumed to be the same protective experiences in non-Westernized cultures (Ungar, 2008). Concomitantly, adverse childhood experiences in Westernized or industrialized cultures differ from those of non-Westernized cultures, including poverty, food insecurity, and war. Approximately 689 million people, 9.2% of the world population, live in extreme poverty, while 38 million of those people, less than 1%, live in the United States (World Health Organization, [WHO], 2021). Additionally, 11.7% of the global population faced food insecurity at a severe level after the coronavirus disease 2019 (COVID-19) pandemic (WHO, 2021), particularly in sub-Saharan Africa and Southeast Asia. Lastly, the average death rate due to conflict and war has doubled in the past 5 years, at a rate of 2.5 deaths per 100,000 (WHO, 2021). An international perspective of childhood adversity must address these unique hardships and, consequently, the unique protective experiences across different cultures. Finally, although the burden of ACEs is universal, some individuals are disproportionally more likely to experience ACEs than are others (Merrick et al., 2018). Individuals with marginalized identities, including people of color and people who are economically marginalized, are more likely to experience adversity through transmission of intergenerational trauma and historical trauma compared to individuals without marginalized identities (Fitzgerald et al., 2021). The intergenerational transmission of trauma and historical trauma may be passed down through narratives and collective memories (Crawford, 2013). Similarly, healing from intergenerational transmission of trauma and historical trauma requires passing down resilience-enhancing factors, such as racial socialization, enhancing community systems, and keeping cultural traditions (Fitzgerald et al., 2019). When assessing adverse and protective experiences using a more global lens, it is important to include both qualitative and quantitative methods, allowing individuals to tell their trauma and resilience stories, and utilize more standard assessments to examine within and between cultural differences. Moreover, taking a trauma-informed and culturally humble approach to assessment emphasizes mutual learning, self-reflection, the role of implicit bias and power differentials, and compassion (Ranjbar et al., 2020). One of the most widely utilized surveys of ACEs from an international perspective is the ACE-IQ, which is described below.

Adverse Childhood Experiences International Questionnaire (ACE-IQ) The ACE-IQ was created for the purpose of measuring childhood adversities in all countries to better understand the cultural salience of adversity and how these experiences uniquely and differentially impact behaviors and health outcomes (WHO, 2011). The ACE-IQ (https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq)) assesses 13 categories of adversities across 4 dimensions including (1) abuse, (2) neglect, (3) family dysfunction, and (4) violence outside the home. Unique to the ACE-IQ, violence questions assess exposure and experiences that include bullying, community violence, and globally relevant collective violence, such as terrorism, displacement, or war (WHO, 2011). In a systematic review of the literature examining ACE-IQ prevalence rates, Pace et al. (2022) found that the average lifetime prevalence of adversity was 75.01% and that emotional abuse was the most common type of adversity. Although the ACE-IQ broadens the global experience of different types of adversities, it is important to acknowledge the need for continuous adaptation of the measure to include culturally appropriate questions and terminologies. For example, Quinn et al. (2018) adapted the ACE-IQ for an underserved and low-resource community in South Africa. Following several focus groups with community leaders, the researchers observed that questions about sexual abuse history were especially distressing to the community and required sensitive wording, and, so, the researchers modified the ACE-IQ language to reflect common words spoken in the community to more accurately assess their experiences (Quinn et al., 2018).

There are a limited number of measures of adversity and resilience from an international perspective. Although the ACE-IQ is a helpful tool to address unique adversities that occur globally, it is not able to assess adversities from multiple cultural or regional perspectives. To address this limitation, researchers have advocated for using qualitative methodology to observe and understand context-dependent risk and resilience factors across cultures (Beasley et al., 2018; Quinn et al., 2018). For example, Ng et al. (2012) designed and implemented a descriptive assessment of a parent's socialization goals for their child. During the assessment, parents were asked to identify and rank a list of qualities they value and desire their child to possess as they develop (Ng et al., 2012). This assessment is important because a parent's values of their child's qualities are directly aligned with their culture and norms (Durgel et al., 2009), and researchers have found that parent's values of their child's qualities varied across ethnicity and socioeconomic background (Tamis-LeMonda & Kahana-Kalman, 2009). This is an example of how researchers can measure the dynamic and nuanced factors that impact risk and resilience across cultures and context, and such methods will improve our understanding of how early childhood experiences may differ in predicting resilience and adaptation across cultures and communities.

Summary and New Directions

Assessing childhood adversity is necessary for identifying children at risk for poor outcomes and for identifying problematic areas needing large-scale programmatic interventions and policy changes in order to reduce their prevalence. Likewise, measuring and analyzing the effects of protective experiences to mitigate the effects of adversity is also imperative for programs and policies. We advocate for always assessing protective factors in conjunction with adverse experiences, as they provide an important component of context that cannot be ignored when examining development and functioning. Moreover, reporting on protective experiences allows participants to reflect and report on factors that likely had a positive impact on their lives and bring back positive feelings and images in contrast with just reporting on ACEs. The ICARE model (Hays-Grudo et al., 2021; Hays-Grudo & Morris, 2020) provides a framework for examining both adverse and protective experiences across the spectrum of interventions, from primary prevention to therapeutic interventions (see Fig. 14.1). As a research tool, the ICARE framework provides a comprehensive view of the effects of early experience on development across stages and systems. Moreover, it highlights the complex effects of caregivers' adverse and protective experiences on parenting and on the next generation.

The availability of measures of adverse and protective experiences that adequately reflect the unique and shared values of many sociocultural populations are wanting, although research is beginning to inform the field with more diverse perspectives and constructs (for example, see Carlo et al. (2022), Ivanich et al. (2022), and Smith et al. (2022)). As the field of infant and early childhood mental health becomes more diverse and inclusive, research and clinical initiatives gain from the development of more varied and culturally valid perspectives. The challenge for both researchers and clinicians at this stage in our understanding of the role of environmental exposures in children's early development is to collaborate across the disciplinary, cultural, linguistic, and geopolitical barriers to develop and utilize reliable and valid assessment tools. Altogether, the following key points and takeaways include:

1. It is imperative that researchers and providers assess for adverse and protective experiences among infants and caregivers to holistically promote infant mental health.
2. An intergenerational perspective is needed to mitigate risk and promote protective experiences for infants, thus understanding that a caregiver's history of adversity and protection, as well as their current experiences, are necessary for assessment.
3. There is meaningful variability within and between cultural experiences of adversity and protection, and, thus, using a mixed methods approach is best when measuring adverse and protection across cultures. The ACE-IQ may be an appropriate tool to use.
4. In clinical settings and policy efforts, screening for both adverse and protective experiences is feasible and appropriate to determine eligibility for services and inform treatment.

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Appendix

Protective and Compensatory Experiences (Baby PACEs)

When answering these questions, think about the last 12 months. On a scale of 1–5, fill the circle of the number that best describes how often each of the items occurred.

Never	**Rarely**	**Sometimes**	**Often**	**Very Often**
1	**2**	**3**	**4**	**5**

		1	2	3	4	5
1.	When my child was upset, I was able to comfort and soothe them.	Never O	Rarely O	Sometimes O	Often O	Very Often O
2.	My child was attached to at least one other adult caregiver.	Never O	Rarely O	Sometimes O	Often O	Very Often O
3.	My child had opportunities to play with a child of the same age or a sibling close in age.	Never O	Rarely O	Sometimes O	Often O	Very Often O
4.	My child was part of a formal or informal play group with children of similar ages.	Never O	Rarely O	Sometimes O	Often O	Very Often O
5.	I encouraged my child to be helpful and caring in their interactions with others.	Never O	Rarely O	Sometimes O	Often O	Very Often O
6.	My child had daily, weekly, or other routines (bath time, meal time, etc.) and consistent rules and limits appropriate for their age.	Never O	Rarely O	Sometimes O	Often O	Very Often O
7.	My child lived in a home where needs were met, for example, safe to explore, regular meals, and clean and uncluttered.	Never O	Rarely O	Sometimes O	Often O	Very Often O
8.	My child had at least one caregiver (mom, dad, teacher) who read or talked to them daily.	Never O	Rarely O	Sometimes O	Often O	Very Often O
9.	My child had opportunities to play and be physically active.	Never O	Rarely O	Sometimes O	Often O	Very Often O
10.	My child had outings at parks, zoos, libraries, or other places where they could experience drawing, painting, or music.	Never O	Rarely O	Sometimes O	Often O	Very Often O

Protective and Compensatory Experiences in Adulthood (Current Adulthood PACEs)

When answering these questions, think about the last 12 months. On a scale of 1–5, fill the circle of the number that best describes how often each of the items occurred.

Never	**Rarely**	**Sometimes**	**Often**	**Very Often**
1	**2**	**3**	**4**	**5**

		1	2	3	4	5
1.	I felt loved and did not doubt that I was cared for.	Never O	Rarely O	Sometimes O	Often O	Very Often O
2.	I had someone I trust that I could turn to for advice, mentorship, or support.	Never O	Rarely O	Sometimes O	Often O	Very Often O
3.	I had at least one best friend, someone I could count on and had fun with.	Never O	Rarely O	Sometimes O	Often O	Very Often O
4.	I was engaged in at least one social or faith-based group.	Never O	Rarely O	Sometimes O	Often O	Very Often O
5.	I did things to benefit others or participated in community-helping projects.	Never O	Rarely O	Sometimes O	Often O	Very Often O
6.	I had regular routines for things like sleeping, eating, and exercising.	Never O	Rarely O	Sometimes O	Often O	Very Often O
7.	I lived in a space that was clean, safe, and uncluttered.	Never O	Rarely O	Sometimes O	Often O	Very Often O
8.	I had opportunities to learn and grow as a person or in my work.	Never O	Rarely O	Sometimes O	Often O	Very Often O
9.	I was physically active, either alone or with others.	Never O	Rarely O	Sometimes O	Often O	Very Often O
10.	I enjoyed at least one hobby or leisure activity.	Never O	Rarely O	Sometimes O	Often O	Very Often O

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15

Advancing Equity Through Engaging Communities to Address Measurement Disjuncture in Indigenous Infant and Early Childhood Mental Health

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Infant and early childhood mental health and wellbeing are foundational priorities in American Indian and Alaska Native (hereafter referred to as "Indigenous") communities and are embedded in ceremony, relational practices, and connectedness. Although Indigenous and non-Western communities around the world have similar cultural values and relational worldviews, this chapter focuses on our collective work with Indigenous communities in the United States. Existing measures relevant to early childhood often fail to consider Indigenous worldviews, values, and practices that nurture and protect the health and development of families with young children. Misalignment of worldviews not only results in measurement disjuncture (Sul, 2019, 2021) but also undermines equity in Indigenous early childhood programs, practices, and policies. The goals of this chapter are to: (1) describe measurement disjuncture and share how community and cultural contexts impact infant and early childhood measurement in Indigenous communities; (2) propose a common language for approaches to adapting and developing measures across a cultural continuum; (3) provide examples of measurement with Indigenous communities across this continuum with considerations for cultural tailoring, specificity, and use; and (4) share strategies to improve the field of early childhood measurement.

Measurement Disjuncture

Measurement disjuncture occurs when there is a misalignment in measurement tools across different worldviews, cultures, and contexts (Sul, 2019, 2021). Disjuncture is especially pronounced when tools are developed within the context of a specific worldview and applied in the context of another worldview (e.g., measures developed within a Western context that are applied in Indigenous communities) (Sul, 2021).

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Measurement disjuncture not only leads to measurement error but also calls into question the validity of instruments when used in different contexts (Sul, 2019). Disjuncture related to content validity includes the misalignment of items in a measurement tool with the culture and context of the community or population of focus (Whitesell et al., 2015). Disjuncture related to construct validity is the misalignment of constructs in a measure with theory, culture, and context (Walls et al., 2019). Also of concern is disjuncture that affects cultural validity, which is the misalignment in a measurement tool that considers ways of knowing, understanding, and experiencing the world (Walls et al., 2019).

In addition to measurement disjuncture contributing to issues of reliability and validity, there are inherent risks for applying measurement tools that were developed for Western contexts in Indigenous communities. One risk is conformity to a Western worldview, which is often found in federally funded early childhood home visiting programs that require the use of evidence-based models and validated measurement tools. Although using validated tools is a best practice, most of the existing tools that Indigenous communities must choose from are, in fact, neither validated for nor culturally specific to their populations (Del Grosso et al., 2011; Hiratsuka et al., 2018; Walls et al., 2019). Conformity to a Western worldview diminishes the importance of community and family contexts within Indigenous communities. For example, mainstream conceptualizations of family structure often align with Eurocentric definitions of nuclear families (Jensen & Sanner, 2021); these measures have little context and appreciation for extended kinship and intergenerational families, which are common in Indigenous communities and other non-Western cultures around the world (Jensen & Sanner, 2021).

Another risk of measurement disjuncture is misalignment in cultural contexts when developing measurement tools. This manifests in the lack of consideration for cultural strengths, values, knowledge, and beliefs within Indigenous worldviews. Failure to consider ways of knowing reinforces measurement error (Sul, 2019). Moreover, misalignment in cultural values and beliefs is a missed opportunity to measure attributes that are important and are of value in the community (Walls et al., 2019). For example, measuring cultural outcomes is a key challenge among the Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grantees, as cultural context is not included in most existing home visiting models (Whitesell et al., 2018). With few measures that are relevant to cultural context in early childhood, the Tribal MIECHV grantees are faced with using or adapting Western measures or developing new culturally grounded measures, which require additional time, resources, and expertise (Whitesell et al., 2018). For example, established measures of parent–child interactions are insensitive to respectful ways of interacting with family members and relatives in Indigenous communities, such as avoiding eye contact and prioritizing nonverbal communication (Whitesell et al., 2018), yet measures that are sensitive to cultural patterns of interaction have not yet been established.

Impact on Practice and Research

Although the concept of measurement disjuncture is abstract, its potential for harm becomes tangible in practice and research. For example, Indigenous parents may be unduly alarmed when a developmental screening tool reveals a potential concern because of cultural misalignment rather than a sign of a true developmental issue. This "false positive" may lead to wasted time and effort on unnecessary diagnostic evaluation and/or intervention as well as mental distress and other negative consequences for caregivers and/or children due to labeling and stigmatization (Whitesell et al., 2022).

In addition to harming caregivers, measurement disjuncture can be harmful to tribal early childhood professionals.[1] For example, buy-in from tribal home visitors is challenging when

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[1] We consider the term "early childhood professionals" to be inclusive of home visitors, Head Start staff and teachers, childcare staff, family support specialists, and others working with young children. Some examples in this chapter refer to a specific role (e.g., home visitors) and will be described as such.

there is cultural misalignment in the measures that are used for assessing parent–child interactions (Whitesell et al., 2018). Validated tools such as the Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO™) (Roggman et al., 2013) and CHEERS Check-In (CCI) (LeCroy & Milligan Associates, 2017) provide little context for relationships beyond the primary caregiver and child, missing critical extended family interactions, and use observational methods that have been shown to work poorly in Indigenous communities (Walkup et al., 2009).

Using observational methods by an "objective outsider" is a best practice for measuring parent–child interactions. However, replacing the ease and comfort of natural interactions between the caregiver and child with an isolated observational assessment can be anxiety-inducing to both caregivers and early childhood professionals. The experience of being observed and recorded can be unsettling to both Indigenous caregivers and home visitors who serve as "objective outsiders" yet are members of the community (Walkup et al., 2009). Moreover, standardized timing of the assessment can be challenging and inconsistent with a family's readiness to be assessed. This unsettling experience is a by-product of measure disjuncture. Culturally meaningful observations can address this disjuncture and generate better data by allowing families to be more authentic. For example, a culturally grounded measure of parent–child interactions (as described later in this chapter regarding the development of a measure of early relational wellbeing (ERW)) might replace observational methods with a guided conversation between a tribal early childhood professional and family in a relaxed, natural setting.

Impact on Equity

Measurement disjuncture is an issue of equity, and early childhood practice is misguided when research tells a false story. To address disjuncture, we must acknowledge the root causes of inequity in measurement, including the underrepresentation of Indigenous communities in early childhood research and lack of awareness of Indigenous theories and frameworks related to early childhood development and relational identity (Ullrich, 2019; Walls et al., 2019).

Indigenous communities are underrepresented in the development of early childhood measures (Walls et al., 2019). As a result, they are often faced with using Western measures that fail to align with their cultural worldviews. This results in misalignment of indicators, measurement error, unreliable results from infant and early childhood developmental assessments, unnecessary or lack of treatment, and feelings of stigma among families (Asdigian et al., 2022; Whitesell et al., 2018, 2022). Measurement disjuncture will continue reinforcing inequities until we disrupt the cycle, changing the system of research and practice through engaging Indigenous communities in the adaptation and development of measures (e.g., centering community wisdom and priorities, leading with culturally grounded or immersed measures, making measurement more holistic). In addition to the underrepresentation of Indigenous communities in the development of early childhood measures, the body of research that underlies the development of the major theories of child development is based on samples in Western communities (global outliers) and does not align with non-Western communities (Henrich et al., 2010). Unfortunately, these theories have spurred subsequent theories and frameworks, all of which guide mainstream practices (Henrich et al., 2010).

Measurement disjuncture is harmful to Indigenous communities and reinforces longstanding inequities in practice, policy, and research. Culturally aligned measures and frameworks are needed to address and prevent measurement disjuncture, center the design and development of assessment tools within community and cultural contexts, and allow for the measurement of Indigenous identities, priorities, and values.

Toward a Common Language in Measurement

Inconsistency of language around the culture and context of measures is yet another measurement disjuncture that has implications for practice and research. To begin addressing the harm and inequities that measurement disjuncture reinforces, we need a common language and a shared understanding of measurement approaches with culturally diverse communities. According to Sul (2019), scholars have described culturally based practices and interventions with Indigenous populations using terms such as "culturally appropriate" (Au & Jordan, 1981), "culturally congruent" (Mohatt & Erickson, 1981), "culturally compatible" (Jordan, 1985), "culturally responsive" (Cazden & Leggett, 1981; Erickson & Mohatt, 1982; Ladson-Billings, 1995), and "culturally specific" (Sul, 2019). The evolution of these terminologies falls across a cultural continuum and is mirrored in the language used to describe the integration of culture into prevention interventions with Indigenous communities (Dutta, 2007; Okamoto et al., 2014).

Okamoto et al. (2014) proposed a continuum of approaches to developing and culturally adapting prevention interventions with Indigenous communities that includes non-adaptation/surface-structure cultural adaptation, deep-structure cultural adaption, and culturally grounded interventions. Non-adaptation and surface-structure adaptations reflect interventions that are implemented "as is" or with minor modifications, such as adding culturally relevant images or terms to the curriculum (Castro et al., 2004; Okamoto et al., 2014; Resnicow et al., 2000). Deep-structure adaptation reflects more extensive changes to infuse cultural values, beliefs, norms, and worldviews into the intervention while maintaining fidelity to the original intervention (Castro et al., 2004; Okamoto et al., 2014; Resnicow et al., 2000). Alternatively, a culturally grounded approach reflects interventions that are forged from the ground up through authentic community engagement and in full alignment with community and cultural constructs/worldviews (Okamoto et al., 2014).

To our knowledge, there is no common language for developing and culturally adapting measures with communities. We believe that it is important to use language consistently and thoughtfully, and, thus, we propose a common language for describing approaches to measurement with Indigenous and non-Western communities that aligns with common terms from intervention research (Okamoto et al., 2014). In doing so, we propose a cultural continuum for measurement that includes four approaches: non-adaptation, surface-structure adaptation and development, deep-structure adaptation and development, and culturally grounded or immersed (see Table 15.1).

As we describe this continuum of approaches, it is important to consider how and why a particular type of measurement falls into each category. Non-adaptation and surface-structure adaptation approaches may be appropriate when there is complete alignment in constructs across worldviews or they may be the best available option due to limited resources (i.e., no resources for intensive measure development). Deep-structure adaptation of a measure is more appropriate when the key constructs are in alignment but there is a need for major modification of the items to make them more culturally and contextually relevant. Culturally grounded or immersed approaches to measure development are ideal when there is little or no alignment in the constructs of interest between an existing measure and the community or context of focus. This approach is time- and resource-intensive and requires community engagement from conceptualization of constructs to interpretation and dissemination of results (Walls et al., 2019). Our intention is to advance the field of infant and early childhood measurement with and for Indigenous and non-Western communities by providing a common language for practitioners and researchers to describe and share their work. We recognize, however, that embedded within this common language are layers of context, resources, and priorities to consider and that the best alignment of culture and measurement often remains aspirational due to practical constraints.

Table 15.1 Common language and considerations for measure adaptation and development with Indigenous communities

	Cultural continuum of measure adaptation and development			
Process	Non-adapted	Surface-structure adaption or development	Deep-structure adaptation or development	Culturally grounded or immersed
Description	Measures that are validated for use with other cultural groups	A measure that has been adapted or developed to fit within a cultural context	A measure adapted or developed to operate within a specific worldview that reflects constructs of importance to practitioners and researchers	A measure deeply rooted and forged within a specific worldview
	Often developed within a Western worldview	Adaptions may include adding terms or pictures that represent an Indigenous culture, language, or community	The resulting measure will have some misalignment in the measurement approach	Involves community engagement and strong focus on community power in creation or co-creation of a measure that reflects cultural strengths, knowledge systems, and values of importance to the community
		A developed measure may focus on Indigenous concepts within a Western framework		
		The resulting measure will have some misalignment in constructs, operationalizations, and measurement approaches		
Level of cultural tailoring	None	Adapted measures often involve surface-level changes to a common measure (e.g., changing images and specific language to improve cultural fit)	Adapted measures involve surface- and deep-level changes to common measures (e.g., engaging community in adaption of images, language, and constructs), but the measure maintains the original measurement approach	Measures are developed with and for community or population of interest
		Developed measures may focus on aspects of culture, but the underlying framework and the measurement approach does not reflect the cultural context	The underlying framework of the developed measures reflects aspects of cultural context, but the measurement approach is not fully aligned with cultural context	All aspects of measure, including images, language, constructs, and the measurement approach, are reflective of the cultural context
Level of cultural specificity	No cultural specificity	Often adapted or developed for a specific tribe or multiple tribes with shared cultural values relevant to the construct		

(continued)

Table 15.1 (continued)

	Cultural continuum of measure adaptation and development			
Process	Non-adapted	Surface-structure adaption or development	Deep-structure adaptation or development	Culturally grounded or immersed
Considerations for use	Appropriate when there is complete alignment of constructs and measurement approaches across worldviews	Involves adapting existing measures to include culturally relevant examples or wording of items without fully adapting constructs, operationalizations, and measurement approach	Involves adapting existing measures to ensure alignment of constructs and operationalizations, but adaptations are not made to measurement approach	Involves adapting existing measures to ensure alignment of constructs, operationalizations, and measurement approach
	Allows for cross-population comparison	Involves developing a measure that is culturally aligned at concept level, but constructs, operationalization, and measurement approaches are not culturally aligned	Involves developing a measure for which overall concept, constructs, and operationalizations are culturally aligned, but there is some level of misalignment of measurement approach	Involves developing a measure for which overall concept, constructs, operationalizations, and measurement approach are culturally aligned
		Adapted or newly developed surface-structure measure is appropriate when either (1) constructs, operationalizations, and measurement approach are fully aligned, or (2) more work is needed to identify cultural alignment in constructs, operationalizations, and measurement approach	An adapted or newly developed deep-structure measure is appropriate when either (1) operationalizations and measurement approach are fully aligned, or (2) more work needs to be done to identify cultural alignment in operationalizations and/or measurement approach	An adapted or newly developed culturally grounded measure is appropriate when existing measures are in complete misalignment with culture

(continued)

Table 15.1 (continued)

	Cultural continuum of measure adaptation and development			
Process	Non-adapted	Surface-structure adaption or development	Deep-structure adaptation or development	Culturally grounded or immersed
Limitations	Risk of misalignment in constructs and measurement error (reliability and validity)	Risk of misalignment in constructs and measurement error	Risk of misalignment in constructs and measurement error	Time- and resource-intensive
	Implementation can be burdensome and harmful to staff in AIAN communities who serve as a cultural bridge	Although implementation might improve, misalignment of constructs can still be burdensome on staff who serve as a cultural bridge	Difficult to maintain fidelity to the original measure when changing items	Typically involves research expertise for measure development and validation
	Implementation can be harmful to families in AIAN communities due to stigma, false positives, and unnecessary intervention		Can be time- and resource-intensive	Requires authentic community engagement
			Requires authentic community engagement	Should be guided by Indigenous framework(s)
Example(s)	Existing early childhood screeners	Family resources check-in	Native culture and language in the classroom observation (NCLCO)	Stress and resilience scale
	PICCOLO			Early relational wellbeing
	CHEERS check-in			Culturally grounded classroom interactions

In addition to terminology, we believe that it is important to acknowledge that Indigenous ways of knowing and thinking about early childhood and developmental milestones have been practiced for millennia. Although these knowledge systems are rarely found in published literature, these ways of thinking and viewing child development are very much alive and have been sustained through storytelling, ceremony, language, and relationships. For example, Indigenous knowledge is embedded in sacred ceremonies that take place within a child's first year and nurture the child's spirit and family connectedness. Moreover, the call for culturally grounded measures and frameworks of child development in recent decades has demonstrated the value and appreciation for Indigenous knowledge systems and interest in their application (Ullrich, 2019; Walls et al., 2019).

Approaches to Measurement Adaptation and Development with Indigenous Communities

Developing measures with and for Indigenous communities requires an intentional process that engages experts from within communities alongside researchers who have experience in creating valid and reliable measures (Walls et al., 2019). The process is iterative. It begins with collaboratively defining meaningful constructs (conceptualization) and proceeds to translating those constructs into observable, measurable indicators (operationalization), identifying effective approaches for gathering those indicators (implementation), and accurately interpreting the data that result (interpretation) – and then returning to reconsider the conceptualization based on the empirical findings. At each phase in this process, decisions must be made about appropriate tailoring for cultural and contextual relevance and accuracy (Walls et al., 2019). Developing measures that can provide accurate data for Indigenous communities requires attention to cultural fit at each phase of measurement, and attention to cultural fit requires engagement of Indigenous communities.

Below, we describe examples of adapting, developing, and implementing measures

from our collective work around infant and early childhood assessment with Indigenous communities. Each one describes the measure, measurement approach (non-adaptation, surface-structure adaption/development, deep-structure adaption/development, and culturally grounded/immersed), and considerations for cultural tailoring, cultural specificity, and considerations for use.

Non-adaptation

Measures in this category include those that are used in their original form with no specific attention paid to cultural alignment. This section provides three examples of non-adapted measures that have been used in Indigenous early childhood settings and programs. The first two examples describe the experiences of tribal early childhood professionals when applying the PICCOLO (Roggman et al., 2013) and CHEERS Check-In (LeCroy & Milligan Associates, 2017) with Indigenous families, which are observational measures of parent–child interactions. The third example describes lessons learned from the Pilot Exploration of Developmental Screening in Tribal Communities Study (Tribal PEDS) about how to optimize the process and outcomes of early childhood developmental screening in American Indian and Alaska Native communities, given that screening tools have not been developed or validated for Indigenous populations in the United States (Asdigian et al., 2022; Whitesell et al., 2022).

Measures of Parent–Child Interactions

The PICCOLO and CHEERS Check-In are validated and widely used observational measures of parent–child interactions in home visiting programs (LeCroy & Milligan Associates, 2017; Roggman et al., 2013). However, there are common challenges with cultural fit, implementation, and constructs when implementing these early childhood measures in Indigenous communities. Tribal early childhood professionals have described cultural misalignment of the primary construct in these measures (i.e., parent–child interactions), which fails to consider healthy and respectful family interactions from an Indigenous perspective. In this example, the focus on parent–child interactions as a primary construct does not connect with a relational worldview and makes both families and home visitors feel uncomfortable. From an Indigenous worldview, the PICCOLO (Roggman et al., 2013) and CHEERS Check-In (LeCroy & Milligan Associates, 2017) observe a narrow frame of what a positive interaction looks like between a primary caregiver and child; these measures do not include extended multigenerational families and communities. Interactions such as responsiveness, teaching and learning through observing, and nonverbal communication (e.g., body language, subtle looks, lack of eye contact as a form of respect) are important in Indigenous communities and counter to existing measures of parent–child interactions that prioritize verbal communication, eye contact, and more directed teaching and learning.

Timing is another challenge when applying these measures in Indigenous communities, as efficiency is built into screening tools and may conflict with issues that families experience. For example, the CHEERS Check-In (LeCroy & Milligan Associates, 2017) utilizes a 15-minute observational window to assess parent–child interactions within a home visit that typically takes 1 hour. Although an early childhood professional considers a family's schedule when conducting the observation, the timing of the assessment does not always coincide with when children are at their best, due to hunger, fatigue, or the family experiencing a crisis. Another conflicting aspect of these measures is that they prioritize efficiency and are mere snapshots of unnatural observed moments of interaction. In contrast, a more relational approach includes a conversation between the early childhood professional and family that prompts feedback from a caregiver who can provide the topography of their interactions.

Measures of Early Childhood Development

Many tribal communities rely on existing early childhood developmental screening tools like the Ages and Stages Questionnaire (Squires et al., 1997) or the Brief Infant-Toddler Social and Emotional Assessment (Briggs-Gowan & Carter, 2007; Briggs-Gowan et al., 2002) because developing and/or validating screening instruments specifically for Indigenous children is a time- and resource-intensive undertaking that would require years to accomplish if it were ever initiated. The Tribal PEDS study (Whitesell et al., 2022), which was conducted to examine early childhood developmental screening systems in Indigenous communities, demonstrated that the use of non-adapted, Western screening tools in these communities requires careful attention to the processes used for administering, scoring, interpreting, and communicating results back to families. The lessons learned and recommendations that emerged from Tribal PEDS about developmental screening tools also apply to other early childhood assessment instruments like the PICCOLO and CHEERS Check-In described above.

One key recommendation from the study was to ensure that caregivers of Indigenous children understand and trust the process and goals of early childhood developmental screening before it is initiated. Doing so helps address commonly held fears among parents that screening results will be used to stigmatize Indigenous children or justify their removal from the home. Establishing trust in the people and institutions involved was also identified as essential, as was interpreting screening results in the context of a child's culture and in light of supplemental information provided by teachers, home visitors, and others who know the child. The contextualization of screener results is particularly important given the increased potential for false positives when using screeners that are not normed for Indigenous children or created with Indigenous child development, culture, or language in mind. In addition, professionals who are familiar with the local community and culture are best poised to interpret screening results for children in context and to work with families to support evaluation and intervention plans, if appropriate. When used by trained early childhood professionals, these strategies can improve outcomes in tribal communities that need to rely on non-adapted measurement tools that were developed and validated for Western populations, including early childhood developmental screening tools and other measures of early childhood mental health and wellbeing.

Cultural Tailoring and Level of Specificity

When using a non-adapted measure, there is no cultural tailoring or adaptation to the original measure. The key constructs are assumed to align between cultural contexts, and there is no tailoring of items in the measures. Similarly, non-adapted measures lack cultural specificity (or adaptation for specific cultural groups or communities) and are instead used widely across culturally and geographically diverse Indigenous communities.

Considerations for Use

The examples above from practice and research illustrate the strengths and limitations of using common, non-adapted measures with Indigenous families and communities. This approach is especially relevant when time and resources are limited and, more importantly, when constructs of interest are in complete alignment across worldviews.

Surface-Structure Adaptation or Development

Measures in this category are those that have either been adapted from existing instruments or developed specifically for use in a specific cultural context. For an existing instrument to fall into this category, surface-level adaptations are made to increase the cultural alignment of the instrument. Changes in the existing measures adapted to fit within the surface-structure category generally include replacing words and images with more culturally relevant choices. For example, an early childhood program within a Lakota community in the Northern Plains of the United States could translate English words for “child” and “family” in the program curricula or measures into Lakota with “wakanjeja” (child, literally meaning sacred gift) and “tiyospaye” (extended family and relatives). A newly developed instrument would fit in this category if the instrument addressed culturally relevant concepts and constructs using operationalizations and methods that are minimally culturally relevant. The following example describes the development of a measure with surface-structure cultural relevance to enhance the ability to measure family economic strain in tribal communities.

Family Resources Check-In

This example describes the process of developing a measure of family economic resources, the Family Resources Check-In (FRC), in collaboration with Indigenous communities as a part of the Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) (Whitesell et al., 2017). This study involved 17 communities funded by the Tribal Maternal, Infant, and Early Childhood (Tribal MIECHV) program to deliver home visiting services to Indigenous families. The design of the MUSE study, created in collaboration with the 17 programs implementing Tribal MIECHV, called for an assessment of family economic resources; in addition, all Tribal MIECHV grantees were required to screen for family economic strain as a part of federally mandated benchmark reporting. The challenge was the lack of a brief economic resource measure that aligned with the contexts of most families being served by these programs. Existing screeners were seen as missing important sources of economic strain and resources among American Indian and Alaska Native families and, at the same time, included indicators largely irrelevant to the contexts and cultures of communities.

Cultural Tailoring and Level of Specificity

In response to this measurement disjuncture, the MUSE study team collaborated with the MUSE grantee partners to develop a tool tailored to Indigenous families with young children. MUSE researchers gathered existing tools, reviewed the literature on economic strain and resources, and consulted with researchers working with Indigenous communities about their approaches to assessing economic wellbeing and strain. This information was shared with grantee partners, who identified important elements of family economic context that were missing (e.g., childcare expenses) as well as items on existing measures that should be eliminated due to lack of relevance (e.g., health insurance) or reconceptualized due to contextual misalignment (e.g., employment, housing). Once the essential elements were refined, MUSE researchers worked with grantee partners to identify a pool of screening items for each element, refine meaningful response options, and create a process for administering and scoring the FRC. The draft FRC was pilot tested with home visitors and other Tribal MIECHV program staff. MUSE researchers conducted a modified cognitive interview process, discussing the FRC with groups of home visitors who had pilot tested it. The results of this process led to revisions in the FRC (e.g., item wording, response options), and the FRC was finalized. FRC data were collected by MUSE grantee partners from June 2019 through December 2021 and are currently being analyzed to examine the psychometric properties and further refine the FRC.

Considerations for Use

Applying a surface-structure approach to adapting existing measures might involve adding culturally relevant examples or changing the wording of items without fully adapting constructs, operationalizations, and measurement approaches. Similarly, developing a new measure using this approach will result in a measure that is culturally aligned at the concept level. However, the constructs, operationalizations, and measurement approaches will be lower in cultural alignment. As described in this example of adapting the FRC, a surface-structure approach was an appropriate method and helped generate a meaningful measure to implement in families served by tribal home visiting programs.

Deep-Structure Adaptation or Development

Measures in this category are those that have either been adapted from existing instruments or developed for use in a specific cultural context. For an existing instrument to fall in this category, whether it be a revised measure or a culturally grounded measure, the words and images used in the measure, the underlying concepts and constructs, and the operationalizations of the constructs will be culturally aligned. The following example describes the adaptation of a measure that had been developed for use in Indigenous early childhood education classrooms called the Native Culture and Language in the Classroom Observation. This measure, originally developed in 2015 (Barnes-Najor et al., 2019), was designed to gather information about the inclusion of culture within early childhood classrooms.

Native Culture and Language in the Classroom Observation 2022

The first version of the measure, based upon the continuum of cultural alignment of measures, fits the surface-structure alignment category. The measure has since been adapted to enhance the ability to measure culture and language in AIAN early childhood classrooms. The adaptations were guided by psychometric analyses of the Native Culture and Language in the Classroom Observation from the AIAN Family and Child Experiences Survey 2015. Although the analyses demonstrated that the measure was reliable, the measure was unidimensional and some of the original items needed to be excluded from the final analysis. After several discussions with community partners, the team concluded that the measure needed to be three dimensional to reflect the distinct importance of (1) the presence of culturally relevant items, (2) children's experiences participating in cultural activities, and (3) the use of native language in the classroom. Revisions were made to the measure for use in the AIAN Family and Child Experiences Survey in 2019 (Barnes-Najor et al., 2021a, b) to strengthen the native language use section of the instrument. However, the items about native language use were set within a Western education context. Specifically, all native language use was coded as occurring within either a formal or informal context. Our community partners strongly advocated for the removal of this distinction, sharing the lack of relevance of this distinction in an Indigenous-based learning environment. For the third iteration of the instrument, the Native Culture and Language in the Classroom Observation 2022, this categorization of formal/informal contexts has been removed and information relevant to dual language learners has been added. Furthermore, this version of the measure has added items so that the measure reflects all three recommended dimensions: (1) the presence of culturally relevant items, (2) children's experiences of participating in cultural activities, and (3) the use of native language in the classroom. The revisions to this instrument, occurring in stages, moved the team toward being able to gather information about cultural experiences in the classroom that will be more reflective of Indigenous-based learning environments. Moreover, these revisions led to a more culturally aligned measurement approach that was piloted in the fall of 2022. It is important to note that there are still elements of the 2022 version that fit within a Western perspective. For example, the measurement of the presence and absence of cultural items through a checklist reflects a more Western perspective. The blending of Indigenous and non-Indigenous frameworks and methodologies used within this measure is what places the measure in the deep-structure adaptation category.

Cultural Tailoring and Level of Specificity

For adapted measures, such as the Native Culture and Language in the Classroom Observation, this approach involves surface- and deep-level changes to an existing measure (e.g., engaging community in the adaption of images, language, and constructs) while maintaining the original measurement approach and fidelity. When developing new measures using deep-structure approaches, the underlying framework reflects aspects of the cultural context, but the measurement approach is not fully aligned with the cultural context. For example, a new measure might include thoughtfully developed items that align with the community and cultural contexts. However, the underlying framework might operate from a different worldview (e.g., Western conceptualization of child development or caregiver–child interactions).

Considerations for Use

A deep-structure approach is helpful when the overall concept, constructs, and operationalizations need to be culturally aligned without changing the measurement approach. Although the measurement approach may be somewhat misaligned with the cultural and community contexts, it should not compromise the implementation and trustworthiness (reliability and validity) of the measure. Adapted or newly developed deep-structure measures are appropriate when either the operationalization or the measurement approach is fully aligned or more work needs to be done to identify cultural alignment across operationalizations and measurement approaches.

Culturally Grounded or Immersed Measurement

Measures in this category are deeply rooted within a specific worldview through authentic community engagement. Community power, perspectives, and voices are centered during the conceptualization of constructs and development of a new measure that reflects cultural strengths, knowledge systems, and values of importance to the community. All aspects of the measure, including images, language, constructs, and measurement approach, are reflective of the cultural and community contexts. The following examples describe the development of three culturally grounded measures on stress and resilience, early relational wellbeing (ERW), and culturally grounded classroom interactions.

The Inter-Tribal Council of Michigan (ITCM) Stress and Resilience Scale

In recent years, the Inter-Tribal Council of Michigan (ITCM) has begun developing a culturally grounded measure of stress and resilience to inform its tribal home visiting program and the families it serves. A new measure was needed because the tribal home visiting program was required to evaluate client experiences of stress and resilience. Although existing measures could be used to meet funding requirements, the ITCM wanted to explore how they could use a culturally grounded assessment of stress and resilience as an opportunity to inform programming.

Moreover, there was a cultural misalignment in the construct of stress from a Western worldview, which seemed to place blame on an individual for the stress they experience rather than focusing on the influence of external factors.

To begin, the ITCM team sought to understand what stress means and how it is experienced from an Indigenous perspective. Using culturally grounded approaches, they considered definitions of stress and resilience that were informed by the Ojibwe language, worldviews, knowledge keepers, and using foundational values and traditions. Although not everyone in their community speaks the Ojibwe language, all live within the same worldview and share common values. There are no direct English translations of stress and resilience in the Ojibwe language, and the descriptions of stress and resilience are verbs rather than nouns. Similarly, the teachings are described using verbs, which have helped explain the concepts of stress and resilience in a more dynamic and holistic way. The new stress and resilience measures will be further informed by key informant interviews completed with home visitors that serve the tribal communities participating in the home visiting program. In addition, a photovoice project was completed to collect perspectives of stress and resilience from home visiting participants. To conceptualize stress and resilience, a visual of a path that shows the interconnections between stress and resilience was developed.

Development of the ITCM Stress and Resilience scale is underway and is a beautiful example of when culturally grounded measures are needed to prevent disjuncture and prioritize information that the community values and understands.

The Indigenous Model and Measure of Early Relational Wellbeing

The Tribal Early Childhood Research Center (TRC) is partnering with a Community of Learning comprised of American Indian and Alaska Native early childhood program leaders, academic researchers, and federal partners to understand and measure early relational wellbeing (ERW) within Indigenous communities and tribal early childhood settings. Our focus on understanding ERW from an Indigenous perspective began with efforts to culturally adapt measures of parent–child interactions in early 2021. As described in the previous sections of this chapter, the existing measures of parent–child interactions fail to consider the importance of relationships beyond the caregiver–child dyad. This type of measurement disjuncture is driven by complete misalignment of constructs and requires a new way of conceptualizing the way families interact with young children. We first identified early relational health (ERH) as a more culturally aligned construct that prioritizes relationships at the family and community levels. However, the existing frameworks and measures of ERH remain focused on the parent–child dyad (Willis et al., 2022). We then expanded our focus and adopted ERW as a more inclusive and expansive construct of relational practices that nurture young children in Indigenous communities and cultures.

After an extensive literature review that helped us identify Indigenous values of nurturing and raising young children, we formed a Community of Learning to explore how ERW is conceptualized in American Indian and Alaska Native families. Our formative research is guided by an Indigenous connectedness framework (Ullrich, 2019) and Indigenous research methodologies, which are often grounded in conversations and stories. With our Community of Learning, we have developed a conceptual model of ERW in Indigenous communities and are using a group concept mapping approach (Kading et al., 2019; Kane & Trochim, 2009; Rosas & Ridings, 2017) to develop a culturally grounded measure of ERW. Our first step is collecting a comprehensive list of relational practices that support ERW from our Community of Learning and other partners. With a full list of practices, we will engage Community of Learning members in helping us sort and rate practices based on relevance to ERW and families in their communities. These findings will guide the development and inclusion of items in a measure of ERW that will be piloted in 2024.

Culturally Immersed Classroom Interactions Scale

Most measures that assess interactions between adults and children in the classrooms focus on the quality of emotional and instructional support provided to children (La Paro et al., 2004; Pianta et al., 2004). Although some aspects of the existing measures on classroom interactions are relevant within Indigenous-serving childcare and early childhood education classrooms, there are important learning styles that do not fit within this framework. For example, scholars from different disciplines have noted the importance of learning by observing (Correa-Chávez & López-Fraire, 2019; Hedges, 2021; Rogoff, 2014), described by Barbara Rogoff as learning by observing and pitching in. For example, children observe their older siblings, cousins, and other family members and intuitively help within their capabilities. However, Indigenous-based teaching and learning approaches are not included in the existing measures and therefore are also missing from the literature on quality classroom interactions (Barnes-Najor et al., 2021a, b).

To fill this void, collaborators from the TRC have developed an observational measure to document preschool classroom interactions among children of ages 3–5 years that are culturally immersed. Specifically, the measure will document: (1) cycles of observation, reflection, and action, (2) sophisticated collaboration, (3) nonverbal communication exchanges, (4) children displaying autonomy within classroom routines, (5) children displaying autonomy when solving problems, and (6) instances of co-regulation among members of the classroom (adults and children). Documentation will include both qualitative and quantitative data, allowing for both quantification of these experiences and the richness of these interactions to shine. The measure, which was piloted in the fall of 2022, is aligned with Indigenous-based teaching and learning frameworks at the conceptual and operationalization levels.

Cultural Tailoring and Level of Specificity

Culturally grounded measures are developed with and for the community or population of interest, and all aspects of the measure, including images, language, constructs, and measurement approach, are reflective of the cultural context. Although culturally grounded measures can be developed for Indigenous communities overall, these measures are often developed for a specific tribe or multiple tribes with shared cultural values relevant to the construct of interest. In the examples above, the complete misalignment of constructs led to the need for a culturally grounded approach to conceptualizing and measuring stress and resiliency, early relational health and relational practices during the early years, and classroom interactions within Indigenous early childhood settings.

Considerations for Use

An adapted or newly developed culturally grounded measure is appropriate when the existing measures are in complete misalignment with the culture. The process of adapting the existing measures ensures there is full alignment of constructs, operationalizations, and the measurement approach. Similarly, developing a new measure ensures the overall concept, constructs, operationalizations, and measurement approach are all culturally aligned. Both processes are time- and resource-intensive and often involve research expertise for measure development and validation. Most importantly, this approach requires ongoing, authentic community engagement and should be informed by an Indigenous framework and Indigenous research methodologies.

Summary and Key Points

Indigenous worldviews and knowledge are foundational to understanding early childhood development and advancing the field of measurement through nonlinear and holistic ways of thinking about children, families, communities, and relationships. The current field of infant and early childhood measurement largely operates within the limited boundaries of linear and reductionistic ways of thinking about early childhood development. Unfortunately, this misalignment in worldviews results in measurement disjuncture. The stories and examples in this chapter describe the potential harm of measurement disjuncture and underscore the need for considering cultural and community contexts when developing or adapting measures with Indigenous communities. The common language proposed in this chapter provides a way to talk about context, equity, priorities, and resources around measure use, adaptation, and development. Similarly, the cultural continuum of measurement approaches provides a roadmap for advancing the field of infant and early childhood measurement and beyond. With a common language and continuum of approaches, practitioners and researchers can begin to co-create more equitable, resourceful, trustworthy, and culturally aligned measures in partnership with Indigenous families and communities. To support these efforts, we recommend the following strategies for funders, researchers, and practitioners to improve measurement.

Strategies for Improving Measurement

Center Community Wisdom, Voices, and Benefit To honor Indigenous communities, we must start by centering community wisdom, voices, and benefit. Collaboration between communities, practitioners, and researchers is essential throughout measure selection, adaptation, development, and implementation. Through centering the community, we will deepen our understanding of what needs to be assessed, what is valuable and helpful for programs serving families with young children, and what issues are worth addressing and/or changing to fit cultural and community contexts. Furthermore, this process strengthens relationships, trust, and engagement across communities, practitioners, and researchers, and it provides space for community and tribally driven research questions to emerge.

Make Things Right We need to do a better job of making infant and early childhood measures right for Indigenous children and families. We also need to honor traditional ways of knowing and acknowledge that making measures "right" will never be enough, as measures are embedded in larger systems of knowledge, history, and values. Just as systems of knowledge and history evolve, we must continue to evolve, refine, and be responsive to family and community priorities. Assessment is well-positioned to serve as a bridge between research and practice by making better connections across meaningful constructs (conceptualization) and measurable indicators (operationalization). Systems within tribal communities may be set up differently than those in other jurisdictions, which may require extra time, flexibility, and additional funding opportunities to develop or adapt culturally aligned measures.

Lead with Culturally Grounded Approaches We should lead with culturally grounded or immersed measurement approaches, which strive to address the disjunctures and inequities that are described in this chapter. Although more time- and resource-intensive, supporting culturally grounded or immersed approaches is a greater return on investment. This approach is not only in the best interest of Indigenous families and communities but is also a better benchmark for assessing outcomes that are valued in the community and a long-term solution that will benefit generations to come.

Increase Value and Reduce the Burden of Measures We should acknowledge the reality of how Indigenous communities are offered, and often required to use, measures that do not fit the cultural or community context. To reduce the burden of misaligned measures and to increase their value, we should be mindful of how Indigenous families experience early childhood assessments, which are often a requirement of participation in programs. Strategies for effectively engaging Indigenous families in the assessment process include educating caregivers about the goals of assessment and how it will work; promoting trusted, ongoing relationships with caregivers to foster confidence in the people and institutions involved in assessment; and interpreting assessment results in the context of a child's culture and in light of supplemental information provided by caregivers, early childhood professionals, and others who know the child. Moreover, we should consider the experiences of early childhood professionals who administer assessment tools. Doing so honors families and practitioners as key partners in the measure development process and contributes to family and community benefit. Engaging them as partners in measurement also provides opportunities to share the value of measures and strengthen informed consent for research purposes and/or provide transparency regarding whether and why assessments are required for specific programs or funding.

Make Measurements More Holistic As described throughout this chapter, measurement methods that involve rigid timing within observational approaches or gather information in a way that defines the data within a Western education framework reinforce measurement disjuncture when used in Indigenous communities. Just as the framing of constructs on a measure influences the relevance of those constructs within a particular cultural context, the way we conduct observations also influences the relevance of the measure. Specifically, the timing and structure of observations are important to consider. From an Indigenous perspective, early childhood professionals are always observing and helping families navigate new situations. There is tension in highly structured point-in-time caregiver–child observations as the observed interactions are unnatural for families and home visitors; this type of observation can also be repetitive because home visitors are always assessing the caregiver–child relationship. The resulting tension can result in measurement error, as the structured point-in-time observations fail to capture the richness and complexity of relationships.

A more holistic approach to measurement should focus more on Indigenously framed concepts and measurement approaches. For example, rather than observing a highly structured specific point in time, a tribal home visitor might have guided conversations with families using relational questions (e.g., "What did baby do when you…" and "How did you feel when…"). Tribal early childhood professionals understand that an assessment is not done in a vacuum and that it is part of a larger system of information, including cultural ways of understanding and knowing. The field of early childhood measurement should honor this understanding and explore other ways for more holistic approaches that foster relationships and conversations with families.

To conclude, Indigenous communities have been assessing and promoting infant and early childhood mental health for millennia through relational practices and intergenerational systems of care. Over the last century, the assessment of infant and early childhood mental health has been largely driven by Western worldviews and priorities and has resulted in measurement disjuncture. What existing measures tell us about young Indigenous children often cannot be trusted to be reliable or valid, and these measures often do not measure outcomes important to Indigenous families and communities. In this chapter, we offer a common language and continuum of measurement approaches for funders, researchers, and practitioners to address and prevent measurement disjuncture. We recognize that we have much to learn on this pathway to culturally grounded measurement and that change will not happen immediately. However, the strategies we recommend will advance equity in Indigenous communities and contribute innovative approaches to the field of infant and early childhood measurement and beyond.

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Part III

Clinical Infant Mental Health

16 Clinical Infant Mental Health

Joy D. Osofsky

This section of the *WAIMH Handbook of Infant and Early Childhood Mental Health* is crucial to the field of infant mental health as it includes chapters reflecting the changing theoretical understanding of the field and the emergence of developing clinical treatments. The different approaches to infant mental health treatments address not just current developmental, behavioral, and emotional problems but also prevention of later more serious problems with development and adjustment that, without treatment, are likely to emerge over time for infants, young children, and parents/caregivers. According to the ZERO TO THREE Infant Mental Task Force, "infant mental health" (IMH) is described as "the developing capacity of the child from birth to 3 years to experience, regulate (manage), and express emotions; form close and secure interpersonal relationships; and explore and master the environment and learn -all in the context of family, community, and cultural expectations for young children" (Nov 7, 2015).

Interestingly, in the first *WAIMH Handbook of Infant Mental Health* published in the year 2000, it was stated that infant mental health had its origins in the infant psychiatry work of Rene Spitz (1945) and the clinical social work of Selma Fraiberg (Fraiberg et al., 1975), with a focus on the mental health needs of infants and their families. These descriptions of infant mental health, one from more than two decades ago and one from the past 10 years, provide a perspective on the development of clinical infant mental health and the different components of understanding and clinical treatments that compose this section. Furthermore, we have learned from a variety of disciplines that comprise clinical infant mental health that most babies are born ready and wired to form relationships. One of the leaders in the field, the pediatrician T. Berry Brazelton, MD, who was also influenced by psychoanalysis, helped so many of us learn about the importance of behavioral observations with newborns and infants. He taught us and showed us through sensitive observations that from the moment of birth, infants form connections, develop social responses, and learn about themselves and the world around them. The Brazelton Neonatal Assessment Scale (1973) provided a crucial understanding of clinical infant mental health by helping us gain an observational perspective on early development and relationships. Observations of the infant–caregiver relationship then helped us develop clinical interventions and treatments recognizing that development may not have been going well.

The first chapter in this section by Weatherston and her colleagues describes infant mental health with an overview of the origins of Fraiberg's

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model of infant–parent psychotherapy, a relationship-based clinical treatment with a background of psychoanalytic and developmental understanding of disturbances, especially in the caregiving–infant relationship. These authors help the reader understand an attuned developmental, clinical, and relational approach to working with infants and caregivers.

Psychodynamic and psychoanalytic theories have been important for the development of both infant mental health thinking and therapeutic treatments. Klauber's chapter emphasizes the integration of infant observation and psychoanalytic developmental theories in the development of clinical infant mental health treatments. She elaborates on what is the most important for infant mental health treatment, focusing on the importance of infant observation and psychoanalytic development of clinical infant mental health. This chapter begins by emphasizing the psychoanalytic observation developed by Esther Bick in 1948 and then moving on to the importance of observation for all infant mental health work and services ranging from gaining an understanding of the caregiver–young child relationship to the importance of observations for diagnosis. Klauber goes on to also emphasize the importance of observations for training as a strategy for developing sensitivity in clinicians providing clinical services.

The section on Clinical Infant Mental Health then includes chapters on clinical infant mental health theories and others describing trauma-informed evidence-based treatment. Chapter 19 describes child–parent psychotherapy (CPP) with several clinical examples written by Ghosh Ippen and Lieberman. CPP is closely related to Fraiberg's infant–child psychotherapy by providing a similar relationship-based model moving up the ages (birth to 6 years) for implementation. This chapter is followed by Chap. 20 by Kai von Klitzing who elaborates further on psychodynamic approaches to infant mental health by delineating some of the concepts of psychoanalytic developmental theory. He provides case examples and findings from clinical studies that support psychoanalytic developmental theory and psychotherapeutic strategies. He goes on to share that the main psychoanalytic concepts being considered in this approach are infantile sexuality, the maturing object relationship, and the developmental significance of triangulation from this perspective. Based on these examples, he not only expands on psychoanalytic thinking in this area but also draws conclusions for psychotherapeutic strategies through which safety, hope, and repair are promoted.

The section continues with two chapters related to trauma-informed interventions and treatment for young children and parents/caregivers exposed to trauma. Chapter 21 by Osofsky and colleagues describes evidence-based attachment and biobehavioral catchup and child–parent interaction therapy. These treatments involve joint work with the parent/caregiver. In addition, a group treatment intervention, Daring to Care, is described that is implemented prior to the more intensive dyadic therapy to help support parents who have also experienced trauma earlier in their lives, especially during their own childhood that, if not worked through, may impact their parenting of their own children. With continuing concerns related to the impact of trauma on young children, the next chapter by Vogel addresses the implementation of trauma-informed dyadic therapy for young children who have been exposed to psychological trauma such as abuse, neglect, separation from parents, and also have developmental delays or disabilities. Vogel shares information on the treatment needs of these young children and their parents/caregivers, which includes specific training for service providers and trauma-informed therapies that will be the most helpful. For all infants and young children, relationships are crucial in general and especially important when they experience trauma. In Chap. 23, Osofsky and Osofsky describe how the coronavirus disease 2019 (COVID-19) pandemic impacted young children in some ways that were similar to being exposed to natural and technological disasters and to war. Both young children and their caregivers had to cope with continual changes in their routines and increased anxiety caused by the introduction of an invisible danger. They emphasize the importance of relationships with parents, caregivers, schools, and community resources as another type of intervention to foster security for children who experienced an "indefinite disaster" on being exposed to COVID-19.

Continuing with the emphasis on the importance of early relationships, Willis and colleagues introduce Early Relational Health (ERH) that is not a new field but one that is multidisciplinary, building on knowledge from infant and early childhood mental health, neurodevelopment, and related fields that focus on safe, stable, and nurturing relationships within resilient communities to support child and family well-being. The framework of ERH represents a paradigm shift in healthcare with focus on early relationships in partnership with families and communities to provide support.

In Chap. 26, Meunweisen and colleagues emphasize the importance of cross-disciplinary mentoring using reflective supervision and consultation (RSC) to support clinical infant mental health work. They describe how providing reflective supervision with perspectives from both supervisors and supervisees is important with emphasis on diversity, equity, and inclusion. They note that RSC models were developed originally from Eurocentric perspectives and have yet to fully incorporate perspectives from marginalized or Indigenous communities that will inform definitions of reflective practice, reflective consultation, and reflective supervision. In addition, they note that the overall field of infant mental health has also not yet sufficiently integrated concepts of social justice and anti-racism into its research, practice, and policy domains.

Poulsen and colleagues in Chap. 25 describe a different type and model of intervention, Circle of Security, which includes a graphic illustration of ways to translate and share attachment sciences with both high-risk caregivers and a broader range of caregiving contexts across different cultures. This topic is important for understanding clinical infant mental health and the differences in how relationships develop and evolve across cultural groups, including intergenerational caregiving. The different models include Circle of Security Intensive and Circle of Security Parenting and, most recently, has even been used in classroom and early care environments with evidence presented on the impact of the model.

With all of the different intervention and treatment models presented and described in this section on Clinical Infant Mental Health, there has been emphasis throughout on the importance of supporting positive relational health within the infant and young child's caregiving environment. McKelvey and colleagues in Chap. 26 describe and highlight the importance of clinical and prevention interventions that are part of home visiting. Professional development and implementation support is essential in order to provide help that is needed in home settings. However, they note that failure to develop a core set of competencies for home visitors contributes to failure for best practices to be identified and verified and to tie best practices to the diversity of local cultures.

Community-based interventions for families with young children are very important. In Chap. 27, Puma and colleagues present current evidence for community-based centers providing mental health to infants, young children, and parents or caregivers. This chapter considers different contextual levels for engagement and care at each level. In the spirit of Ackoff's (1999) observation, "a partial solution to a whole system of problems is better than a whole solution to each of its parts taken separately" (p. 324) because the parts are all intertwined in relationships, which, in aggregate, generate properties that are not affected when only a part of a system is solved. Puma et al. describe a public health framework designed to change systems, particularly systems that provide infant mental health (and other) services to families. Moreover, they note that efforts to change complex community systems focused on complex community system problems require use of the principles of community-based participatory engagement in order to have multiple knowledge involved in the formation and implementation of community change efforts (McCall et al., 2015). In Chap. 28, Huber and colleagues continue the theme of community involvement. They emphasize that infant and early childhood mental health (IECMH) work is being developed and/or implemented in parts of the world other than Western, educated, industrialized, rich, and democratic (WEIRD) countries and communities (Henrich et al., 2010). It is very important to focus on IECMH using different approaches to science and to conceptualizations of family,

family values, and sources of knowledge because the majority of infants and young children with the greatest need live in those countries. In many cases, issues related to survival through the impact of endemic poverty, lack of food, exposure to war, and/or discrimination are ever present with insufficient resources to deliver nearly any of the interventions described in these volumes.

In the final chapter of the Clinical Infant Mental Health section, Miri Keren shares the theoretical, clinical, and ethical challenges for infant mental health in a constantly changing world with much turmoil. She wonders with us about the impact of increasing digitalization, artificial intelligence, and robotics on child development. Furthermore, it is important to consider how many of the readers of this handbook have sat with a young child and a parent or caregiver at home, office, restaurant, or waiting room where the parent was continually immersed in her/his phone and/or the young child continually playing games or looking at images on an iPad. This chapter also emphasizes some cases in which there is disconnection of procreation from relationships and are intimacy. The COVID-19 pandemic, as emphasized in an earlier chapter, has also taken a toll on relationships with mandated social distancing. She concludes with an emphasis on the need for WAIMH to develop a code of ethics that would include the concepts put forth by the WAIMH Position Paper on the Rights of Infants (Keren et al., 2019) as well as the Diversity-Informed Tenets for Work with Infants, Children, and Families (Thomas, et al., 2019). There has been recent emphasis on the importance of ethical practices related to justice and care within infant mental health. The editors of the WAIMH Handbook strongly endorse this important direction not only for WAIMH but also for the infant mental health field now reflected in this section on Clinical Infant Mental Health.

Conclusions

The section on Clinical Infant Mental Health includes 30 chapters that define the field. An overall emphasis in many of the chapters is on the importance of relationships for infant mental health. In addition, several chapters focus on the importance of observations in order to understand the infant–parent/caregiver relationship. Theoretical frameworks range from psychoanalytic and psychodynamic to more behavioral approaches in evidence-based trauma- informed interventions and treatments for young children, including those with developmental delays and disabilities. This section expands on the definition of infant and early childhood mental health to include an understanding of the importance of early relational health for the well-being of children and families. It is also emphasized that interventions can take place at homes, offices, and in the community. Finally, given the many changes and challenges occurring in current society, the final chapter emphasizes the need for WAIMH to develop a code of ethics that is built on the earlier WAIMH Position Paper on the Rights of Infants (2016).

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17

Infant Mental Health: An Attuned Developmental, Clinical, and Relational Service in Accordance with the Fraiberg Model

Deborah Weatherston, Catherine Maguire, and Rochelle Matacz

This chapter explores Selma Fraiberg's original developmental and clinical model, *infant mental health,* including the procurement of resources, emotional support, developmental guidance, advocacy, and infant–parent psychotherapy (Fraiberg, 1980). The intent of this model is to reduce the risk of delays or disorders in infancy, strengthen parental capacity to respond appropriately and sensitively, slow or alter the cycle of abusive or neglectful care, reduce the intergenerational transmission of trauma, and attend to the parent's social, emotional, and mental health treatment needs, as appropriate. Infant mental health (IMH) allows for the remembering of stories about more thoughtful care, inviting the angels to dance with the ghosts, strengthening the caregiving responses of the parent and the protective attachment relationship between parent and child (Wright, 1986; Lieberman et al., 2005a, b; Weatherston & Tableman, 1989/2015).

What current approaches make IMH work? Is IMH an effective global approach for reducing risks in infancy and early childhood, enhancing the social and emotional well-being of parents, and providing effective interventions across diverse cultures and family groups? What adaptations of the Fraiberg strategies provide effective interventions across diverse cultures and family groups and make it possible to bring IMH service to scale? What does the research contribute? What more needs to be understood?

Origins

The origin of IMH as designed by Selma Fraiberg and her colleagues in the early 1970s is deeply rooted in the early work of psychoanalytic, developmental, and contextual theorists who shaped the understanding of infancy and early childhood, the nurturing role that parents play, and complex forces that contribute to an infant or young child's social and emotional growth within the context of the parent–child relationship. What follows is a brief description of those who contributed to Selma Fraiberg's thinking.

Sigmund Freud, father of psychoanalysis (Freud, 1938), was most significant to the evolution of Fraiberg's thinking about infants and parents, recognizing emerging capacities in infancy,

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and showing compassion for circumstances that jeopardized early parent–child relationship development. Freud's understanding of infancy and early childhood evolved as he listened to adult patients recall events, dreams, and early relationship experiences (Miller, 1993) and contributed mightily to Fraiberg's understanding of forces that shaped and threatened a very young child's social and emotional health, beginning in infancy and continuing through the first years of life. Other important classical and contemporary scholars who influenced Fraiberg included Anna Freud, Erik Erikson, John Bowlby, Mary Ainsworth, Donald Winnicott, and Jean Piaget. Their conversations, writings, or correspondence clearly influenced Fraiberg as she constructed the clinical and developmental model for intervention with parent and child together in the infant's first 3 years, the model she called infant mental health.

Anna Freud, strongly influenced by her father, Sigmund Freud, extended classical psychoanalytic thinking to include psychosocial and emotional development in infancy and early childhood. Her interest in normality as well as pathology provided a framework for organizing contemporary thinking about an infant and young child's development along multiple lines of development within a relational context (Freud, 1965). She explained that "inherent potentialities of the infant are accelerated or slowed up" depending on the quality of maternal care (Freud, 1980, p. 233), shifting from an intrapsychic standpoint to an interpersonal one. Erik Erikson and his collaborator, Joan M. Erikson, studied the developing child within a broad, social context, through a series of 8 psychosocial stages beginning in infancy (Erikson, 1950, 1980). Careful observers of infants and children, the Eriksons were deeply aware of the power of the parent–child relationship, the family context, and the culture to shape and transform a young child's identity in an increasingly complex social world.

John Bowlby, a British psychologist, psychiatrist, and psychoanalyst, departed from the classical Freudian tradition, incorporating his interest in ethology and the etiology of disorder and adaptive behavior (Bowlby, 1958). His studies led to the formulation of Attachment Theory, shaping the understanding of early relationship development, separation, and loss to a baby's sense of security within the caregiving relationship (Bowlby, 1969, 1973, 1980). Bowlby viewed the infant as an active contributor to the developing parent–child relationship and understood the importance of maternal sensitivity to healthy development across the life span. Mary Ainsworth, an American-Canadian developmental psychologist and research scientist, was Bowlby's major collaborator. She carried out observations of mothers and babies in their homes, deepening practitioners' understanding of the uniqueness of a baby's attachment to his mother, naming, and classifying each relationship as secure or insecure (Ainsworth, 1973). It is this concept of the attachment relationship as a "safe base" that translated to Fraiberg's work with the infant and parent together in the first 2 years of life.

The work of Donald Winnicott, a British psychoanalyst, pediatrician, and developmental specialist, expanded the clinical application of Attachment Theory, writing and lecturing about mothering care that affects the infant's sense of security within the caregiving relationship (Winnicott, 1965). Well held by the mother (or caregiver) who is "good enough" and secure in that relationship, the infant flourishes. His attention to safety within the caregiving relationship and the impact on the infant's development was artfully woven into Fraiberg's work with the parent and child together.

Jean Piaget, a distinguished Swiss psychologist and developmentalist, was curious about how very young children think and acquire knowledge (Piaget, 1954). Closely observing his own infants, he developed a cognitive structural theory from the sensorimotor period of infancy to the formal operational period of adolescence, defining development as orderly and sequential, and the infant as a contributing participant to early relationships. His observations, along with developmental and contextual theories, built a bridge to the clinical world of infancy and early parental care. Piaget's emphasis on development and observation influenced Fraiberg's commitment to developmental guidance as a cornerstone of the IMH psychotherapeutic model.

It was this enormously varied body of work that clinical social worker and professor, Selma Fraiberg, and her interdisciplinary team of scientists and clinicians drew on when constructing and carrying out the Fraiberg Infant Mental Health Model. They realized that traditional methods of psychotherapy, requiring parents to come to the office with the baby, might not be effective with overburdened, underresourced parents who lacked transportation and whose relationships with their vulnerable infants were in great jeopardy. Creative in her thinking, Fraiberg moved the work into the home where an infant and family lived, aptly calling it "kitchen table therapy" (Fraiberg, 1980). Of additional importance, Fraiberg believed firmly that the study and understanding of emotionally vulnerable infants, their affective and cognitive development, the developing attachment between parent and child, parental history of trauma or loss, and environmental conditions that place the baby's early development at risk was "a treasure that should be returned to babies and their families as a gift from science" (Fraiberg, 1980, p. 3).

What follows is the story of this elegant, multifaceted intervention, firmly rooted in psychoanalytic and developmental understanding, developed, and carried out by an interdisciplinary team of health and mental health professionals under Fraiberg's direction at the Child Development Project in Ann Arbor, Michigan, beginning in 1972.

The Model

Recognizing the importance of an infant's mental or social and emotional health in the first 2 years of life, Fraiberg named the developmental and psychoanalytically informed intervention *infant mental health*. She asked, "What about the baby?" Believing that an infant's development takes place within the context of the parent–child relationship, Fraiberg also wondered about the parent and experiences, past and present, that shape a mother or father's abilities to nurture their baby? Although Fraiberg's early work focused on the mother as the infant's primary caregiver, IMH is a powerful intervention for the support of the father–child relationship and reduction of risk as well. Throughout this chapter, the use of the word parent is inclusive of mother, father, and other carers. To understand the infant's developmental capacities or delays, the parent's strengths or needs, and the developmental opportunities within the parent–child relationship that contribute to the baby's health and growth, Fraiberg and her colleagues, psychologists, social workers, and other health professionals proposed translating new knowledge about infants into clinical practice with the infant and parent together, often in the intimacy of their own homes (Fraiberg, 1980; Emde, 1987; Weatherston, 2001; Weatherston et al., 2020).

Unique in its attention to early infant development and the emerging parent–infant relationship, infant mental health service, an interdisciplinary approach, required a dramatic and simultaneous shift in focus to the infant, the parent, and their developing relationship. The infant's presence in the intimacy of the therapeutic visit with the mother or father invited observation of the baby's development and interactions between parent and child, leading the IMH therapist and parent to wonder and explore together the meaning of the infant to the parent, the parent's caregiving capacities and struggles, and the nature of the developing infant–parent relationship. This shared focus on parent and child continues to be the hallmark of IMH practice in the Fraiberg model (Weatherston et al., 2020; Rosenblum et al., 2020).

The Practice

Meeting infant and parent(s) together allowed the IMH therapists to understand an infant's history, a parent's present caregiving capacities, and to reflect on possible links between the parents' own early care experiences with negative or conflictual projections and attributions toward their baby. As well, the therapists and parent(s) could think about what was going well, listen to a parent's immediate hopes, worries, or concerns, and, as experienced, each parent's history of trauma or loss that placed burdens on the ability to respond to their infant with nurturing and appropriate care. The Fraiberg model offered a unique therapeutic context to observe, understand, and directly intervene with the developing infant and parent, placing the parent–child relationship at the center of the work and using the therapeutic relationship as the instrument for growth and change in the parent's and infant's abilities to interact and respond sensitively to one another, strengthening the development of a secure and enduring attachment relationship. The intervention as designed was complex and multifaceted (Fraiberg, 1980; Weatherston, 2000; Weatherston et al., 2020; Rosenblum et al., 2020). The core components of the original model are briefly described below. An IMH therapist might use a few or all component parts to address the developmental, relational, and clinical needs of the infant and the parent(s), as well as their developing attachment relationship:

1. *A sensitive and responsive trusting relationship* between therapist and parent/infant pair essential for an effective infant mental health intervention.
2. Assistance in *identifying current stressors*, e.g., economic insecurity, isolation from family and friends, homelessness, adolescent parenthood, single parenting, an infant with special needs, and *procuring resources* to meet those needs, e.g., pediatric care, childcare, social supports, shelter, food, and clothing.
3. *Emotional support* in response to immediate realities, e.g., a premature birth, a difficult delivery, death of a parent, hospitalization of an infant.
4. *Developmental guidance* specific to the infant or toddler referred and parent's level of understanding, e.g., sharing the observation with a parent that the infant will be walking soon.
5. *Advocacy* in response to the immediate needs of the infant or family, e.g., speaking up for the rights of a baby to remain with her family or the need for immediate removal to foster care.
6. *Infant–parent psychotherapy* specific to the parent's past experiences of trauma and unresolved losses as they affect the parent's responsive, protective care of the baby, e.g., "ghosts in the nursery."

Fraiberg's goal was to support a secure relationship between parent and infant, nurture the infant's social and emotional development, and support a parent's emotional health and responsive caregiving capacities. Infant–parent psychotherapy invited parents to explore their own early care by mothers or fathers or other caregivers who were neglectful or abusive, making it difficult for parents to nurture or protect their child. This approach, known as "ghosts in the nursery" (Fraiberg et al., 1980), helped to reduce the significant risk of relationship disturbance or psychopathological disorders of infancy by removing an infant from the complexity of a parent's past, strengthening a parent's present caregiving capacities (Fraiberg, 1980; Weatherston et al., 2020). Infant–parent psychotherapy was developed as a strategy to be carried out within the context of an established therapeutic relationship, with one or more of the IMH service components to support and sustain the infant, the parent, and their relationship, e.g., the use of emotional support, developmental guidance, and infant–parent psychotherapy (Rosenblum et al., 2020).

A number of core beliefs were developed to guide IMH practice (Table 17.1). These beliefs helped IMH therapists to understand their role and cherish each encounter with an infant, young child, and caregiver as they thought deeply about the meaning of a developmental and clinical intervention founded on a commitment to relationship (Stinson et al., 2000).

The Process

IMH therapists bring their full selves to the experience with families. Whether in families' homes, or in a community setting or in a clinic, the therapists meet with parents and infants together, acutely, or entirely present to their strengths and vulnerabilities, their interactions, and their stories.

Table 17.1 Basic beliefs or assumptions that guide IMH practices

The first 1000 days of an infant's experience with his caregivers are important in developing capacity for social communication, interaction, and relationship.
Optimal growth and development occur within nurturing relationships.
The birth and care of an infant offer a family the possibility of new relationships, growth, and change.
What happens in the early years affects the course of development across the life span.
The infant has a fundamental right to therapeutic intervention.
Working with the infant and parent/caregiver together helps the caregiver to hold the infant in mind and think more openly about the infant's strengths and needs.
Early developing attachment relationships may be distorted or disturbed by parental histories of unresolved losses and traumatic life events ("ghosts in the nursery").
Being with the baby, the IMH therapist and parent actively work to offer the infant a felt experience of relationship.

Believing that the parent–child relationship is the instrument for growth and change in the baby's social and emotional well-being (Weatherston & Tableman, 2015; Lieberman & Pawl, 1993), the IMH therapist's role is to establish a secure and trusting relationship with the parent on behalf of the infant and the developing relationship between parent and child. This parallel relationship offers the parent the experience of being cared for, nurtured, understood, and emotionally held so that he or she may offer a similar experience for the baby.

The IMH Therapist

What qualities describe the IMH therapist in better assuring engagement and the building of a working alliance with vulnerable infants and families? IMH therapists are:

- Kind
- Nonjudgmental
- Open and curious
- Dependable and consistent
- Respectful and thoughtful questioning when asking about the baby's needs, the parent's health, and the parent's concerns
- Emotionally present and supportive, of past and present realities
- Able to soothe and contain emotional states
- Close observant of the infant, the parent, their interactions, and the environment
- Able to listen without interruption
- Honest in responding to what is seen, heard, felt, and understood
- Aware of potential countertransference reactions
- Culturally sensitive

Significant Adaptations

Fraiberg's original model was later adapted by health, mental health, and educational practitioners in the USA and in other parts of the world. Most remain true to the principles and strategies as described above, although there is variety in terms of who provides the intervention, where the services are carried out, and whether there is an emphasis on the parent's reflective capacities or the developmental capacities of the infant or young child or the relationship between them. Examples are outlined below in Table 17.2.

Although differing in the ways in which they are constructed, these programs share a commitment to the principles and practices of Fraiberg's original model of service and have emerged as important to the reduction of risk for children 0–6 years of age and their parents.

The Burden of Early Social and Emotional Problems

As attention to the needs of infants and their families for early and supportive interventions has grown, contemporary researchers across the world have carried out extensive studies to examine the prevalence of infant and early childhood

Table 17.2 Examples of contemporary programs adapted from Fraiberg's original model

Program and authors	Brief description
Minding the Baby (Slade et al., 2020)	An intensive reflective home visiting service for at-risk mothers and their infants (0–2) carried out by a nurse and social worker team with a focus on interrupting the intergenerational transmission of disorganized or insecure attachment.
Child–Parent Psychotherapy (CPP; Lieberman et al., 2006)	A relationship-centered treatment for children birth to five who have experienced trauma and show evidence of mental health or behavioral difficulties
Child First (Lowell et al., 2011)	Carried out at home with parent and child (0–6 years of age) together. The program assigns two professionals to work with a family: a case worker to handle concrete service needs and a mental health worker to manage the mental health needs of the parent and infant/young child.
Watch, Wait & Wonder (Muir et al., 1999)	A manualized, child-led, psychotherapeutic approach that specifically and directly uses the infant's spontaneous activity in a free play format. Clinic-based, the intervention focuses on observing the interaction between parent and infant, inviting parents to reflect on what they see and understand about themselves, their babies, and their developing relationship.
Parent–Infant Psychotherapy (Barlow et al., 2016; Joyce, 2005; Baradon & Joyce, 2005)	***Parent–infant psychotherapy*** Parent–Infant Psychotherapy (PIP), emerged from "kitchen table therapy," a home visiting program developed by Selma Fraiberg (Fraiberg, 1980), which has a relationship base focused on the parent–infant dyad and functions to address problems in the parent–infant/young child relationship structure

mental health problems (Skovgaard, 2010; World Health Organization, 2003).

Establishing prevalence rates is considered problematic due to lack of awareness and the associated difficulties assessing and diagnosing young children. Existing figures suggest that the prevalence of problems in young children is like the data available for older children and adolescents (Von Klitzing et al., 2015).

Lyons-Ruth et al. (2017) highlight the consequences of failure to act when children have been exposed to significant mental and emotional disorders. The authors report the likelihood of significant consequences which can result in increased risk of suffering, due to the lifelong risk of mental or somatic disorders, coupled with heightened social services, healthcare, and legal costs in addition to the risk of social disintegration and violence.

Considerable worldwide and government attention has been given to the economics of early intervention (Heckman, 2006; Heckman et al., 2010) and the benefits of timely intervention for infants, young children, and families at risk of traumatic and adverse childhood experiences (Lyons-Ruth et al., 2017; World Health Organization, 2003).

The Importance of the Evidence Base

Fraiberg (1980), in her seminal work, cited the importance of research, evaluation, the need for sensitive and reliable rating scales, and the benefit of case-by-case analysis of their detailed clinical methods when determining outcomes for the infant and their family.

Shulman (2016) also highlights the importance of evaluation in infant and early childhood interventions on several levels: intervention studies can test theories about the importance of early childhood experiences, in particular the plasticity of early childhood behavior. In addition, program evaluations enable policymakers to assess the outcomes of specific programs they have funded. Shulman and other researchers (Klein Velderman et al., 2006; Kraemer et al., 2002) draw attention to the need to know the precise aspects of the program that have effect, the degree of the effect, and under what circumstances has the effect been noted; specifically, "what is working well and why."

Challenges Faced

There is global consensus regarding the contributions as infant–parent models of psychotherapeutic intervention to address parent and infant mental health problems. As noted above, several parent–infant programs have been successful in garnering funding to evaluate their adaptations of the Fraiberg model. With these exceptions in mind, many challenges remain in addressing the limitations of research that often fails to adequately demonstrate the effectiveness of these models. Further analysis is necessary to investigate what are the issues hindering effectiveness while also finding the most robust instruments which sensitivity measure change processes. Such research measures are urgent. Research has also established the crucial importance of timely therapeutic infant mental health interventions in reducing the risks of mental health problems in the parent and infant across the life span, as well as lowering the long-term burden of ill health on society.

Almost 50 years since its inception, Fraiberg's model has transitioned into twenty first century within an ever-changing society where there are disparate communities and many changes within the family structure and the way infants and young children are reared.

However, despite the paradigm shifts that the infant mental health model has afforded, challenges remain regarding its administration within diverse family groups alongside the task of maintaining fidelity to the delivery of high-quality services. We need to understand what supports, training, and reflective supervision needs are required to build programs to respond to the needs of all infants, young children, and families. We also need to establish what will enable infant mental health therapists and practitioners to remain flexible, self-aware, and sensitive to the many diverse, equity, and inclusion needs of family populations that are in a state of transformation.

System issues often challenge access to training time, resources, and budgets particularly for early years practitioners who possess a pivotal caregiving role outside the family structure. Within these systems, there is the added burden of frequent staff turnover and low-paid employment. In addition, the interdisciplinary nature of infant mental health raises challenges regarding access to high-quality and effective training models which advance competency across disciplines and at multiple levels of service. The Infant Mental Health Competency Framework® developed by the Michigan Association for Infant Mental Health (MI-AIMH, 2018), adopted across 34 IMH Associations in the USA and including Western Australia and Ireland, provides one very effective pathway for upskilling and continuous professional development.

Returning Attention to the Michigan IMH-HV Model Research Base

The IMH home visiting model (IMH-HV) as Fraiberg developed it in Michigan in the 1970s has been in place in the state's public mental health system as a prevention service for infants at risk of early relationship failure and potentially resultant developmental delays, maltreatment, and behavioral and emotional disorders (Lawler et al., 2017). Originally supported by the Michigan Department of Community Mental Health in the early 1980s and then funded through Medicaid as a home-based service for eligible families in Michigan beginning in the 1990s, with continuing support through home-based initiatives, IMH-HV was recognized as a beneficial intervention for babies and families, but there had been no rigorous evaluation. By 2012, Michigan legislators determined that sustainability and funding of IMH-HV services would be contingent on such an evaluation, with key benchmarks and evidence-based outcomes. The challenge to evaluate the model was urgent. This led to a remarkable community-university-state collaboration charged with the design of a gold standard evaluation of IMH-HV programs across Michigan. Rosenblum et al. (2020) explored the effectiveness of Selma Fraiberg's Infant Mental Health Home Visiting (IMH-HV) model (Fraiberg, 1980; Weatherston & Tableman, 2015), carried out in Michigan for over 40 years, and based soundly on developmental and clinical theories and principles. The intent of the model, described above in this chapter, is to support nurturing environments and healthy caregiving relationships in infancy and early parenthood and to reduce developmental and relational disturbances that come with adverse experiences, e.g., parental mental illness, trauma, or poverty, in infancy or early parenthood (Lawler et al., 2017). This preliminary evaluation, an open trial, pre-post design, examined the delivery of relationship-based IMH-HV services to maternal caregiving sensitivity, a variable that is crucial to the reduction of risk and attachment security in early childhood. The evaluators were also interested in the use of video feedback review of parent–child interaction. Seventy-two parents and their infants aged 0–24 months participated in the study. Parent–infant pairs who received the highest number of IMH-HV sessions showed the greatest improvement in caregiver sensitivity especially when video feedback reviews were provided, suggesting that this model promotes positive parenting, offsetting developmental and clinical risks. Of note, the IMH-HV model is a psychotherapeutic model, with infant–parent psychotherapy as a core and significant component, corresponding closely to other home visiting evidence-based models, including Child–Parent Psychotherapy (Lieberman et al., 2005a, b) and Child First (Lowell et al., 2011).

Key Concepts Underpinning IMH Home Visiting Practice

There are several key concepts specific to Fraiberg's IMH-HV practice: the use of the therapeutic relationship as the primary instrument for change; the power of working with parent and infant together; the invitation to the parent to talk about the infant and early parenting experiences and listening closely as the stories are shared; recognizing the importance of the infant's contributions to the developing parent–child relationship, as well as the parent's sensitivity and response. Of additional importance is the role of the baby's presence in triggering unconscious thoughts and feelings in the parent while listening to the therapist's reflections that contribute to the parent–infant relationship. This practice opens the possibility of growth and change for the infant and the parent, as well as the reduction of developmental and clinical risk to each.

Parental memories may be reawakened with intensity following the birth of their infant. Referred to as "ghosts in the nursery" (Fraiberg et al., 1975), these memories may make the care of an infant difficult for parents. In the presence of their baby, parents may remember neglective or abusive care at the hands of their own parents, abandonment by a parent, removal to foster care, etc., experiencing anxiety, rage, despair, sorrow, or fear associated with these traumatic events. Parents may draw on defenses that once protected them from these feelings by shutting down, withdrawing from their infant, becoming angry and projecting their negative feelings on their infant, or running away. A parent's re-enactment of this cycle – from remembering to feeling to defending against the trauma or loss – places the infant at serious developmental and clinical risk. Parents may fail to respond to the infant's cries for food, warmth, or affection; may be harsh, hostile, or punitive; or may avoid entering a close or lasting attachment relationship with the infant. Consequently, the infant may retreat, avert gaze, fail to smile, cry inconsolably for long periods of time, sleep for longer periods of time than developmentally appropriate, quickly showing signs of significant social, emotional, and cognitive delays (Weatherston & Tableman, 2015; Wright, 1986; Lieberman & Pawl, 1993). The cycle is painful to observe; the risk of disorder for the infant or relationship failure increases for both parent and infant.

An IMH therapist, skilled in the offering of IMH services and who has established a trusting relationship with parents, invites a parent to talk and then listens. The stories shared are often of abandonment, parental abuse or neglect, substance use, domestic violence, trauma, or loss. As the parent talks, the IMH therapist listens, aware of and affected by the emotions expressed, clarifying, and interpreting the past as it makes its way into the present. This process reduces the risk of repetition, separates the infant from the parent's painful past, and improves the chances for a healthier relationship between parent and child (Weatherston, 2000).

Reflective Supervision

Because the IMH therapist is very likely to experience a myriad of emotions in the presence of vulnerable infants and their caregiving parents, most leaders in the field believe that a supervisory relationship in which a therapist can reflect on the work and on her/his self is an essential component of infant mental health (Eggbeer et al., 2010; Emde, 2009; Heffron & Murch, 2010). Exposed to an infant's sobering and unsmiling stillness, emotional disturbance because of abuse and neglect, as well as a parent's deeply felt history of early abuse at the hands of their own mothers or fathers, removal to foster care, exposure to domestic violence, social injustices, or extreme poverty, the therapist feels their pain and sorrow, too. The arousal of these feelings makes it essential for the IMH therapist to have a time and place in which to be seen, to share what is observed, to be heard (Shea et al., 2020). As well, supervision helps to regulate feelings of loss or despair and to refuel to continue the therapeutic intervention in which the ghosts can be banished (Fraiberg, 1980) and the angels understood (Lieberman et al., 2005a, b).

Reflective supervision has been defined in many ways: a relationship for learning (Fenichel, 1992), a time and place in which the therapist can share observations and concerns about the infant and experiences with the family (Schafer, 2007), offer thoughts and feelings about the work (O'Rourke, 2011), and be curious and questioning (Tomlin et al., 2014). It is time to refuel within a responsive, consistent, and nurturing relationship (Shea et al., 2016). More recently, reflective supervision has been described as a collaborative process in which both supervisor and IMH supervisee can explore shared thoughts and feelings that arise when working closely with and on behalf of vulnerable infants and their caregivers (Shahmoon-Shanok et al., 1995; Weatherston & Barron, 2009; Wilson et al., 2018; Watson et al., 2017) and strengthen self-awareness (Virmani & Ontai, 2010).

A supervisor who is *compassionate*, *tolerant, or nonjudgmental*, *self-reflective*, *reliable, and predictable* is believed by experts to offer a supervisory relationship that offers support and strengthens the reflective capacities of IMH therapists with whom they work (Tomlin et al., 2014). Of particular importance:

> Influenced by Fraiberg's approach to therapeutic work, infant mental health therapists and supervisors believed that supervision could provide a safe place where personal histories, past emotional injuries, and early relationship experiences as related to the work with infants and families could be explored. (Tomlin et al., 2014, p. 2)

Of additional importance, the supervisor needs to have the capacity to contain overwhelming emotions and stirrings that are aroused during supervision. The evocativeness of this work can give rise to many projections that manifest in the blurring of boundaries between the parent and practitioner and unfold in splitting behaviors.

Memories, personal and professional, unfold in the course of the work between parents (mothers, fathers, and other caregivers) and IMH therapists, e.g., memories of difficult separations, the loss of a sibling, and the death of a child. These memories affect a therapist's capacity to listen, to hold the emotions of another, and to respond to the family with curiosity or empathy. As therapists share the felt experiences of IMH, they become increasingly aware of the use of the self as a tool for introspection (Emde, 2009) to gain a deeper understanding of who they are, the richness of their own stories, the grief and loss they may have experienced (O'Rourke, 2011), as well as new perspectives about the infants and families with whom they work. The exploration of oneself within the context of the supervisory relationship is believed to result in greater capacity for exploring and sustaining relationships between very young children and their families within an infant mental health framework.

Diversity, Equity, and Inclusion

IMH therapists live and work in an increasingly diverse world. Of great importance to best practice are the diversity-informed infant mental health tenets, a landmark publication developed by the Tenets Work Group in 2012 with support from the Irving Harris foundation. They are needed:

> To create a just and equitable society for the infants and toddlers with whom its members work, the infant mental health field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded in society. (St. John et al., 2012, p. 1)

The tenets give us a framework for individual work that moves well beyond the individual. The tenets challenge us as individuals, as supervisors, as leaders, and as a field to explore who we are, what our biases and differences are, and support us as we work for change and commit to disrupting the impact of racism and discrimination on families we serve. First and foremost, the tenets focus on self-awareness, requiring all to reflect on their own cultures, values, and beliefs. They invite the acknowledgment of discriminatory practices and privilege, honoring of diverse family structures and child-rearing practices, and advocacy toward more inclusive policies and systems (Irving Harris Foundation, 2018).

Increasingly aware that the exploration of diversity is central to equitable practice within the IMH community, therapists today further define reflective supervision as a space for mutual exploration of values and honest conversations about biases, culture, and race (Norona et al., 2012). Wilson, an IMH reflective supervisor, and her colleagues emphasize that inclusive reflective dialogue requires courage, time, and trust (Wilson et al., 2018). Supervisors and therapists ask: Who am I? Who are you? How do you perceive me? What are your racial biases? What are mine? What early experiences have I had that affect my perceptions of you or how you perceive me? These questions are at the center of honest dialogue about the intimate work of infant mental health/IPP and can open the possibility for new understanding across racial, ethnic, and cultural differences. With these questions in mind, reflective supervision becomes a place for social justice reform.

A Contemporary IMH-HV Intervention

What follows is a clinical case story of a baby, her mother, and an IMH-HV therapist to illustrate the therapeutic process of contemporary infant mental health intervention, carrying out Fraiberg's original model, principles, and practices. The names have been changed to protect the identity of the family and permission given to share the case material. The family lives in Australia, illustrating the universality of the model birthed long ago in Michigan, USA.

Rochelle Matacz, IMH therapist (AU), carefully narrates her work in the following case study as it unfolded over several months with an infant and her family who were referred to her for at risk for developmental and relationship failure.

> Liz, a young mother, arrives at the clinic with her 2-month-old daughter, Abby. She places Abby who is asleep in her pram at the opposite end of the couch from where she is sitting. Liz is guarded, finding it difficult to speak and offer information in this initial session. She looks sideways when answering questions. The practitioner is immediately struck by the strong feelings present in the room. Liz appears hesitant, physically uncomfortable, and resistant. She has few words to describe Abby, speaking of her as a 'stranger' and sharing that she has 'felt this way since she was born.' It is easy for Abby to fall out of her mother's mind as she is hidden from view and barely acknowledged by her mother during our conversation.
>
> The referral was made by Liz's husband, Richard, who had grown increasingly concerned for his wife's emotional wellbeing and for Abby as he observed Liz distancing herself from Abby's care. In the referral it was noted that the GP had placed Liz on antidepressant medication and raised developmental concerns for Abby who was failing to gain weight.
> Questions:
>
> Will the IMH therapist be able to make a connection with Liz on behalf of Abby given how withdrawn she appears in this first session?
>
> Can Liz meet Abby's needs and make a connection when she seems so engulfed by her own feelings?

Is Abby robust enough to reach and connect with her mother?

What has Liz experienced that may account for her withdrawal from Abby and her listless state in this first session with the therapist?

How does Abby experience the world through her relationship with her mum?

Where does the hopefulness lie?

Infant Relationship as Client

Infant Mental Health offers a unique form of intervention identifying the parent–infant relationship as the client (Stern, 2004). Rather than focusing on a single person, the catalyst for change and mechanism for therapeutic action lies within the relationship. An infant–parent dyad is a multi-layered tapestry of rich behavioral and representational material from both partners in the relationship. It is complex in nature and requires the therapist to develop specialized observation skills, expertise that allows her to attend to the parent and the infant simultaneously, and to wonder what each contributes to the relationship.

The port of entry into the relationship can differ. It can be a parent who is struggling with postnatal anxiety and depression or an infant who cries for hours each day and is hard to settle, placing such stress on the infant–parent relationship that there is little joy or delight in being with each other. IMH infant–parent psychotherapy centers on alleviating suffering in the parent and the infant, and repairing relationship functioning that has been derailed, placing the baby at high risk of social, emotional, or relationship failure. The growing relationship between the therapist and parent provides a space that supports a parent to bravely access, reveal, and understand their own histories or “ghosts in the nursery” (Fraiberg, 1980) and, optimally, discover those “angels” who provided loving care (Lieberman et al., 2005a, b)

As the therapeutic process unfolds and stories of trauma and loss are shared with the IMH therapist who responds with empathy, kindness, and understanding (Bowlby, 1940), parents may also remember people who cared sensitively or responsively, that is, angels in their nursery (Lieberman et al., 2005a, b; Weatherston et al., 2020; Wright, 1986). The intertwining of these memories, painful and positive, is at the heart of infant–parent psychotherapy component of the Fraiberg model.

The therapist works with the infant and parent together, observing their interactions, identifying the infant’s developmental strengths, the parent’s caregiver capacities, the difficulties for each that place their relationship at risk, and where the hopefulness lies (McDonough, 2004; Weatherston et al., 2020).

The weaving back and forth between a parent and their baby is the beginning of creating the relational template that is special and unique to each dyad. It will reflect the baby’s way of being in the world and is intricately tied to his or her parent’s own experience of being parented. The ordinary everyday interactions (feeding, play, and bathing) are the building blocks of their relationship and, when characterized by consistent, nurturing, and sensitive caregiving, creates the foundations for security and empathy across the life span. Becoming a parent can be a developmental stage of great vulnerability and reactivate/reawaken painful unresolved emotional pain from the past which makes its way into the parent–infant relationship and can jeopardize infant and parent well-being.

The IMH therapist learns to “become an accomplished baby watcher” (Jacobs, 1994, p. 748) and develops the capacity to hold all parts of the relationship in mind. What is observed in the parent–infant relationship is recognized as intentional communication, that, when brought to the attention of a parent and reflected upon, can result in positive changes in the way the parent cares for and responds to their baby. Careful observation provides a window into understanding the underlying meaning of a parent and baby’s interactional patterns and insights into clinical disturbances that may be present and expressed through a variety of ways (sleeping and feeding difficulties, infant dysregulation, attachment, relationship disturbances, and parental mental health disorders).

Centrality of Nonverbal Communication in Parent–Infant Relationships

> The most significant relevant basic interactions between a mother and her child usually lie in the visual area: the child's bodily display is responded to by the gleam in the mother's eye. (p. 117, Kohut, 1971)

Making meaning of the nonverbal felt experience in the relationship between the parent and infant and in the relationship between practitioner and parent is integral to knowing how a parent and their infant communicate, process emotions, and attune to each other. Patterns, postures, greetings, and separations are carefully observed. The way a parent holds her baby, the tone of voice she uses calling his name, and how she responds to his cries offer insight into how the baby is "held" by his mother whilst developing emotional regulatory capacities. This nonverbal dance begins in pregnancy as Raphael-Leff so eloquently explains, "the maternal heartbeat is the baby's soundtrack" (p. 47). As he is growing in utero, he is becoming sensitive to maternal cues and absorbing many parts of his mother's experiences of pregnancy (Raphael-Leff, 2015).

> Returning to Liz and Abby, the wordless sensations experienced in the first session provide hints into the vulnerabilities of this dyad and persist over the next 3 sessions. Observations reveal minimal interaction between them. An absence of any chatty comments is noted, and the silence is palpable. Liz avoids eye contact and physical closeness with her daughter, responding with resentment when Abby's nappy needs to be changed. Abby's brief agonizing screams are haunting as Liz goes through the motions/mechanics of changing her nappy. As Abby screams, Liz retreats into her own mind, spaces out, and looks out the office window.
>
> Being with this dyad evokes a sense of 'unbearable pain' that must be held and tolerated by the IMH therapist until more deeply understood. The therapist will gently create space to wonder with Liz about her own childhood experiences and how they may be connected to feelings about mothering Abby and defending herself against forming a close emotional connection with her child Through the reflective supervision process, the therapist comes to understand that Liz's physical distancing from Abby represents an effort to emotionally distance and psychologically remove herself from the intense feelings experienced, preventing her from engaging in a relationship with her baby. During supervision, the supervisor helps the therapist put words to her strong urge to 'rescue Abby' and recognizes parallel processes occurring as the therapist feels disconnected from Liz and her experiences.
>
> Withdrawing in despair.
> Abby is alone in her distress and already avoids her mother's gaze. There is no opportunity for Abby to be held by her mother or to mold against her mother's body. The absence of communication and failure to mutually adapt to each other is painful for the IMH therapist to observe and supervision becomes an important place for the therapist to understand her own emotional responses during these moments. Abby's long hours of sleep may be her way of protecting herself from her mother's absence or neglectful care. Sleep may be experienced as a way of coping with this painful reality of caregiving, providing a refuge rather than offering a state for restful refueling.

The Working Alliance

Developing and using the therapeutic relationship as the primary instrument for growth and change, offering a model for mutual trust, one that offers the parent a new way of interacting and relating to the infant (Fraiberg, 1980; Lieberman & Pawl, 1993; Lieberman & Zeanah, 1999).

Building a therapeutic connection takes time. The parent must learn to trust that the therapist is dependable, kind, and respectful of the family's needs and strengths. The therapist observes the interaction between parent and infant and listens carefully to the stories as they are told. She is fully present and holds the parent and infant in mind as she supports the development of the infant, noticing what the infant brings to the parent, as well as the parent's capacity to nurture and respond. The goal is to reach a shared understanding of their relationship, the difficulties, and the joys, as it develops over time. The IMH therapist works hard to remain attuned to the feeling states of the parent and baby, resonating with each to build a relationship in which both feel trusting and safe.

She enters a dialogue with the parent, maintaining interaction through conversation, inviting the parent to talk about the baby, early parenting experiences of the baby, worries, concerns, hopes, and dreams (Cramer, 1998), and listening carefully.

> Emotional safety begins to build over several sessions. Liz shares her feelings of resentment toward Abby and slowly counterbalances these feelings with moments of connection, delight, and thoughtfulness about her baby. Over time the IMH therapist learns that feelings of disappointment, anxiety, pain, and anger were awakened with the birth of her 3rd child, Abby. She herself is her mother's third child and was immediately rejected by her mother who had desired a boy. Liz never felt loved by her mother and recalled it was like staring at herself when Abby was born-the familiar jet-black hair. She felt like a burden to her own mother, riddled with guilt, shame and fear. When Abby cried, she heard her mother's torments and voice, 'You're not good enough!' She had felt constantly rejected by her mother, all of this awakened in the presence of her new baby.

Within the safety of a therapeutic relationship, the imprints of the deep rejection Liz experienced with her mother is spoken out aloud for the first time. Abby's haunting cries are a clue that she is experiencing something frightening from her mother that is intense and overwhelming, a feeling that cannot be contained. The IMH therapist may have an urge to relieve herself from this intolerable pain through offering a strategy to lessen Abby's crying bouts to distance herself from this mother's pain. Instead, she must listen, remain present, and bear the intolerable herself before naming the inner turmoil and emotional pain that Liz experienced in the presence of her baby's cries. Most optimally, this would help Liz to begin to separate painful past experiences from her experiences with her baby. Reflective supervision plays a vital role in providing the therapist with a relationship in which to experience emotional continuity and safety, while grappling with the infant's unmet needs, the parent's painful distress, all the while keeping the parent–infant relationship at the center of the work.

Helping Parents Envision Their Infant's Inner World

A core component of IMH is infant–parent psychotherapy, promoting sensitive and responsive parenting, helping the parent to put themselves into the mind of their baby, understanding that their baby's behavior has meaning and is driven by internal experiences such as feelings, thoughts, desires, and intentions (Slade, 2005). Through working directly with the relationship, the therapist can help to reframe parental attributions placed on the baby and be a voice and advocate for the baby's experiences and point of view. Being able to understand the world from the child's perspective helps a parent to anticipate, interpret, and respond (Bateman & Fonagy, 2012) to the infant's behavior in ways that build a young child's capacity to regulate their emotions.

> The therapist draws Abby's (now 4 and a half months old) attention towards her and notices out loud and as she whimpers, searching for her mother's face, 'Abby, I see you are becoming upset and searching for your mum's face to help make sense of what is happening inside of you'. Abby's body relaxes in response to the therapist attending to her in this way.

Through mirroring (matching), the therapist helps Liz make meaning of Abby's feelings. Arising from the therapist's comment, Liz responds by acknowledging that she can't bear to look into Abby's eyes when she is crying and avoids having to comfort her during these times.

This moment creates an important opportunity for Liz. For the first time, she names out aloud and reflects on the scary feelings she experienced during childhood. Liz recalls the terror she felt looking into her own mother's eyes when her mother was angry and shouted repeatedly to Liz, "You're useless!" Having her own feelings held and understood helps to release Liz and Abby from the force of these unspoken feelings of hurt, sadness, rejection, and terror experienced long ago. This enables Liz to begin to think about how this memory is connected to avoiding closeness with Abby. Slowly, in the presence of the therapist, Liz draws Abby closer to her as she wonders out loud if Abby may feel lonely and scared, too.

Working with Ruptures and Repairs

The breaking and restoring of connections between an infant and parent, as well as the capacity for a parent to repeatedly repair the disruption, is pivotal for healthy developing relationships during infancy and the early years (Tronick et al., 1978). In therapy, one of the IMH therapist's roles is to observe interactions between infant and parent and notice moments of attunement, rupture, and repair. The therapist needs to be sensitive and aware of the affective tone and what is communicated nonverbally through facial expression, tone of voice, eye gaze, and body posture. Questions to consider include:

- How long does it take the parent to repair?
- How long is the infant left in distress?
- What does the parent do during these times?
- What does the infant bring to the interaction and possibility for change?

> Over the course of this IMH intervention, Liz processes long buried feelings she holds from childhood and learns how they are linked to her struggles to connect with Abby. Although trying hard to protect Abby from her pain, Liz is now aware that Abby experiences her distress. Liz grows more sensitive to Abby's way of responding which is to turn away as her mother experiences prolonged periods of distress.

Supported by the IMH therapist, Liz begins to make herself available to Abby when she shows signs of distress. As a result, disruptions are less intense and the capacity for repair becomes possible. Liz places herself close to Abby's buggy and when she cries, Liz responds by picking Abby up and gradually works out ways to sooth her distress. The IMH therapist sits alongside Liz and encourages her to "stick with it" even though she voices feeling "utterly useless" during these bouts of crying. Liz practices speaking to Abby in a soft and calming voice and saying, "Mummy is right here, Abs, and will stay with you until you feel better." This is the beginning of Liz gaining confidence in reading Abby's cues, responding sensitively, and helping Abby to better regulate moments of rupture and repair, resulting in longer periods of attunement.

Ruptures and repairs also occur within the therapeutic relationship between infant, parent, and therapist. Being attentive to ruptures that occur provides an opportunity for the therapist to offer a new experience of relating, one in which relationship repair, characterized by warmth, understanding, and acceptance, is possible within the therapeutic relationship.

Parental Mental Health

Parenthood is one of the most diverse and demanding experiences in life, bringing with it upheaval and an emotional intensity unlike any other developmental stage. The enduring responsibility, coupled with the psychological and physical demands that come with parenting an infant, can be overwhelming but is part of normative processes during the transition to parenthood. Becoming a mother is a period of identity transformation. With time, a mother will integrate the different parts of the self, including her new maternal role (Stern, 1991). Adapting to this new identity requires an integration and normalizing of feelings, experiences, ways of relating, and functioning that evolves over the post-partum period.

Emotional disturbances and significant psychological suffering that persist or are exacerbated during the perinatal period can lead to serious mental health problems that impact on parenting capacity (Lovejoy et al., 2000) and child outcomes (Field, 2010). Early identification of parental risk factors that impact on the developing attachment relationship and infant development is crucial in ensuring vulnerable families receive timely interventions needed to mitigate the development of serious emotional disturbances within the parent–infant relationship. An infant mental health assessment needs to include exploring a parent's mental health history (including past and present mental health disorders) and understanding experiences of adversity in a parent's life, including past or present abuse, neglect, loss, and/or trauma. It is important for the IMH therapist to recognize depression, other significant mental health issues, and underlying personality vulnerabilities that may interfere with a parent's sensitive attention to the infant, treating those issues, and/or referring the parent for more intensive treatment, as needed. As part of IMH treatment, the IMH therapist's role may include strategies to reduce parental postpartum psychological disturbance in conjunction with improving parental sensitivity and attachment security.

Returning to Liz, we note she came into treatment with a diagnosis of postnatal depression marked by persistent low mood, a sense of futility, and avoidance of caring for Abby. Over time and careful observation, we learnt it represented two significant risks to Abby and the developing attachment relationship:

- Liz was consumed by her own highly distressing emotional states and could not recognize and respond to Abby's needs.
- Abby's neediness as a vulnerable infant came to represent to Liz a hated part of herself and that which was rejected by her own mother, resulting in anger and resentment toward Abby.

Subsequently, Abby's early infancy was void of experiencing her mother acknowledging and responding to her being. Liz was unable to provide Abby with the experience of being noticed by another which resulted in her becoming wary, silenced, and emotionally withdrawn in sessions.

Liz's depression enveloped her in a dark, angry, heavy cloud that she couldn't make sense of at the beginning of therapy. Over time, Liz shared memories of being rejected by her mother and came to understand the roots of her depression and why she felt such hatred toward Abby. This discovery evoked an outpouring of tears representing the sadness, despair, loneliness, and unmourned losses she had been holding within since childhood.

Over several sessions, the IMH therapist worked with Liz to help integrate the overwhelming traumatic childhood experiences that were awakened with Abby's arrival and began the arduous work of separating these "ghosts" that threatened the relationship with her baby, Abby. Gradually, Liz's mood improved and her capacity to hold Abby's experiences in mind increased and Liz expressed feeling "love" toward Abby for the first time since she was born.

Six months into therapy, the shift in Liz's state of mind has opened new possibilities for Abby and their developing relationship. Liz's increased capacity to be emotionally attuned and respond sensitively gives Abby an experience of being seen. Abby senses this change in her mother and over time becomes an active participant with a sense of her own agency, eager to engage her mother whenever possible. The therapist observes playfulness emerging as games of peek-a-boo become routine in sessions.

> Abby (7 months) covers her face with the muslin cloth and Liz in a curious and gentle voice asks, 'Abs where are you?'. Abby quickly pulls the cloth down, smiles with slight hesitation whilst looking up at her mum and Liz responds by laughing and there is a meeting of each other's eyes. Abby erupts in giggles and revels in her mother's joyful laugh.

This way of being with each other is new and different, and the therapist can see there remains some tentativeness on Abby's behalf. With Liz's capacity to place herself in the mind of Abby, they are now creating shared meaning where dialogue and engagement give Abby space in which to navigate a brave new world.

At 18 months old, Abby enters the room with bright eyes and a sense of excitement, and without hesitation, she proceeds to leave her mother's side and confidently move around the space. Abby's urge to explore the surroundings and the vitality in her movement is in stark contrast to the passive, silent, and solitary existence she first presented with. This is paralleled with a new sense of connectedness and deep joy that Liz feels toward Abby as she celebrates and revels in Abby's newfound motor abilities. Liz and Abby's conversations are now characterized by Liz responding to Abby's movements with curiosity and asking questions such as "what are you up to Abby?" New relationship patterns are developing with more depth, and this is nourished by Liz's capacity to nurture Abby in times of joy and in times of distress.

Summary and Key Points

Selma Fraiberg's pioneering model, IMH Home Visiting, created a unique developmental, clinical, and relational intervention for vulnerable infants, very young children, and their parents. The thoughtful and reflective intervention which she initially described as "*kitchen table therapy*" provided services for infants and toddlers who were at high risk for social, emotional, and cognitive delays or disorders as they struggled within fragile parental caregiving relationships. The model offered compassionate insights to the many factors contributing to early relational dyadic distress, e.g., economic insecurity, isolation, adolescent parenthood, unresolved loss, a history of parental mental illness, abuse, and neglect, including prematurity, illness, or hospitalization of a baby.

Fraiberg's infant mental health program, underpinned by classic psychoanalytic, developmental, relational, and contextual theories, ensured the legacy of profoundly important thinking into current services with at-risk infants, young children, and their families. Fraiberg's work has made these early theories accessible to today's frontline clinicians. With the emphasis on early relationship development, infancy, and parenthood, and because many families have experienced intense trauma and unresolved loss, those working from this perspective find reflective supervision an important addition to Fraiberg's early thinking (O'Rourke, 2011; Tomlin et al., 2014; Shea et al., 2020). The additional focus on diversity, equity, and inclusion (St. John et al., 2012) further expands the exploration of today's infant mental health work force through reflective practice.

In posing her seminal question "*What about the Baby?*" Fraiberg created a unique paradigm shift in current clinical practice with the creation of her community-based infant mental health home visiting model which enabled the infant to be present in the parent–infant therapeutic work and the parent–infant relationship to become *the client* at the center of the intervention. This infant mental health model facilitated an opportunity to sensitively observe complex and struggling parent–infant relationship interactions as they unfolded. It also enabled the IMH therapist to understand the mental health status of the parent, and the relational ghosts and angels (Lieberman et al., 2005a, b) residing in the nursery or family home that affect profoundly the care of the baby. This is possible within the security and containment of the therapeutic relationship.

Futuristic and visionary as a social worker, child psychoanalyst, and leader in the field of early relational development, Fraiberg's standards for early intervention with vulnerable infants and their parents provided a pathway for the creation of training programs to enable delivery of the core principles and processes, thus ensuring fidelity to the model (Fraiberg et al., 1980).

The detailed case study included in this chapter illustrates the ways in which a carefully trained IMH therapist works with a parent and infant together, keeping the Fraiberg principles and practices in mind. The work as it unfolds is complex. It demonstrates how the IMH therapist's sensitive, skillful approach facilitates change in the early relationship struggle and details the hopefulness of repair for the infant, parent, and the infant–parent relationship. We observe the therapist as she holds the baby's urgent developmental needs for mothering care and the mother's mental health needs to feel held and understood. Both are possible within the Fraiberg model. Many questions guide the therapist's thinking as she works to build a safe and secure space in which she, mother, and baby sit. These questions help the reader to follow the intervention over several months' time. The study places relationship at the center of the work illustrating the power of the IMH therapist's nurturing relationship with the mother and infant to invite reflection about early caregiving experiences as they interfere with the mother's capacity to nurture her own new baby. There is hopefulness in the intervention as we witness the infant's awakening as she attends and responds to her mother's overtures and the mother's capacity to attend, respond, and care lovingly for her baby.

As developmental and clinical practitioners, we ask, "Where does the hopefulness lie?" The answer might lie in what we discover about the human condition and our own humanity through the world of an infant and in relationship with their parent(s).

> In spite of the turmoil, the clinician-developmentalist remains optimistic. Infancy does that for us… The human condition is infused with hope, and the special adventure of childhood is revealed as giving us all a chance for new discoveries about ourselves… It is hard to be in the same place afterwards. (Emde, 1987, p. vii)

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Infant Observation

18

Trudy Klauber

There is something compelling about watching babies and small children. The urge to relate to a baby is strong in most adults, and babies at birth have a considerable capacity and appetite for social interaction. While much of this is attributed to "hard wiring," birth is not the beginning for mothers or babies. Mother and baby have spent a long time with each other during the pregnancy, and babies' hearing is present from the twelfth week. Anecdotally a friend, who had two much older children, had a late baby. When the baby was born, he simply would not settle, despite all that she and her husband tried. Suddenly, the mother had a brainwave and asked the two teenagers to come and join them. They said hello to the baby, who settled as soon as the older siblings talked to him and began to talk to their parents. It seemed like magic. His mother had realized that throughout his life in utero, the baby had been listening to the voices of his family. As they all chatted, the baby in his mother's arms fell asleep. That mother's intuition seems to make perfect sense. The baby could settle, it seemed when he made the connection between life in the womb and life outside it. Newly born, he needed to breathe, to adjust to brighter light, louder sound and, of course, to gravity. It might not be surprising that he could not settle. Yet, as soon as everyone in the immediate family was there, it seemed that he knew where he was, listening to the family talking to each other just as he had in the womb and, his mother believed, he felt complete, and in a familiar place again, and he could rest. There was little doubt in that mother's mind that the baby was communicating urgently through his distress. He had a mother and father who were thoughtful and who worked out a possible reason for his inability to sleep, believing that his communication had meaning, to which they responded.

In this chapter, Infant Observation refers to the psychoanalytically informed model of observation devised by Esther Bick and introduced at the Tavistock Clinic in 1948. There are, of course, many different practices and styles of observation. John Bowlby, the psychologist, psychiatrist, and analyst who invited Esther Bick to develop a training course and to include her model of observation, had become increasingly interested in the effects of separation on babies and small children, the work of Anna Freud and Dorothy Burlingham (Young-Breuhl, 2013; Freud & Burlingham, 1973) on wartime, evacuee children. He was also influenced by Rene Spitz's work on orphanage care (Spitz, 1945, 1950)). Bowlby, Anna Freud, Burlingham, and Spitz all used evocative observational material for discussion and in developing their thinking and hypotheses about infant and child development, the effect of separation on infants and children, and

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the significance of the qualities of their relationships. These kinds of observations were often of children with specific histories, difficulties, or diagnoses, while Bick wanted future clinicians to have an experience of the "ordinary." All would have agreed on the fundamental importance of the quality of relating from birth and of the impact of adverse circumstances. Mary Ainsworth, who also worked with Bowlby, researching and extending his ideas used detailed observations of children in the Strange Situation test, defining different styles of attachment. James and Joyce Robertson (1953) provided powerful observation evidence, using documentary film, of the extreme separation anxiety and distress of toddlers, separated from their mothers who were in hospital or nursing home, giving birth to another baby. The psychoanalyst and pediatrician, Donald Winnicott, was an extraordinarily acute clinical observer, as seen in his papers on pediatrics and in his published psychoanalytic work with children, notably, "The Piggle" (Winnicott, 1977). He followed in a long line of eminent, psychoanalytic thinkers, beginning with Sigmund Freud (e.g., Freud, 1905 reprinted, 1962), continuing with Sandor Ferenczi (1932), Anna Freud (see Ludwig-Körner, 2017), Karl Abraham (1927), Melanie Klein (e.g., Klein, 1929), and Donald Winnicott (e.g., 1977) all of whom based their thinking on careful detailed observation.

Bick's particular and specific intention was that Child and Adolescent Psychotherapy training should begin their training with a 2-year period of baby observation, starting as near to the birth of the baby as possible. The task began with finding a couple, due to have a baby relatively soon, using the help of an intermediary, who might be a health professional, a distant acquaintance, or someone known to a member of their extended family whom the observer would *not* meet socially. Not knowing each other was important so that the observer could *get to know* the baby,

> ….in relation to his immediate family, and thus to find out for himself how these relations emerge and develop. (Bick, 1964 in A. Briggs (ed.) 2002, reprinted 2018)

Once introduced, the observer was to describe him (or her) self as someone studying infant and child development, who would like to learn by direct observation of one baby during an hour's observation every week. The expectation was that everyone should go about family life as usual, and the observer would be a quiet, unobtrusive presence, friendly in demeanor, and

> not taking notes, as it interfered with free-floating attention and prevented the student from responding easily to the emotional demands of the mother. (Bick, 1964)

Infant Observation is a practice that encourages students to look for meaning and to understand babies' communication and development week by week, as observers, like the parents, tune-in consciously and unconsciously, to try to understand the baby. The practice of observing babies and small children, making, and discussing observations is a powerful way of learning about babies' development in a family, and a wonderful preparation for all kinds of work with children, adolescents, adults, and parents. The lens of understanding in this chapter, as in the practice of infant observation, is psychoanalytic.

I continue with an extract from an infant observation I recently heard read by an observer, who was an experienced nursery teacher. It was presented at a psychoanalytic study weekend whose subject was the importance of using observation of others, as well as of ourselves. The presentations were all from mature students already working in child mental health, child development, or in education settings. All were either completing a psychoanalytically framed observational study course or had moved on to clinical training to become child and adolescent psychotherapists.

Introduction to Baby, Amandine, and her Family

Amandine's parents, Nicholas and Lily are experienced parents, who already have two older daughters, 7 and 5 years of age. Amandine was relatively small at birth. She had been born at

37 weeks' gestation, weighing 2.37 kgs, just over 5 lbs. Mother's raised blood pressure meant the baby had to be induced early. Mother only mentions the delivery once to the observer. She simply says she had not wanted an epidural, but in the end, she needed it; then she had to have a general anesthetic when she began to hemorrhage. She said, "I hadn't expected that; it all went too fast; She (the baby) wasn't ready." Despite this start, Amandine breastfeeds very well. The observer's notes go on:

> …. Mother and Amandine had been able to go home quickly. Mother's family were there to help from the start. Family bonds were strong. I happened to do several observations when Lily's mother or sister were there. Father's family was more distant. Lily's sister was there on my very first observation visit. On that occasion, I could not see much of the baby as her mother was holding her very close; she was wearing a little hat and her face was tucked right into her mother almost the whole time.

Two weeks later:

> **Amandine at 25 Days Old:**
> Nicholas (Father) opens the door. It's the first time I've met him. He greets me warmly and invites me in. Amandine is nursing. She is calm and motionless, wrapped in her mother's arms, in a tight, soft contact, as if they are stuck to each other. Father says I won't be able to observe much when the baby is at the breast. Amandine is no longer wearing her little hat, and so I discover her nicely rounded head and rather thick brownish hair. She stops sucking. In one hand she's holding on to the neck of her mother's tee-shirt. Her head nods a bit, and she goes back to suckling. The parents are talking to each other about Claire, their 5-year-old daughter who doesn't like the school dining room. "She's difficult", says Lily turning to me, "She's not too keen on school". Amandine is very peaceful. I cannot see any movement. Lily gets her phone and opens it while wrapping her other hand around her baby. I wonder if my observing bothers her. Father is getting ready to go back to work. He says goodbye and goes to the door, with his back to Amandine and Lily. Amandine lets go of the breast, moves her arms and half opens her eyes. Her head nods and she is looking in the direction of her father's back as he leaves. He stops suddenly, turns around and comes back to Amandine and her mother. He apologises to the baby for not even having said goodbye to her.
> Once father has gone, Amandine returns calmly to the breast for a short while, then she lets go; she is asleep. Lily sitting at the edge of the couch, gently moves her away. She seems unsure about putting her down. Amandine reacts slightly to this change in position, half opens one eye then the other. Her eyelids are heavy, she yawns, she stretches. Lily is wondering where to put her down. I stand and come close to Amandine. I look at her, in her mother's arms and discover her fine, delicate face. Her head is round, she has a rather dark complexion and a small, slightly upturned nose. Her mouth is open and her lips are white. Lily says, "It's because she's been at the breast a long time". Amandine's mouth remains open; she breathes hard. In her sleep she brings her fist to her mouth, which she closes briefly. She moves her arm away and stretches it. She leans against her mother, with her lips against her sweater, her mouth now half-open. With delicate gestures and while talking to her, Mother softly puts Amandine down on a baby nest/pod on the floor and covers her with soft blanket. She then goes off to the kitchen. Amandine is asleep. I observe the faces that she makes. Her eyelids are moving from right to left. She smiles, and soon she opens her eyes; they sweep from side to side, she moves her hands, her mouth opens and closes, she makes a face, twists around, whines and starts crying.

It is very easy to picture this well-described observation.[1] The observer recalls a lot of detail, and her account evokes many feelings. The baby, at 5 weeks, has not yet reached the due date for her delivery. One imagines the speed of her transition from womb to world. In the observation, she seems to seek a feeling of being enclosed, as if she wants to return to the familiarity of the womb. She seems shocked in her "nest" when she wakes. Mother is not there, and she grimaces, twists, and turns as if to get away from being alone she cries, almost, one might imagine, that she is reexperiencing the swift and sudden, perhaps shocking, entry into the world as she is lifted out of the womb.

Lily, despite the events of the baby's birth, is an experienced and confident mother who can readily help her baby to settle and who enables her to latch on to the nipple and to feed, although the first observation is not clear whether the baby is actually sucking all the time that she has the

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[1] I am very grateful to Anne Drouet, from the Centre d'Etudes Martha Harris, Larmor Plage, Brittany, France for permission to quote from her infant observation.

nipple in her mouth. Her lips are white. Is there tension in the way she presses them together? Perhaps pressing them together, gives her a sensation of holding on tight which makes her feel better, or safer. Perhaps little by little as she opens her eyes, she catches just a tiny glimpse of the world in which she now lives, but that seems to be enough; she shuts her eyes again. Her mother is helping her to adjust as she herself recovers from the unexpected events of Amandine's birth. Lily is observant herself, noticing, for example, that Amandine's gaze is getting sharper. Perhaps the Welcome Amandine banner, hanging in the room, which mother does not want to take down yet, implies that the welcoming is taking longer than with her first two babies, after the baby's sudden arrival. All the family members need to adjust, and there are probably unconscious feelings in everyone, but perhaps particularly in the children. In the observation, mother tells the observer that Amandine's 5-year-old sister, Claire, does not like school, particularly the dining hall. One might imagine that she is full of strong infantile feelings, aroused by this new baby who has taken her place at home, as the youngest, and at the breast, to which she might like to return (her original exclusive dining room).

The observer describes in a lot of detail and evokes a lot of feeling in the reader. Having heard about the dramatic labor and the premature birth, one might readily imagine that Amandine really is not yet fully comfortable in the outside world. Perhaps she does not feel ready to be out, to be born. She is sleepy or asleep a lot either tucked into her mother or asleep in her soft baby nest, as if she is really inside again. She seems to be shocked when she wakes in her "nest" and mother is not there. When she is asleep, she smiles; as soon as she is awake, her eyes sweep from side to side, her hands move and her mouth opens and closes. She seems neither, calm nor relaxed, making a face, she twists, whines, and begins to cry.

While mother herself adjusts to the speed of events, she is also noticing such things as that Amandine's gaze is getting sharper. All the family members need time, and there are probably unconscious feelings in everyone, and particularly in the children.

Father, as he left, had to return; he had momentarily forgotten that Amandine was there and that he needed to say goodbye to her. Mother's wish to keep the big "Welcome Amandine" banner up in the living room hints at her own need for more time to get used to the needing more time, for both mother and baby. It is taking time to digest the events of the baby's birth ending with the need to perform a C-section.

Esther Bick and Infant Observation

The extract above gives a flavor of Infant Observation, as devised by Mrs. Esther Bick who was a Jewish refugee who had escaped Austria, through Switzerland to get to safety in England. She was Polish, from an Orthodox family, highly intelligent, eager to learn, and always interested in babies and children. She managed to get to Vienna to study with Charlotte Bühler and to complete a psychology doctorate using systematic observation of young children; she did not like that kind of observation very much. Bick settled first in Manchester, England, where she worked in nurseries, discovered the psychoanalytic community there, and had analysis with Michael Balint. She moved to London to train as an adult and child psychoanalyst and went into analysis with Melanie Klein. Her passionate commitment to study "the ordinary life of babies, in their own family environment" continued (see Rustin's descriptions for the website of the London Institute of Psychoanalysis and the Melanie Klein Trust, 2013).

Bick was known to John Bowlby, then Director of the Tavistock Clinic Children's Department, and in 1948, he invited her to join him to create and lead a child and adolescent psychotherapy training, the start of which was to be a 2-year baby observation, which she wrote about much later in a paper of 1968. Bick and Bowlby managed to work together until 1960 when finally he asked her not to take on another cohort of trainees and she removed herself to the London Institute of Psychoanalysis where she introduced and taught infant observation to candidates. Bick continued to supervise trainee and qualified child psychotherapists for the rest of her life.

By the end of the 1950s Anna Freud introduced Mother-Baby Observation into her Hampstead Child-Therapy Course.[2] There was little contact between the Hampstead Clinic and the Tavistock Clinic at that time, following the *Controversial Discussions* (see King & Steiner, 2005) between the Anna Freudians and The Kleinians at the London Institute of Psychoanalysis in the early 1940s. The Hampstead Clinic had already begun observations of traumatized evacuee children separated from their families to protect them. Hampstead Child Psychotherapy trainees continued to observe children in the Nursery after the War ended as well as doing mother–baby observation.

Esther Bick was, by all accounts, dogmatic and demanding, which was difficult for some to tolerate, while others experienced her teaching and supervision as exceptional in the attention to detail and her imaginative connection with observational and clinical material. She was really able to feel and imagine her way into the minds of babies and children. Martha Harris, one of the first Tavistock Child Psychotherapists to train at the Tavistock Clinic, took over, wrote in her obituary of Bick, in 1983.

> Her introduction of Infant Observation within the family as a central part of the training of child [psychoanalytic] psychotherapists was a *stroke of genius* (my italics) which has helped to establish a tradition in child analysis founded upon attention to close observation and description rather than on ideology and theory. (Harris, 1983)

Infant Observation: A Stroke of Genius[3]

Harris's description grounds Bick's position, and her own, firmly in detailed description and open-mindedness, not seeking evidence for specific theoretical positions, not illustrating concepts. Bick wanted,

> "… to help students to conceive vividly the infantile experience of their child patients" (when their clinical training began), and "to resist being drawn into roles involving intense infantile transference and countertransference". (1964, p. 241)

Observers were to follow a baby's life and development week by week. Bick was interested in babies' emotional and mental development, and their individual response to separations however brief. She applied her extraordinary imaginative capacity to thinking about the meaning of what the observers described, focusing closely on the baby. In mentioning the infantile transference and countertransference, she is also clearly introducing observers to an important aspect of unconscious communication. They needed to pay attention to how the baby reacted to them (the transference) and to their own emotional response (the countertransference, how they felt, which might come from within themselves or be a communication from the baby.)

Bick also wanted observers to have direct experience of the *transference* that they would be perceived, not in accordance with how *they* felt, but how the baby, his mother, and father (and later their patient) experienced them at that moment. For example, a baby whose mother has just left the room might burst into tears at the sight of the observer—who, in the baby's mind, was not only, *not* mother, but might be experi-

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[2] Frances Thomson-Salo writes that from 1960 infant observation became an integral part of the first-year curriculum of the British Psychoanalytical Society and then of the Hampstead Child-Therapy course. Having spread to Europe and North and South America, infant observation is practised worldwide and is a vital component for many clinical trainings, enabling psychoanalysts and psychotherapists to experience and contain powerful emotions and process them as part of training.

[3] The importance of infant observation for psychoanalysis lies in its potential to enable observers to become increasingly receptive to the impact and meaning of emotional experience, transference, countertransference, and projective identification and to thoughtfully contain the impact of the information that these convey about unconscious mental content. It seems fitting at this point in time to acknowledge how monumental an achievement Bick's introduction of infant observation was and how powerful and transformative infant observation can be (Thomson-Salo, 2018).

enced as threatening, or bad in the baby's mind. The baby's hatred or anger has transformed his perception of the observer into someone bad or nasty. The dramatic minute-by-minute changes in very young babies' feelings and perception are a hugely important discovery for all observers as well as being helpful in understanding patients later.

In a brief illustration, an observer had been present at the baby's bath time, a joyful and happy time with his big sister. They and their mother really loved splashing and laughing together. Then mother wrapped the baby in a warm, soft towel and sat him facing her on her lap to dry him gently, a moment of complete pleasure. Then, mother suddenly got up, put him on the observer's lap and left the room to get his bottle. The baby leant forward and bit the observer's cheek. It was very painful. When his mother returned, he was again all smiles, reaching toward her, and settling into her arms, for another lovely time drinking from the bottle, gazing lovingly at his mother as she talked to him. The observer, in some physical pain, was physically given the baby's anger and painful distress at the sudden ending of a heavenly time, and on his mother's return, there was no anger addressed to her.

Observers will themselves, at one time or another, be stirred up by observation; some struggle with painful feelings, related to events in their own babyhood, and they may have strongly critical ideas about mothers, which might not always relate to the observed mother, but rather to unconscious resentment about neglect or anger related in their own infantile experience. Bick expected all observers to be in a personal analysis, which was the case in the early days. More recently, many observers in the British child psychotherapy trainings do not begin analysis until they have a place on a state-funded *clinical* training and a financial contribution toward their analytic fees, only *after* completing a 2-year observational studies course. Some, of course, can pay for analysis themselves and do so before training. Public funding for a child psychotherapy training is unique to the UK.

Bick wanted observers to notice and take in all the minutiae of interaction. The presence of a quiet, friendly observer is welcome in many families, although by no means all. Thoughtful, sensitive observers may bring a containing, friendly, helpful presence. Families look forward to their visits and miss them when they are away. Parents and other children also feel the containment of the observer's presence and interest, and their nonjudgmental attitude. However, observed families and parents will also be self-conscious to some degree, especially early on. In research projects, mothers who have been interviewed have admitted that the experience was never entirely comfortable. They might have agreed to it to be helpful to the observer, or because they have themselves needed help with their university research, in the past, yet they never felt entirely comfortable, and some felt quite persecuted but did not want to let the observer down (Perez et al., 2018, and see also Watillon, 2008 whose interviews of observed parents indicated a high level of persecution in many). Parents *are* being observed. They do not know what the observer thinks of them and their parenting, or their family values, and they know from course descriptions, and documentation, that the observer writes notes, presents observations in seminars, and they do not know that the observer will write a paper. New observers can inadvertently provoke more anxiety. A young mother who I met socially, asked me about the observation she had agreed to. She asked whether it was normal procedure for the observer to stand, like a statue, looking serious and silent, in the middle of the room; and, she added, *why* would he not accept a coffee? If he refused coffee the next time he came, she was going to end the observation. Clearly, he, the wooden observer, was highly anxious, perhaps exacerbated by being a man, and anxious about observing breastfeeding. I suggested she could talk to him about sitting down, to make everyone feel more relaxed, and tell him that she had heard from other mothers that accepting a coffee was the norm. She could, of course, also talk to a course organizer, or she could end the observation if it was too uncomfortable.

There are many accounts of enjoyable and interesting observations and of some observers who also had a therapeutic effect on the family or on the baby. There are observers who have kept in touch with their families and have become friends. Dilys Daws, the well-known British Child Psychotherapist, and founder of AIMH UK, who was in one of Bick's seminars, discovered that the sister of the baby she observed had later enthusiastically offered herself and her baby for observation because she remembered that time in their family life so positively (Daws: personal communication).

On the observers' side, most are very grateful for the opportunity. They feel that observation profoundly changes their way of looking, enhances their capacity to notice, and enables them quietly to take in what they see and hear, to be able to remember and reflect, in a genuinely contained, thoughtful, and friendly way.

Bick not only continued to teach infant observation and to supervise British trainees, she also supervised visitors from several countries, and in a memorable infant observation seminar near the end of her life (she was 79 years of age when this seminar began). Jeanne Magagna asked her for help. She had been asked to teach infant observation and wanted Mrs. Bick to lead a seminar in which she could present her observations. As it happened there were no other observers, but there was a group of interested seminar members. Magagna (1987) writes,

> …. [and it] became a seminar of 6 to 13 child psychotherapists who were doing a second infant observation seminar. One year of observing led to three years of weekly observations which I presented to the seminar. [….]
> How to prepare for the new task? Mrs Bick spent several seminars describing in detail how I should introduce myself to the professional worker, in this case a physiotherapist, who would find a mother. She indicated a simple way of introducing baby observation to the mother. I should say, "I want to know more about babies and how they develop. I would find that useful." The arrangement with mother included meeting with father, to establish my acknowledgement of how my visits would affect both parents. Also, my meeting father gave the message that I considered him to be crucial for the baby's development. I was to introduce myself as simply as possible as someone wanting more understanding of babies rather than as a professional, a child psychotherapist. I was to set as regular day, time and the hour limit of the visit as well as delineating possible time when I would not be visiting at Christmas, Easter and in August. There was to be a regular commitment to the visiting arrangements, just as there is in therapy arrangements with a patient. This was considered crucial to the task of the observations. Our seminar discussions about the visits stressed accommodating the mother in order that she would feel that I was not making demands on her or intruding upon her need for rest, her routine, the baby's sleep. I was to be the container and support for the baby and the family as much as possible, rather than that the family would be available to meet my demands. Making changes in appointments was considered to be making a demand on the family and disrupting their routine. Being emotionally present for the family's sake was emphasised sufficiently for me to withstand the initial stresses of visiting. (Magagna, 1987)

Magagna describes Bick's instructions to her very clearly. She was to say that she wanted to know more about baby and child development, not to say she was a child psychotherapist. She was to meet mother and father and to be clear from the outset that she would, if they would agree, visit every week when they were available, except for the summer break and two major public holidays. The family was helping her, she was not to impose on them, or disrupt their routine. She was, quite consciously, to see herself as a container for them and *to be as supportive as possible.* Making changes was not on. The instructions are highly prescriptive. In Bick's own description of infant observation in *Notes on Infant Observation in Psycho-Analytic Training* (1964) and an earlier paper *Child analysis today* (1962), she provides an account of her method, whose points I have summarized below:

- "Infant Observation would help the students to conceive vividly the infantile experience of their child patients, so that when, for example, they started the treatment of a two-and-a-half-year-old child they would 'get the feel of the baby that he was and from which he is not so far removed'" (p. 558).
- Observers would see, week by week, the baby's emotional, mental, and physical devel-

opment and his or her response to separations however brief.

- Observers should "resist being drawn into roles involving intense infantile transference and countertransference" (p. 241).
- It is not unusual for observers to feel unconsciously and strongly identified with the impatient, desperate baby and to become unreasonably critical of the mother.
- Observation would enable the development of the capacity for "free-floating attention," or what she describes as an "unconscious attitude" of mind (p. 558).
- There was the impact of the baby on the family, and how the baby would change family dynamics.
- Bick expected that having completed an infant observation, child psychotherapists would use observation to better understand play and other nonverbal communication when they started seeing child patients and that they should use their observation experience to help them to make sense of parents' description of their child's behavior and symptoms.

Magagna noted that when she agreed to lead the seminar for Magagna's second observation, Bick was facing the latter part of her own life as the baby began his. She also notes that she herself found Bick sufficiently frightening to regret wanting to learn from her in order to understand observation better. She gives a vivid example of a sudden instruction from Bick who told Magagna that she must be like a zoom lens moving the baby into very close, clear focus, and then she shot a sharp question, "It's no good saying he is kicking- ***how*** is he kicking?" (Magagna, 1987).

Dilys Daws and Alexandra de Remantaria, in their introduction to a paper entitled, "In the footsteps of Esther Bick; continuing the legacy of infant observation" (2021) write:

> Bick established at least three important factors in developing a psychoanalytic perspective. Firstly, the need to be put in touch with infantile anxieties, secondly, understanding that the trajectory of such anxieties depends largely on the social environment of the infant's family and his relationship to his carers and siblings and, thirdly, that it is in the act of receiving projections and making sense of that experience that the observer learns to work with transferential phenomena.

Daws goes on:

> Bick's seminars were wonderful. She could be both lovable and terrifying, but the knowledge we gained was inspirational. Soon after I qualified, I read her paper, 'Notes on Infant Observation in psychoanalytical training' (Bick, 1964). The baby 'James' quoted in this was the one I had observed. She had neither asked me nor told me she was using my notes. Rather different from the policy these days! She was more entranced by the internal emotions of the baby…

She explains that her group of trainees had infant observation with Mrs. Bick for the first year and then John Bowlby for the second.

> …. he (Bowlby) showed how physical proximity in a mother feeding a baby leads to the love that grows between them. This anticipated his later world-influencing work in *Attachment and Loss* (Bowlby, 1963), where he showed how crucial separation is to a child. He emphasised how family relationships affect a child's development and that clinical work with children should include work with their parents.

Bick stressed the need to keep the mind open while observing as intensely as possible. She linked this need to clinical work with children in which:

> …. one may have to sit with children for a long time completely in the dark about what is going on, until suddenly something comes up from the depth that illuminates it…. (1962, p. 31)

Joan Symington (2002), an another observer in a Bick-led seminar, describes how Bick would focus on the role of the observer, her identification with the baby and the wider family, and that she was profoundly anxious for any infant who did not seem to be held by what Bick called "the primary skin relationship" (the need for a feeling of being held together, which required, for the baby, the presence of mother, father, or a confident, trusted caregiver). The absence of the mindful parent or caregiver leads, in Bick's view, to the development of several ways in which the baby holds himself together, by staring at a light, moving around, kicking and waving all the time or by becoming physically tense. This means of holding the self together if it becomes habitual (as illustrated in some of Jeanne Magagna' s observations of the baby, Eric) and leaves little time for the baby to feel held and relaxed, free to look around, and take things in. It prevents the baby from some sort of preparation for brief moments of separation and for understanding that mother or father will come back.

Bick developed vivid metaphorical language to describe the very young baby, feeling unheld, uncontained, or left alone for too long. She referred to "second skin" formations, developing muscularity, continuous movement, or staring, all of which impeded mental and imaginative development and friendly interest in the world. In a later paper (1986), Bick suggests that, without the sense of being held in a "psychic skin," the tiny baby would not know, for example, that his limbs would not float away and she describe him being like an astronaut "…. shot into outer space without a space suit" (1986).

Her concept of the "psychic skin" has some similarities with Bion's concept of Containment (Bion, 1962a, b). She felt that the formation of the "psychic skin," was more primitive; it could be severely disturbed in the early feeding period, creating a "faulty skin formation"[4] which would lead to a general fragility in later integration, organization, and the capacity to develop thought and use the imaginative thinking mind. Bion likened the mental functioning of the receptive mother and father to offering a kind of mental digestive system, which received and metabolized high anxiety, fear, and other primitive emotions, on behalf of the baby so that, sometime later he could take them back, somehow detoxified by understanding. Bion imagined that the baby took back the projected feelings and the mind that had contained them. Bit by bit, in this way, the parents and their containment became established internally, bit by bit, in the baby's mind, to enable him to tolerate separations and not to feel alone with his fears. He would know that his absent parents had not disappeared nor attacked or hated him; they continued to be loving and alive.

Bick's encouragement of observers to recall and write down as much observed detail as they could remember was part of her hope that they would have a vivid sense of what things were like for the baby then and there and to see and make links with earlier observations. She looked earnestly for patterns and read every observation of all the babies presented in her seminar. Observers, when they moved on to clinical work, to identify with her in their growing ability to imagine the baby within the patient and to feel their way toward their imaginative understanding of him or her.

A Personal Experience of Undertaking Infant Observation

I look back at my own baby observation, as so many others do, as a profoundly formative and memorable experience, through which I learnt a lot, both about observing and about that baby boy and his family. I also learnt a lot about, "how to be" with the baby and his family. My initial anxiety, after setting up the observation, was about remembering the detail of what happened and its order. I learnt very soon that if I wrote down my observation on the same day as I had made my visit, that I really could remember an enormous amount of detail and usually get the correct order of what happened when. It was always interesting, when it was my turn to read and discuss my observation, to discover that I had mis-remembered, either in the order of events, or that I suddenly remembered some-

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[4] Roger Willoughby writes: Bick is best known in Britain […………………] for her ideas on the 'psychic' or, perhaps more accurately, proto-mental functions of the skin. The latter began with the idea that the experience of the skin forms one of the most primitive experiences of being passively held together, without which there would be a deadly falling to pieces. Here the experienced skin is an amalgam of the infant's own skin and that of mother obtained through handling. The internalisation of this function, according to Bick, provides the infant with a primitive notion of a body boundary, dimensionality, compartmentalisation and concomitantly a container, necessary precursors of the splitting, projective and introjective mechanisms that contribute to Klein's (theory of the) paranoid schizoid and depressive positions (2001).

thing I had totally missed in the written record. Part of the seminar discussion was about the meaning of forgetting something particular or being muddled about sequence. I discovered I was developing a clear multiple focus, so that I could keep my eye and mind on the baby without excluding his big sister, who was painfully aware that I had not come specifically to observe her. I certainly did not want to make her feel more left out and jealous than she already did, about yet another person putting the baby first. I remember how complicated the situation seemed as I felt pulled in several directions. I was also very interested that I could remember three separate tracks of thought and memory. Bruner (1968) describes this capacity for "two tracked thinking" which begins in babyhood. We can follow one track while "thinking in parentheses" following another. One learns about the capacity and accuracy of human memory and about its fallibility. Anne Alvarez, (personal communication) points out that this is not only something to do with the cognitive capacity to hold on to one thing and attend to another, it is also about moving the attention from one person to another, without dropping anyone. There is a kind of queue in the mind where thoughts or mental activity including who is the focus of the observer at one time or another, waits, without being forgotten.

My confidence, as a baby observer, grew, and I was more able to relax, to present my observation, and to join in the discussion. This skill is, of course, entirely essential for new psychotherapy trainees trying to remember all that happens in 50 min of a clinical session with a child and to get it in order.

The work of observing, writing notes, preparing for a seminar was difficult and time-consuming. It was also good discipline. Inevitably, there was also an element of healthy competition between all the observers in the group, not only about the quality and detail of written reports but about "my" baby. Comparisons of all sorts are made between the "achievements" of the babies some quite close in age[5] and about the quality of parenting and the babies' developmental milestones. Some of us identified quite strongly with older siblings, and others were themselves parents.

As an observer, I was distressed at what seemed to me to be the richer, more interesting experience of others in my group. I was introduced to a family who lived near the school where I worked which was convenient, so that I could observe after work. Mother was eager to have an observer and had already volunteered to be a case study for a student nurse, in the hospital where baby Steven was born. It had not worked out. Her baby boy was born after a short relatively easy labor.

Mother had found breastfeeding him difficult, convinced she did not have enough milk for her hungry boy, and she was struggling to settle her 3-year-old daughter, Karen, who had become very demanding and was more so when mother tried to breastfeed the baby. During my second observation visit, other told me that her best friend had died of cancer just a week earlier. Her friend's funeral was coming soon, and she weaned Steven on to the bottle only a few days later. She seemed a bit sad, a bit distant, and very absorbed in Steven's physical care, while she tried to get Karen involved as her helper, consciously trying to include her wherever possible in baby care. Looking back, I think about her distress and the loss of her best friend, so close to the birth of Stephen. I have always imagined she really missed the companionship of her friend and was probably extremely lonely. She clearly loved her husband and was close to her mother,

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[5] The Tavistock has traditionally tried where possible to create seminars with first- and second-year observers. The second years would provide their detailed observation notes to help the first years to understand that task, a model of detailed observation notes and they could be helpful in talking about meeting parents for the first time, finding intermediaries to help with introductions, and to talk about how they set up their observation, or managed an introductory meeting with parents. Setting up an observation or offer comments on meeting parents. They in turn can cast their minds back to the beginning of the baby's life, perhaps discovering new links with current developments, in preparation for writing a paper about the 2 years.

but I believe that the relationship with her friend had been very important and different.

Steven himself was a relatively undemanding new baby. He slept, fed, smiled, and quietly waved his arms and legs. When he was a little older, I remember observing him a lot alone in a rocker chair in front of the TV which was always on. He often stared at the screen as he rhythmically moved his arms and legs. He seemed to be like some of the babies Bick described, steadied, comforted, feeling held together by the movement and rhythm, while his mother came and went, busily getting on with many things. His mother had clearly already identified him with the men in the family enjoying activity and not talking much. Steven was very different from his passionate, noisy, big sister who chatted a lot, drew pictures, made things to show me and her mother, and was manifestly very jealous. I felt a lot of sympathy for Karen, cast in the role of mother's helper, which mother clearly felt would be helpful, while mother was clearly more distant and preoccupied that her mother was more distant because of the bereavement. Whenever she could, Karen took possession of my bag, the keys, pens, or notecase she found inside, and, more than once, I could not find my keys when it was time to go. While Steven did not make many demands, he had frequent respiratory infections and his skin erupted in painful eczema. These made his mother anxious, and she took him frequently to the baby clinic where he was prescribed courses of antibiotics and skin cream. He loved his mother's careful, physical care, and he always enjoyed movement, splashing in the bath, and being bounced up and down on his mother's lap. He only seemed angry when his mother abruptly stopped playing with him.

When he was much older, during the second year of observation, when Karen was not always at home at the observation hour, Steven, who had learnt to walk, quite early, would look at me, turn, and begin to walk out of the room and into the long hallway. He kept on walking its full length, turning every now and then to check I was following, which made him giggle as he continued on his way. He simply continued to walk, and I was to follow. He was interested and delighted at my interest in him, as he took his walks. His mother was amused at this scene which was repeated every week. He was always very active.

I am convinced that some of the disappointment I felt was rather powerfully linked with the death of the friend and that mother was lonely during the day when Karen was at nursery and her husband out at work. I knew that my regular visits were important to her and that she enjoyed them. She often invited me to stay for a drink and a chat after the observation, and I felt guilty telling her that I needed to get home. I felt very guilty about the times when I was away on holiday, and when, after the 2 years I said goodbye, although I did manage to visit every 2 or 3 weeks for a time, until I changed jobs and had to travel greater distances to and from work.

Martha Harris's Observation Course

Martha Harris, Bick's successor at the Tavistock Clinic, was an innovator. She quickly saw that infant observation was powerful and mind-expanding and could be of great benefit to many. In the 1960s, an increasing number of would-be-students were interested in infant observation and psychoanalytic thinking, but they did not necessarily want to become psychoanalytic practitioners. Harris created her *Observation Course* in response. She developed two further modules from Infant Observation. These were Young Child Observation and Work Discussion. The first required the students to set up a weekly observation of a child between the ages of 2 and 5 years which could take place home or in a nursery or pre-school setting. It was to be for 1 year only. In this observation, the setting would be very different. Outside the home, there would be more children who would be aware of the observer and her focus. The child would be mobile and already verbal or developing speech. There would be play and interaction, drawing, building, and running around. There would also be children filled with distress at parting from their parents or having to wait their turn for an adult to notice them. Observing a young child at home would also be different. In both settings, the children would not always feel the observer to be friendly and some could become possessive. They would very quickly also become aware that the observer was following them almost wherever they went.

There are many articles on observing young children (see, for example, Yeo, 2013) and an extremely interesting and illuminating book, *Young Child Observation,* by Simonetta Adamo and Margaret Rustin (2014), for readers who want to know more. In the book, there is a chapter on the transition from home to school (Wittenberg, 2018), articles about observations at home and in the nursery, therapeutic applications, and examples of research. The vivid examples introduce everyone to the play of young children, a window into their unconscious and their preoccupations, often about what is happening at home. This period of development, which Freud named "Oedipal," is truly about adjusting to separation from home and mother and father, often to the birth of a new baby, and to living with the universal human problem of enduring such a long and slow period of being small and dependent. The need to "jump" into being big, playing at being a parent, or a strong, powerful superhero makes sense as a way of getting away, for a while, from such a long period of dependence, jumping into the role of a grown up who is idealised as powerful and all-knowing.

The second variant of infant observation, Work Discussion, required the students to use the same observational method to think about difficult or puzzling situations with children or adolescents in their workplace. The students would be working with babies, children, young people, or families, and anyone who was in a different kinds of job were expected to take on some voluntary work in order to gain relevant experience. The students in Work Discussion were asked to use their observation skills to give an account of a work interaction and to describe what happened over a chosen length of time, usually about an hour. Unlike the baby and young child observations, there was far more inclusion of themselves as part of the action, in their first-person accounts. They were encouraged to remember the interactions, any dialogue, and the thoughts or feelings that led them to make one decision or another, which meant they had ideas about what the child or young person's behaviour meant. Thinking and decision-making would be linked with a student's role and task and might involve some background description of their workplace.

The seminar group would proceed in the same way as in Infant and Young Child Observation, with an experienced child psychotherapist acting as seminar leader. Different people would spontaneously pick up on and think about various aspects of the account. The seminar leader would act as a facilitator, supporting each member in all parts of the process, to get the most out of the experience. Offers of concrete advice from group members were strongly discouraged. There are very few presenters in Work Discussion seminars who do not initially feel highly anxious and fearful of being criticized. They are describing themselves in their work setting, in a situation that is difficult to manage, painful, or puzzling, and often where they feel they have not done well. The situation in which they find themselves seems often to be linked with a communication from the child or young person with whom they are working. There is unconscious communication in which the worker might be put in touch with the powerful unconscious, and unwanted feelings of the young person. In this way, the Work Discussion students are further introduced to the unconscious world which they have previously encountered in the baby and the pre-school child.

The seminar leader, acting as the group's container, might well feel the need to seek support herself in individual consultation or as part of a group of seminar leaders having their own Work Discussion Group. The use of groups for creative thinking has been a part of the Tavistock model of teaching and learning from Wilfred Bion onwards. Clinical teams and teaching staff groups have traditionally used groups to think, focus, and discover new ideas. Some have used the image of the Russian Matryoshka doll as an image of layers of containment; the student contained by the seminar; the seminar by the seminar leader; the seminar leader by colleagues; and the course within the wider institution. Many students have attended work discussion groups, and they frequently report change for the better in the presented situation. The feeling of being contained and listened to in the seminar discussion changes the worker's perspective, which has an impact on the children or young people they work with. The willingness of the Work Discussion students to take in what happens at work is often transformative, and enables greater understanding of the impact of thoughtful observation in "containing" the client.

In the Observation Course, Harris also included discussions of selected psychoanalytic theory starting with Freud the clinician and his cases and moving on to extracts from the writings of Karl Abraham (1927), and then to Melanie Klein (e.g., 1929) who was analyzed by Abraham in Berlin in the 1920s; this was a particular historic line. Later, Child Development Research was added to ensure that all students, and specifically those who were not university-trained psychologists, would be familiar with it. The course was validated as a Master's degree early in the 1990s.

One of the attractions of the course was, and is, its teaching model, "learning from experience" (based closely on Bion, 1962a, b). This is the antithesis of "learning about," the energetic gathering of information and facts so beloved of some. Modules of Harris' course filtered into many other courses at the Tavistock and learning from experience and attending work discussion seminars found a place in seminars for psychiatrists, psychologists, social workers, counsellors, teachers, classroom assistants, nursery workers perinatal practitioners, and very many more.

Learning from Experience

This phrase of Wilfred Bion, the analyst who had worked at the Tavistock Clinic between the World Wars, and who worked a lot in groups, underlined his interest in learning directly about patients (and others), and how, in so doing, one could not avoid learning about oneself. Margot Waddell (2006) lyrically describes the method as "an extraordinarily refined capacity to see and record." She suggests that Bion, and Bick,

> …. in their respective ways, rigorously sought to ascertain the potential meaning of the minutiae of moment-by-moment experience both in what was being observed in the other and in what was being observed in the self. (Waddell, 2006)

So, whatever the setting and whatever the observational task, the aim is to see what is in front of your eyes and to reflect on what it stirs up in your feelings and your mind.

It would be naïve to suggest that this way of learning suits everybody or that all families always value the presence of an observer. It would certainly be foolish to over-estimate the therapeutic value of an infant or young child observation or to assume that it is always a positive experience. There are families who undoubtedly feel discomfort and unease; they feel watched or even quietly judged (see, e.g., Watillon, 2008). One will never know how much comes from within themselves and how much from an anxious, stern-looking rather stiff observer who never quite manages to find a comfortable place in the family setting. Some observers, like some parents and some mental health professionals, are more naturally containing than others. Some are certainly more or less self-conscious or uneasy, and some are more aware than others that echoes of their own personal histories might render them less able to manage themselves in certain situations.

The Challenge of Change

A much broader, more diverse group of students now registers for observation-based courses. (in the UK National Health Service, only a small minority have the opportunity to apply for National Health Service funded Child and Adolescent Psychotherapy training. Funding is provided for salaries, course fees, travel and part of the cost of psychoanalysis, and the funding only begins when they have a place at one of the five approved training institutions with a linked clinical placement.) Others in the broader group will go on to seek a range of different advanced trainings—in Systemic Family Therapy, Psychodynamic Counselling, Group Therapy training, Student Counselling, amongst many others. I have set this out in detail because public finding, which began at the same time as university validation of the Tavistock Observation Course, attracted and continues to attract a broader and more diverse group of applicants who might, on completion of the course, also be attracted by a publicly funded psychotherapy training. There are many who know very little about psychoanalysis as a theory or as a treatment when they begin the course. Many submit their applications because they have found the course in an internet search. Broader recruitment is, of course, to be welcomed, but combined with a phenomenal rate of social and political change, infant observation, as a discipline, has had to meet new challenges.

Recently, many would-be observers have taken to social media to publicize that they are looking for a family about to have a new baby. Their requests are often upbeat and highly informal or may sound rather desperate and needy. It can be much more difficult in the climate of fast-moving digital communication, to impose an idea of going slowly, one step at a time, noticing one's own anxiety or ambivalence about the process; even noticing that one has questions or doubts about it. There can be unforeseen consequences in trying to move too quickly, and students are often disappointed by rejections sent to them on WhatsApp, without explanation or apology. Some find that the pace of the setting-up phase is replicated throughout the observation period with families cancelling, changing arrangements by text, often at the last moment, or inundating the observer with photos and videos of the baby's activities between observations.

Establishing a regular day and time can be very difficult with some families. In one example, a mother, 6 months into the observation, when asked by the observer if they could stick to the regular time, and day, replied, "But it's no trouble to WhatsApp you in the morning, and it fits better with the way we live our lives these days. We're much more spontaneous now than people used to be." The observer felt that she had no choice but to struggle on. While the observer valued the observation and was learning a lot, there was much discussion about the possible meaning of mother's comment in the observation seminar. The seminar group could see that there was something particular in the mother's communication and her insistence on texting regular minor changes to the start time. This small example raised many questions in the seminar; was it simply a reflection of the way that families currently live? Was it really, as the mother suggested, concern that the observer should not be waiting on the doorstep? Perhaps it said something about the mother's need to be in control, and not to be kept waiting herself

Some students propose that they set up an observation in families in particular circumstances. They may want to observe a baby from their own culture, or ethnic group; they may want to observe a family from another, without thinking at all about the unconscious reasons for their choices. Some have suggested observing mothers and babies who live in women's refuges from domestic violence or in hostels for asylum seekers or refugee groups. It is sometimes difficult to persuade these observers that, for the specific task of infant observation, they need to find a family where there are no known, pre-existing complications. During "ordinary" infant observations, changes in circumstances will arise (birth trauma, family breakdown, bereavement, a diagnosis of disability, illness, changes in a family's economic circumstances, and families moving away) and these become part of the observation experience and require a lot of thought. Observations in groups with known and particularly challenging personal or social circumstances make it much more complicated for the observer to focus. Additionally, definitions of an "ordinary" family has changed a lot in recent years and now include single parents, same sex couples, and all the different possibilities for assisted pregnancy.

After completion of a first observation, many have undertaken second or further observations for a variety of reasons. Stephen Briggs, in 1997, published his doctoral research which involved observing at least five different babies born in families where there was an enhanced level of risk to the babies. Several observations variously called "participant" or "therapeutic" have been done with careful supervision. In northern France, Professor Didier Houzel (1989) an eminent psychiatrist and psychoanalyst and psychiatrist-psychoanalyst colleagues from other regions, trained mental health workers in their teams as 'participant' observers, in order that they could observe families at risk. For example observations /of babies were carried out where one or both parents were highly disturbed or mentally ill. They also organized participant observation in families where there was a child at risk of autism. Their published work suggests there was often therapeutic impact from regular observation visits, which brought about change. The mental health professionals–observers all attended weekly infant observation seminars, to support their work and to discuss observations with colleagues, who could intervene more actively in the event of a crisis. Further research has been done in the UK by Professor Maria Rhode (2021).

Two interesting therapeutic participant observations in the UK should be mentioned. Agathe Gretton (2006), a child psychotherapist in London, undertook a supervised observation of a mother and her baby because of concern that the baby was at risk of pervasive developmental delay or autism, which seemed to be linked to his mother's changeable state of mind. Mother, Mrs. D agreed to a weekly observation, which Gretton undertook, while a colleague spent time with mother. Some time into the work, Mrs. D who had agreed to the observation asked her worker what the observer was doing with her son, suggesting that perhaps the observer was "just playing" Yet, her interest seemed to be a sign of some small but significant, positive development in her relationship with her little boy. The 'participant' part is important because the observation is more active than infant observation to assist the child's development. Gretton's aim was to see whether some regular, thoughtful observation, a lot of attention to her own countertransference, and some active participation would support the baby's development and interaction with his mother. Gretton talked to the baby, allowed him to climb on her lap, and engaged in play, while being careful not to provoke or undermine his mother. There are other examples undertaken in Italy (Ciotti, 2007) and in London by Jenifer Wakelyn (2012, and see 2011, 2019), describing the use of observation as a therapeutic intervention for infants and young children in the care of social services.

The Covid-19 Pandemic

The recent Covid-19 pandemic of 2019–2022 affected the entire world. It touched every aspect of life and work, including infant observation. As lockdowns were imposed on country after country, observations were paused while everyone absorbed the shock of what was happening and began to find ways to continue with some of their pre-pandemic lives.

A relatively newly established infant observation group in Iran, with an online seminar led by Jeanne Magagna, (Daghigi et al., 2020) was very eager to continue observing online using "teleobservation." Mothers would use their phone cameras so that the observers could keep in touch with them and their babies. This group, like a number across the world (e.g., in many cities of China, Taiwan, Russia, Ukraine, and Australia), was already accustomed to their seminars being taught by video link and were well aware of the potential of the new technology, as well as its shortcomings.

While the Iranian group moved quite quickly into using mobile phones with WhatsApp, others, including Tavistock observers, hoped that the observed families might use a bigger laptop or tablet, placed in a fixed position similar to where the observer would have been in an "in person" observation. In either case, observers were at the mercy of the quality of the equipment being used, the strength of the internet signal, and the confidence or competence of the person operating the camera.

Renegotiation of the observation, or, as the Iranian authors put it, "… how to present the idea (of video observation) to each mother," was the task for everyone and they describe their anxiety about the repositioning of mother and observer and the space they had shared. The group, in the second year of observation, was concerned that a toddler was not likely to remain in one place for an hour. Mothers, who were generally the ones managing the video link, were without any freedom for the hour, "to continue as you normally would" (which, apparently, in more than one family, had included getting on with household chores while the observer was present in person observing and baby-sitting simultaneously!)

Some of the second-year observation mothers in UK groups had come to the end of their maternity leave and were now working from home. Grandparental support was reduced or no longer available, and almost all nurseries and schools were closed. Some were trying to maintain the observation while having work to do, older children to teach, along with cooking and housework. Some needed to be in touch with their own "locked-down" parents on the phone or on Zoom. As the crisis wore on, everybody was suffering from Zoom fatigue.

In spite of all the obstacles, many observers managed some sort of arrangement with their "observation families" which enabled them to keep in touch and to have observation presentations to bring to discussion in seminars, which also continued on Zoom. At the Tavistock Clinic, where the largest number of seminars is offered in a single organization, the course team offered support and guidance and negotiated with Clinic and University to set clear boundaries as to what was and was not permitted. They created guidelines on how to conduct the observations, they issued reminders about the painful loss of ordinary life and social contact and the likelihood that everyone, they and their observation families included, would be experiencing anxiety, fear, and distress.

It is interesting, and probably not surprising to note how many parents readily agreed to the video observation, sometimes at exactly the same time on the same day as before. Perhaps it offered some continuity, a link with pre-lockdown life, and some reassurance that normality would return. Some parents did not want to refuse because they wanted to support the observer in finishing their course. Their generosity was remarkable.

Relatively less anxious observers and mothers or fathers stood a better chance of continuing; they could plan and think ahead without making each other agitated. All the observers in my own seminar group were worried about losing the contact. One, in a colleague's group, who was a single parent attending a Tavistock seminar, had to end her observation very quickly. Her three, young children simply could not bear that she was asking them to play nicely by themselves for an hour, when they knew she was watching a baby on her computer. It was painful for the observer to continue attending seminars after she had to stop her own, but she nonetheless took part to hear how others had succeeded in continuing. She did receive photos and video clips of "her" baby and kept in touch with the family until the end of Covid restrictions.

While most seemed to start the new endeavor with energy, enthusiasm, and determination, complexities emerged over the subsequent months and several papers and articles have been written about what was achieved and what was lost (see for example, Ajder & Lumley, 2021).

In seminar groups there were additional technical difficulties. Not everyone had the same broadband speed, there were breaks in communication and some contributors suddenly "froze," or the sound of a voice was suddenly distorted. Again and again, it became evident how different some experiences were from others. While there was pleasure at being in contact, and much patience exercised about the difficulties, the strain was great. The quality of electronic equipment and connections showed up differences in location, and levels of affluence as well as technical ability between families and observers and observers and seminar leaders. On the other hand, in my own and my colleagues' experience, attendance and punctuality were particularly good. There was a strong sense of personal responsibility for sustaining the project.

There are concerns about what could happen to the practice of infant and young child observation in the long term, with the growth of online teaching in universities and online clinical consultations and treatments. The arguments are similar to those which are made in relation to "working at home." The suggestion is that there is a huge saving in traveling time and costs, and there is much less demand on limited teaching space in overcrowded buildings. Training institutions see the potential of reaching "markets" which are further afield, and researchers become excited at the possibility of reaching new research populations. As I write, it is less than 2 years since the end of the pandemic and many papers and articles have been and will be written about online experiences. The psychoanalytic community will need to be able to acknowledge the usefulness of technology in some circumstances, but to argue strongly for the essential experience of in-person observation, with all the elements described earlier in this chapter.

I have alluded to the impact of being online for observers and parents, but I have neither mentioned older children, nor the observed infants themselves. It was often difficult to know what they were making of the face of the observer on the screen, and whether or not they recognized the person as their weekly visiting observer. Two parallel papers written by a seminar leader, and members of her observation group are extremely interesting. I refer here, briefly, to the fascinating article by an Italian observation seminar leader, Patrizia Gatti (2021), on this subject. She writes about sight, and other senses, and notes that looking at each other, the gaze, is mediated by the screen; we can only see what the camera offers, and peripheral vision is lost. She goes on

> …. but with all devices, our gaze misses many particulars and details and this is particularly evident in terms of attempting to make careful, detailed observations of an infant's face. Additionally, our gaze is directed and governed by the video director-parent and is limited in this sense too.

Gatti (2021) goes on to quote from a first video observation of Mara (1 year, 2 months) with her father and brother Giorgio (5 years) after a gap of almost two and a half months:

> […] All three of them are present (Mara, her father and Giorgio), they smile, look curious; they too seem to be observing this new situation and I imagine they are observing me on screen. Mara is smiling, her face is lit up and I see she has grown a lot. She looks at me with curious eyes and inclines her head towards the screen and towards me […]. Every once in a while, she turns her face to the screen, smiles and extends her arm towards me opening and closing her hand as if to ask me to be there with them.

Mara clearly wants to touch the observer and tries to push her hand through the screen. Another online observation of Lia (1 year and 5 months) takes places on WhatsApp after a 2-month break.

> After a few minutes standing near her mother, Lia starts looking at the cell phone that is on a sideboard, I imagine. She moves slowly towards it but stops and looks in my direction […]. She then extends a finger towards the screen and I say hello again telling her that unfortunately we cannot touch each other but only see and talk for the time being. She continues to extend her index finger towards me. After a while she becomes restless and complains […] but all this is not enough for her and when she realises that I am still *in* the screen she starts crying loudly.

Patrizia Gatti (2021), using material from her seminar group of observers, (di Pasquale et al., 2021) notes that both these babies are confused and experiencing "dissonance" as described by two researchers into the impact of video calls (Petriglieri et al., 2020). Gatti (2021) suggests that the dissonance emerges when our minds are in touch, but physically we are not together in the same place. It is also possible to make a link with babies watching TV. In several observations There are descriptions of babies who want to know where the people on the screen *are*. We are all probably familiar with crawling babies and toddlers going to the back of the tv to find the people *inside*. It seems to be particularly painful for the baby Lia, above, not to be able physically to be with her observer, after such a long gap. The observers undoubtedly suffered too. In one observation, the family is in the Italian Dolomites for the video observation; while the observer imagines the fresh air, sees a breeze blowing and that the sky is deep blue, she is at home and indoors. She feels lonely and somewhat ridiculous, while she is simultaneously aware of the effort mother has made to call, and actively to include Eva (the baby of 1 year, 5 months). The observer finds it difficult to stay in role as she becomes aware of the extreme contrast of the two locations, hers and that of the family, and the pain, for her, of feeling trapped in a house, in a city with only on-screen contact because of the virus.

Conclusion

Across the world, there are trends toward favoring psychological therapies which engage the ego of the patient in noticing and thinking about patterns of *conscious* behavior. Outcome measures are similarly based on cognitively achieved, positive changes. Talking therapy, in child mental health services, it is often, in the UK at least, is linked with interpersonal treatments, focused on the conscious functioning of patients and on delivering manualized and measurable interventions. There is much to think about in relation to what might be the impact of all of this, not only consciously but also *un*consciously, on present-day clinicians and on teachers of infant observation and its applications. On the face of it, this world seems entirely different from the world of Esther Bick. Yet so much of what she initiated and developed, survives flourishes and continues to inspire, develop, and sustain thoughtful, sensitive *contained and containing* clinicians and trainers.

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19

Child–Parent Psychotherapy: Acknowledging Ruptures in Safety and Rebuilding the Protective Shield

Chandra Ghosh Ippen and Alicia F. Lieberman

Back in the Kitchen

Our chapter begins in the kitchen, with a metaphor (Ghosh Ippen, 2012) created with a father during our first meeting as we discussed whether he would want to join treatment with his 3-year-old daughter and wife. His daughter had been molested at her childcare setting, and the family was dealing not only with anger, sadness, guilt, and shame around this experience but with the conflict that it caused internally for each parent and between them. Dad felt he had failed his daughter. He had not been able to keep her safe, and this had brought back into consciousness unbearable childhood experiences. He was flooded by memories and nightmares of family conflict and of fleeing from genocide, for dad identified as an indigenous Guatemalan who, as a child, had narrowly escaped being killed by soldiers.

Before continuing, we invite the reader to pause and reflect with benevolence and curiosity on what your body may be feeling as you read this. Writing about what we do in Child–Parent Psychotherapy (CPP) involves sharing stories that most of us would prefer not to hear. As Bowlby (1979, p. 404) stated,

> Children frequently observe scenes that parents would prefer they did not observe; they form impressions that parents would prefer they did not form; and they have experiences that parents would like to believe they have not had.

Bowlby's statement applies not only to parents but also to professionals and perhaps also to society. We would like to believe that infants, toddlers, and preschoolers are protected from harmful events by their cognitive immaturity. We would like to believe that they will not remember, and many people, including professionals, worry that talking about traumatic experiences may make it worse. Avoidance is one of the hallmark clusters of posttraumatic stress disorder (PTSD). It is a foundational defense protecting us against unbearable affect, and yet, as we have learned from Fraiberg and colleagues (Fraiberg et al., 1975) as well as from research in the areas of posttraumatic stress, complex trauma, and epigenetics (Berthelot et al., 2015; Bush et al., 2023; Felitti et al, 1998; Moog et al., 2023), unresolved childhood traumatic experiences, and "ghosts in the nursery" can haunt not only the individual but also generations to come.

Hope comes from remembering what Selma taught us: "history is not destiny." Our clinical

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For Selma Fraiberg, the muse in our "kitchens", and for the families who live in our hearts.

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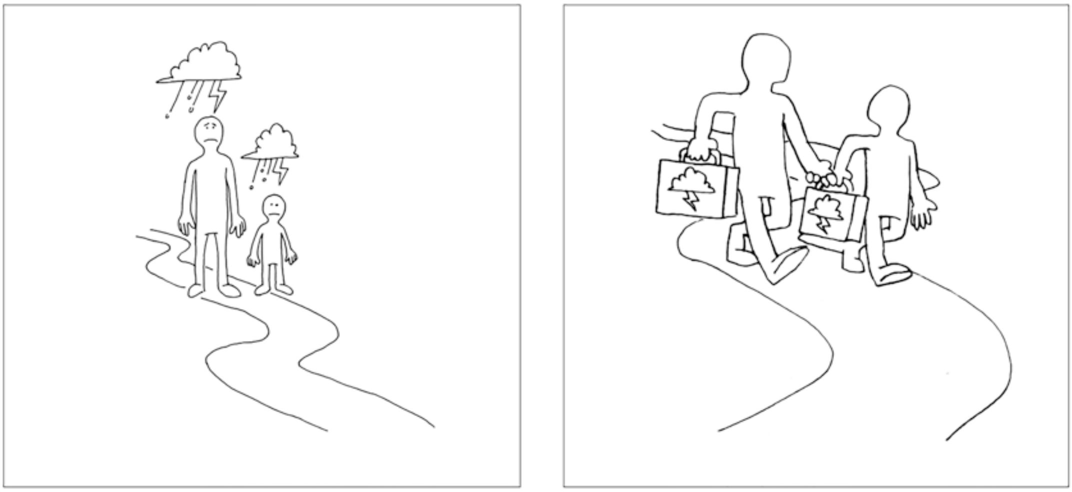

Fig. 19.1 The metaphor of the clouds (Ghosh Ippen, 2012)

work and research since 1996 with families at the Child Trauma Research Program (CTRP) as well as the work of many others (Osofsky, 2013; Osofsky et al., 2017; Pynoos, 1994; Slade et al., 2019; Zeanah et al., 2011) strengthened this belief and led me, the first author, to be at the kitchen table with this father, holding both sadness and hope. On this, our first meeting, not knowing if there would be others, I aspired to both listen deeply and convey what we hold as central to our beliefs in CPP, what Alicia—my mentor and the second author of this chapter—taught me, that there is enormous value to opening the door so that children can "speak the unspeakable" (Lieberman et al., 2015) and explore painful experiences accompanied by love and protection from those most important to them.

The Metaphor of the Clouds

As I listened to the father and felt the weight of the family's experiences of historical, intergenerational, and interpersonal trauma, words failed me, and yet we were there to think about how we might jointly support his daughter, so I asked the father if I might borrow a napkin and a pencil to draw an image. The dialogue that followed was conducted in Spanish and is shared as remembered along with errors I made as a non-native Spanish speaker.[1]

I began by drawing a lone stick figure with a cloud over their head and a road in front of them (Fig. 19.1,[2] left side) and offered an explanation. "El trauma es como una nube feroz… Puede afectar como vemos el camino o como nos vemos el uno al otro." ("*Trauma is like a ferocious cloud… It can affect how we see the road or how we see each other.*") "Puede entrar en el cuerpo." ("*It can come into your body.*") I drew clouds in the figure's body. Dad nodded and said, "Y es bien pesado." ("*And it's very heavy.*") I nodded and added, "La mayoría de nosotros nos han enseñado que tenemos que correr de las nubes, que tenemos que seguir adelante, pero hay veces en la vida cuando hay algo en el camino y nos caemos." ("*Most of us have been taught that we have to run from the clouds, that we have to keep*

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[1] As this is a chapter for the World Association of Infant Mental Health and many of us are working cross-culturally in a language we were not raised with, we felt it important to share the wording used along with any mistakes that were made. We honor that we both train and elevate those who speak the languages and represent the populations served, and that as we do this, we "do not let the perfect be the enemy of the possible."

[2] The drawing is not the original pencil sketch but one recreated by Erich Ippen that is included in the CPP training manual.

moving forward, but there are times in life when there is something in the road and we fall.") Dad looked at me and immediately added, "Y nos agarra bien fuerte." ("*And it grabs us so strongly*.")

We sat in silence looking at the images and then I spoke. "Yo sé que una de las cosas más duras para una mamá o un papá es cuando algo le pasa a su hijo." ("*I know that one of the hardest things for a father or mother is when something happens to your child*.") I drew a smaller figure on the road and added clouds above its head and an extra cloud over the parent's head. He nodded and shared how this had hurt his heart. "Es bien feo." ("*It is so ugly*.") He thanked me for helping his wife and said that he knew that his way of dealing with this experience was causing problems for his family. He was glad if maybe I could help him too, so he would know "la forma correcta de ayudar a su hija" ("*the right way to help his daughter*").

I realized I could not leave the drawing as it was, so I continued. "Pues, estamos aprendiendo que no tiene que ser así. Si uno se puede voltear y ver las nubes con alguien en quien confía, con un ser querido, las puede transformar." ("*Well, we are learning that it does not have to be this way. If you can turn and face the clouds with someone you trust, with a loved one, you can transform them*.") I drew a suitcase with clouds entering it. "Nunca podemos dejar a un lado el pasado, pero podemos cargarlo de forma diferente. En vez de estar encima de uno, como un fantasma, podemos cargarlo así. Y los niños chiquititos necesitan la ayuda de sus padres para cargar su historia." ("*We can never leave the past on the side, but we can carry it in a different way. Instead of it being over us, like a ghost, we can carry it this way. And little children need the help of their parents to carry their story*.") I added the image of the parent and child walking down the road, suitcase between them (Fig. 19.1, right side). I did not say it then, but I have come to realize that when children have their loved one's accompaniment and carry their history in this way, they develop muscles from being supported in making meaning of the unspeakable.

After this day, dad began treatment. We did not speak about the metaphor again, so I was stunned during our final session when dad said, "Yo sé que un día la maleta se va a abrir, y yo si voy a estar." ("*I know that one day the suitcase is going to open, and I will be there*.") I felt a wave of hope and joy. When the clouds emerged at different developmental points in her life, she would not be alone with them. Then, I felt a wave of sadness recognizing that I would not be there. This moment left me with a renewed understanding of why we partner with families, especially as we address traumatic experiences that may affect them or their relationships. As our colleague and co-developer of CPP, Patricia Van Horn, often said, "Our task is to support the parents in serving as the child's guide through traumatic experiences and through life."

CPP Overview and History

As illustrated in the opening vignette, the fundamental goals of CPP are to support family members in connecting emotionally to and making meaning of stressful or traumatic experiences that impact the child, caregiver, or their relationship, to support them in adaptively responding to the understandable sequelae of these experiences, and to restore the child and family to a healthy developmental trajectory. Within CPP, the therapist and family partner to acknowledge and address maladaptive experiences that may be affecting family members. This includes historical and sociocultural trauma and experiences of danger external to or within family relationships. Therapists support caregivers in understanding their own and their child's emotional and behavioral responses, we jointly address harmful perceptions they may have of themselves or each other, and we foster the caregiver's capacity to serve as a secure base, legitimate protective figure, and regulatory partner. CPP is founded on core infant mental health principles, including the belief that relationships are central to healthy development and well-being and serve as the vehicle through which healing from adverse experiences occurs. We also hold that context, including family culture and threat or protection from the larger community, shapes relationships, socialization, and development.

CPP is primarily a dyadic treatment, meaning that the therapist considers and addresses interpersonal dynamics specific to each dyad. However, when advantageous, CPP flexibly includes multiple caregivers and siblings, often resulting in a triadic, quadratic, or multi-dyad approach. Treatment configuration (e.g., whether to see siblings together, how to involve multiple caregivers, and when to have the same therapist versus a team work with different caregivers, particularly in cases involving family violence) is determined after a thorough assessment and is guided by the family's preference, the case conceptualization, and the therapist's capacity as well as by considerations related to safety and the emotion regulation needs of family members. With regard to treatment length, randomized controlled trials (RCTs) conducted by our team (Lieberman et al., 1991, 2005b) and the team at the Mt. Hope Family Center (Cicchetti et al., 2006; Toth et al., 2002, 2006) involved a 1-year period, with an average of 33 sessions (Child-Parent Psychotherapy, 2018). Recent CPP effectiveness trials show that 20 sessions result in beneficial outcomes (Aschbacher et al., 2022; Hagan et al., 2017).

Selma Fraiberg's Infant–Parent Psychotherapy (IPP; Fraiberg, 1980) serves as the rootstock for CPP because even as our model has evolved, it remains grounded in psychodynamic principles and in Fraiberg's clinical wisdom. She, along with others (e.g., Lebovici, 1993; Stern, 1995; Winnicott, 1956), recognized that the transition to parenthood and the process of having a baby often bring back memories, both cognitive and body-based, of a parent's early childhood. Fraiberg and her colleagues (1975) sought the keys for interrupting the intergenerational transmission of maladaptive parenting patterns. They asked, "*What is it then that determines whether the conflicted past of the parent will be repeated with [their] child?*" Their answer? "*Our hypothesis is that access to childhood pain becomes a powerful deterrent against repetition in parenting, while repression and isolation of painful affect provide the psychological requirements for identification with the betrayers and aggressors*" (Fraiberg et al., 1975, p. 420). This premise, that those who connect emotions to their frightening and painful experience are less likely to repeat it, is at the heart of CPP. We help parents and children to not only speak about the unspeakable but also to feel the unfeelable by supporting them in exploring and safely relinquishing the defenses against knowing and reconnecting with the affect of the frightening experiences they endured. Young children are less likely to repress their knowledge and feelings about overwhelmingly frightening experiences when they are given the protective space to express the full range of their affective responses and when caring adults help them correct pathogenic understandings of traumatic events and differentiate between reality and fantasy about their role in making bad things happen. As children, many parents had experiences of danger and fear without the emotional support and protective presence that the father in the opening vignette was trying to create for his daughter. Honoring Winnicott's wisdom "there is no such thing as a baby" and the core infant mental health principle of the parallel process, we understand that to support the child, we need to support the parent. When caregivers are affectively held as they metabolize painful experiences, they are better able to do the same for their children.

The UCSF Child Trauma Research Program (CTRP) was founded in 1996 by Alicia Lieberman and Patricia Van Horn with the purpose of treating children in the birth-five age range who had experienced traumatic events. This extension of the age range led to a change in the name of the treatment, from Infant–Parent Psychotherapy to Child–Parent Psychotherapy. Our initial focus was on young children exposed to domestic violence and traditionally underserved groups, including immigrants from Mexico and Central America, Black/African American families, and economically disadvantaged families, and we conducted an RCT focusing on preschoolers aged 3–5 exposed to domestic violence and their mothers to examine the treatment's efficacy (Lieberman et al., 2005b, 2006). These contextual factors contributed to the evolution of the treatment model. Domestic violence is often accompanied by what Layne et al. (2014) termed a "caravan of risks." Most of the families were economically stressed, and 41% had incomes below federal poverty guidelines (Department of Health and Human Services, 2004). Mothers reported an average of 12 lifetime traumatic or stressful events. Their children, all of whom were exposed to domestic violence, also had a high prevalence of exposure to community violence (47%), physical abuse (29%), sexual abuse (12%), parent substance misuse (16%), and parent mental illness (88%).

Our research procedures, which involved using comprehensive trauma assessment tools in a clinically attuned way during the intake process, enabled the mothers and therapists to have an earlier and more thorough understanding of the ways the child's and the parents' complex experiences contributed to mental health challenges. During research-scaffolded dialogues, the therapist asked about specific traumatic events experienced by the child and the mother and supported the mother in reflecting on how these experiences affected their child's and their own individual functioning and their relationship and how treatment might support repair. This approach to assessment informed the course of treatment. Data on the prevalence of and impact of early childhood trauma (Briggs-Gowan et al., 2010; Ghosh Ippen & Lieberman, 2008; Stover et al., 2019) and our team's involvement in the National Child Traumatic Stress Network (NCTSN; nctsn.org) were also instrumental in helping us delineate a treatment approach that focused on the child's direct experience of adversity and trauma while also attending to parental "ghosts," when clinically indicated, as a relational backdrop that interfered with the parent's capacity to serve as a protective shield for the impact of the child's traumatic experience.

In the course of treatment, children repeatedly showed us that not only were they affected by the violence they had experienced but they were also trying to make meaning of it, and they were not too young to do so. They replayed injuries, putting Band-Aids in the exact location where they or their loved ones were hurt. They created scenes where sometimes the dragon would play with them and give them rides and other times it would destroy the home, an eerie depiction of what it is like to live with a caregiver who is sometimes loving and sometimes scary.

After completing our RCT with preschoolers, the CTRP team returned to work with the full birth-to-five age spectrum and recognized that the way we worked had been changed by what these families had taught us as well as by the research procedures that had compelled us to have difficult but clinically important dialogues from the start. We saw that toddlers were also seeking answers to difficult questions and that infants remembered experiences of danger and needed to be wooed back to safety by caregivers who understood how these experiences might contribute to their reactions. Moreover, we knew that parental "ghosts in the nursery" did not limit their presence to pregnancy and infancy but reemerged at key developmental moments well into the preschool years. For some parents, the "ghosts" took form as the child approached an age that carried difficult memories for the caregiver. For example, although he had not consciously made this connection, a father whose own father had died at age 3 had greater difficulty remaining emotionally available as his child approached toddlerhood than he did when his child was an infant. For other families, a behavior that might be typical at a given age (e.g., separation anxiety and tantrums) seemed more intense or caused greater relational distress due to the adverse and traumatic experiences of caregiver, child, or both. For example, parents who grew up in a home where adults were often frightening when angry or who had recently left a violent relationship often had difficulty responding to their toddler's extreme tantrums. Exposure to trauma tends to exacerbate typical developmental challenges as the dyad encounters not only the stress of the present moment but also the reverberations of prior experiences of fear without protection.

The families that we served, their cultural backgrounds, their strengths, the specific challenges they faced as members of groups that experience inequities and racism within their environmental context, and the diversity of our team led us to more consciously articulate how

CPP addresses sociocultural realities and stressors. Most mothers in our RCT (Lieberman et al., 2005b) identified their children as culturally diverse: 38.7% mixed ethnicity, 28% Latino, 14.7% Black, 9.3% White, 6.7% Asian, and 2.6% other ethnicity. At CTRP, our core clinical team is also culturally diverse. As of the writing of this chapter, 82% are Spanish speaking, 45% are immigrants, and 36% identify as LGBTQIA+. With regard to ethnicity, 18% identify as Asian, 18% as Black, 55% as Latina, and 9% as White. Bowlby integrated his lived experience of loss into his theorizing (van der Horst & van der Veer, 2010), and so too our team has integrated our lived experience as members of groups that have faced racism, homophobia, discrimination, and historical trauma into our understanding of the need for intervention to address these factors (Ghosh Ippen, 2018; Mays et al., 2021). The workers affect the work. We have broadened our lens from "ghosts in the nursery" to "ghosts in society" and have ensured that core treatment goals address harmful sociocultural realities and honor family strengths, angels in the nursery (Lieberman et al., 2005a, 2015), and ancestral angels (Ghosh Ippen, 2018).

Beyond the Child Trauma Research Program: Overview of CPP Dissemination

Before delving deeper into the treatment model, it is important to briefly describe the breadth of CPP dissemination and implementation efforts because our team is not alone in doing this work. The treatment model that began in the kitchen with Selma Fraiberg and at the University of Michigan with her Child Development Project transitioned to the San Francisco-based Infant–Parent Program, continued to evolve at CTRP, and is now thoughtfully implemented around the world. The CTRP national dissemination efforts started with a 2001 grant from SAMHSA that enabled us to form the Early Trauma Treatment Network (ETTN), one of the original 12 NCTSN sites founded to increase access and raise the standard of trauma-informed treatment for children, families, and communities across the USA. ETTN included colleagues with deep expertise in infant mental health and trauma: Betsy McAlister Groves (Boston Medical Center), Joy Osofsky (Louisiana State University Health Sciences Center), and Charles Zeanah and Julie Larrieu (Tulane Medical Center). Our partnership, which has continued to this day and has grown to include the next generation of ETTN leaders, provided the collective wisdom, heart, and energy that made what followed over the next 20 years possible.

Up until 2006, CPP was transmitted primarily through a mentorship model. Staff, interns, postdocs, and psychiatry residents at ETTN sites typically received weekly supervision from at least two different CPP supervisors along with weekly seminars and case conferences to gain experience in the model and foundational infant mental health knowledge and competencies. With the publication of the first edition of the CPP manual (Lieberman & Van Horn, 2005), recognition of the evidence base for CPP, increased interest due to our NCTSN collaborations, and large system, state, and federal initiatives that named CPP as an intervention model for their systems, we needed new training models to support wide-scale CPP dissemination, particularly for providers in community mental health agencies.

Patricia Van Horn partnered with NCTSN colleagues to adopt their Learning Collaborative (LC) model (Ebert et al., 2012) for CPP implementation. The CPP LC model now involves 18 months of training that include an initial core didactic training, two core-competency enhancing sessions held 6 and 12 months after the initial training, and 18 months of twice-monthly consult calls involving case-based learning and discussions related to fidelity and cultural and systems applications. As of this writing in August 2023, there are 83 US trainers who have conducted 456 CPP LCs across 43 states and the District of Columbia. Our CPP Agency Mentorship Program, a within-agency sustainability model, is in the piloting phase with 13 agencies in the USA. Our internship consortium includes four sites across the USA.

International dissemination started in 2010, when Alicia Lieberman and Patricia Van Horn were invited to provide CPP training in Israel by Haruv, an organization based at the Hebrew University of Jerusalem School of Social Work that trains professionals on interventions for child maltreatment. In partnership with Drs. Asher Ben Arieh and Paula David, they conducted three LCs as well as two Train-the-Trainer courses that equipped CPP trainers to conduct LCs in Hebrew to increase training accessibility. There are now 30+ CPP trainers who have conducted 9 LCs and trained 200+ clinicians who provide CPP treatment and apply CPP principles in systems of care that include childcare, primary care, child welfare, and the judicial system throughout Israel. Our second international implementation effort began in 2013 and resulted in the formation of the CPP Nordic Network, a partnership that began with Professor Kjerstin Almqvist of Karlstad University, Ericastiftelsen in Stockholm, and the Regional Children's Mental Health Center in Oslo, Norway. The Nordic Network includes three CPP trainers in Norway and two in Sweden. To date, there have been six CPP LC's conducted in Sweden and four in Norway. In 2016, CPP implementation efforts began in Australia led by Julie Larrrieu and joined later by Chandra Ghosh Ippen in partnership with the South Australian Branch, Australian Association of Infant Mental Health and the child welfare organization, Berry Street Victoria. Thus far, Australia has held four CPP LC's, and Berry Street is pilot testing the CAMP model to enhance CPP sustainability within their organization. Implementation of CPP in the United Kingdom began in 2016 led by Julie Larrieu and has involved partnerships with the National Society for the Prevention of Cruelty to Children as well as the Bradford District Care National Health Service Foundation Trust. Thus far, three cohorts have been trained in both CPP and Tulane Infant Team, a model of working with the courts, the child welfare system, and caregivers to provide intensive intervention for young children who have been maltreated. A fourth cohort is planned for 2024–2025 to increase the number of CPP providers within the National Health Service.

With assistance from sponsors and professional volunteers, the Hong Kong Association for Infant Mental Health (HAIMH) was established in 2014. The clinicians who were part of HAIMH included clinical and educational psychologists, psychiatrists, pediatricians, psychiatric nurses, and occupational therapists. After several invited presentations about infant mental health and the impact of trauma on young children, in 2018, the group decided that they wanted to pursue more intensive training to provide therapeutic services for infants and young children and their parents/caregivers. Therefore, in 2018, Joy Osofsky was invited by HAIMH to provide an 18-month Child–Parent Psychotherapy (CPP) clinical training for frontline clinicians who were working with infants, young children, and their families. Vision was shared about the significance of social and emotional well-being for very young children, in particular, the secure relationship with their primary caregivers which for many families in Hong Kong included intergenerational caregivers. As more professionals were getting involved, IMH psychoeducation and practices began to flourish in clinical settings, educational institutions, family services, and the community. This enabled issues like early bonding with preterm babies, infant attachment with postnatal depressed mothers, feeding difficulties, toddler tantrums, and neurodevelopmental delay to be addressed from an IMH perspective.

Acknowledging the Trauma and Protective Experiences of Families and Communities

As trainers partnering across states in rural and urban communities and across countries, we have been faced with the stunning reality that across settings, the families' stories are surprisingly similar. In 2012, when researcher Kjerstin Almqvist, whom we fondly refer to as CPP's Swedish godmother, contacted our team to explore CPP implementation, I wondered aloud about the widespread need for an intensive trauma treatment in Sweden. In response, Dr. Almqvist informed us of Sweden's domestic violence prevalence rate. The Swedish Crime Survey suggested that 12% of women had been subjected to violence in the previous 12 months, with single mothers with young children at particularly high risk (Leander et al., 2012).

Over the next 11 years, as we trained in multiple states and six countries, many of us shared clinical vignettes secretly hoping someone would say the details were too severe or were unique to our location and not applicable to theirs, but they did not. During consultations, we learned that while, very importantly, the social and cultural context were different, details regarding trauma experienced by young children and their parents were eerily familiar and confirmed what world statistics have shown, that interpersonal violence is a global epidemic that significantly impacts young children (Hillis et al., 2016; UNICEF, 2017). Across settings, there were families with more circumscribed experiences for whom a briefer version of CPP was possible. However, too frequently, there were numerous children experiencing multiple traumas before age 5. Fortunately, CPP, grounded in clinical wisdom with a capacity to integrate complex experiences into our case formulations, enabled us to respond effectively to complex trauma in the early years (Ghosh Ippen et al., 2011). While difficult to face the reality of the danger endured by too many families, we also have a growing sense of hope as we connect with practitioners across countries, recognize the impressive strengths of the families they serve, and understand that across the world there are adults partnering to break intergenerational cycles of violence. Below are vignettes[3] of fictional composite families we might all serve, so that we may consider how, throughout the world, we might work with them in CPP.

Example: Samir, age 6 months
Samir underwent serious medical procedures after birth, including intubation and surgeries due to bowel obstructions. He had difficulty sleeping, pulled away from his mother when she held him, and refused to eat. The doctors were concerned about his weight gain but felt his challenges were not medically related. His parents were exhausted and described living in a constant state of worry, wondering if perhaps the doctors had overlooked something.

Example: Sonia, age 32 months
Sonia was referred to treatment after her family experienced a significant wildfire. Her dad noted that since the fire, she seemed more fearful, she had sleeping problems and more frequent tantrums, and she both rejected him and protested when he left the house.

Example: Kai, age 47 months
Kai has had numerous foster care placements beginning at 7 months when he was removed from the care of his mother. She reportedly used substances and left him with strangers. His maternal grandmother cared for him but had a boyfriend who was violent with her and possibly Kai. Kai was moved to a foster home. He spent 18 months with them. They hoped to adopt him, but Kai was returned to his mother at age 32 months. Soon after, his mother relapsed. His next foster family reported that they were unable to manage Kai's "aggressive behaviors," and he was moved to his current foster home, where he has been for the last 3 months.

Guiding Frameworks

As we explore how CPP might support intervention with families with such varying presentations, we invite the reader to breathe and think about what hearing about these experiences does to each of us. The work affects the workers. And, the work and worker are critically important because without support provided to the caregiver, many children will walk down the road of life, with these stories embedded in their bodies and without the accompaniment of a grown-up who can help them make meaning of these experiences and connect with the resulting emotions.

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[3] We have not provided full details regarding the families' socio-cultural background. We hope that each of you will think about specific families in your location, their intersectional identities, and potential sources of stress and historical trauma related to their identities within your specific context.

CPP Fidelity Framework

As you connect with your feelings and perspective, you are engaging in a core aspect of CPP practice that we call *reflective practice fidelity*. Our fidelity framework (Ghosh Ippen et al., 2012; Ghosh Ippen, 2022a) contains six strands representing our clinical DNA. *Reflective practice fidelity* is the first strand. As we consider working with each of the families introduced above, we may have a range of reactions related to our personal history, the history of the family members, the ways family members relate to each other, and the way systems respond to the family. As Jeree Pawl, the former Director of the Infant–Parent Program (1995, p. 24) noted:

> It is not possible to work on behalf of human beings to try to help them without having powerful feelings aroused in yourself … In working with families who are in great difficulty, rage can become the most familiar affect,—at the system, at a world with too much violence that creates too much helplessness and also at a family who will not be better or even seem to try and then at yourself as an ineffective, incompetent, masochistic fool and who do you think you are anyway?

For this reason, reflective supervision and team support are foundational to CPP. *Emotional Process fidelity* highlights the need to attend to the affective state of each family member and to intervene to support good enough emotional regulation so that family members are within the window of tolerance (Siegel, 1999) and the intervention is therapeutic. *Dyadic relational fidelity* is defined as attuning to both child and caregiver, tracking their reactions, and supporting and strengthening their relationship and understanding of each other. Dyadic relational fidelity also involves thinking about important caregivers who are not in the room, keeping their perspective and relationship with the child in mind. *Trauma framework fidelity* includes identifying and addressing experiences of danger including trauma experienced by the child, the caregiver, their family, and cultural group, acknowledging this history, and connecting these experiences to patterns in behavior, affective responses, and relationships. *Content fidelity* tracks the therapist's conceptualization of the goals of treatment, specific to this family, and examines the match between conceptualized intervention goals and therapeutic interventions. *Procedural fidelity* is met when the therapist and parent engage in phase-specific procedures that create a shared understanding of how current stressors and historical factors are affecting the dyad. Procedural fidelity also enables caregiver and therapist to co-create the structure for how treatment will begin, progress and end, leaving space for the needs and contributions of the child.

Phases of Treatment: Foundational Phase

The intervention is organized around three specific phases: (1) Foundational; (2) Core intervention, and (3) Closing. During the foundational phase, therapists typically meet alone with caregivers except for caregiver–child observation sessions, assessments of child functioning, or case management and crisis intervention focused sessions necessitated by the family's urgent needs and/or safety concerns. Core goals for this phase include the following:

- Create a therapeutic climate where the caregiver feels supported in speaking about difficult circumstances, including traumatic experiences.
- Take steps to understand sources of danger and to increase safety.
- Establish a dialogue about cultural values and approaches to child-rearing, including the caregiver's attitudes about mentioning the child's trauma during treatment.
- Develop a joint formulation of the child's presenting problems that incorporates a trauma-informed perspective, sensitivity to the caregiver's psychological functioning, and attention to the family's ecological context.
- Co-create with the parent a treatment plan that includes an agreement about how to address traumatic events, presenting problems, and other difficult topics with the child.

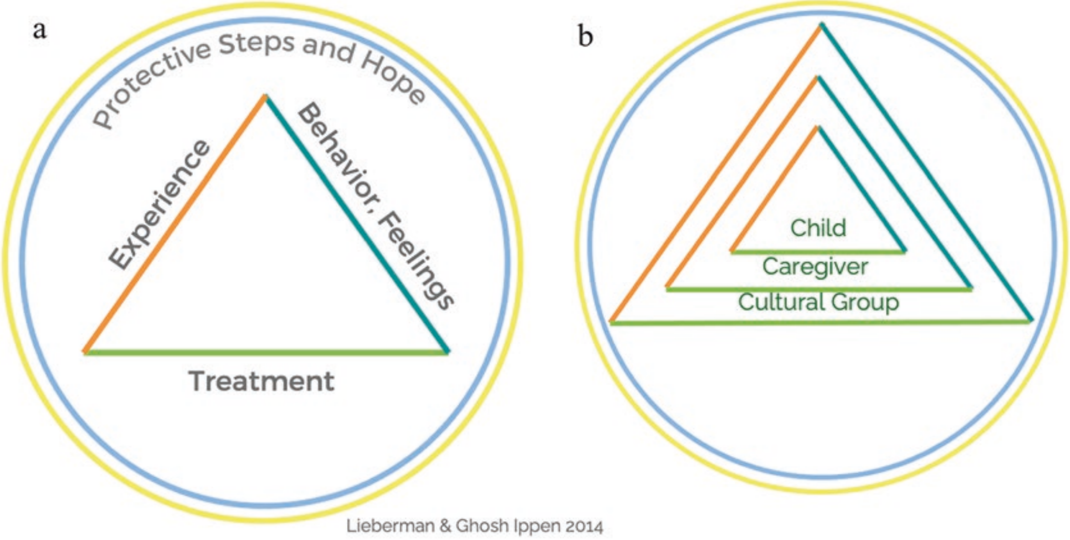
Dialogue about the caregivers' and child's history and symptoms (procedural fidelity for this phase) occurs using flexibly employed semi-structured assessment tools and clinical interviews. The therapist tailors interventions to the caregiver's affective state (emotional process fidelity) and thinks about how the caregiver's history is related to their emotional state and responses (trauma framework fidelity and emotional process fidelity) and to their relationship with their child (dyadic relational fidelity). The foundational phase culminates in a feedback session where therapist and caregiver discuss what each learned, co-construct the CPP Triangle (procedural fidelity and content fidelity), and plan for the next phase of treatment, including deciding how to introduce the child to treatment.

The CPP Triangle of Explanations

The CPP triangle (Fig. 19.2a; Lieberman & Ghosh Ippen, 2014; Ghosh Ippen, 2022b) offers a visual model for holding the case conceptualization. It is typically co-constructed with the caregiver during the foundational phase although the clinician may hold a more complex version with their supervisor. The triangle links experience, including experiences of stress and trauma, to behavior and feelings. It honors strengths and protective steps and guides intervention. Experience may include genetic predispositions, prenatal influences, and both positive and challenging experiences. On occasion, therapist consider potential future experiences (e.g., a placement change, the parents' involvement in violent relationships) to addresses ongoing or future risks to safety. Phrases that guide the formation of the triangle include:

- Experience: You saw, you heard … (e.g., People in our house fight and then your daddy went away).
- Behavior/Feelings: And now, you … (e.g., Don't sleep well. You worry when daddy is not around, and sometimes you hit other kids.)
- Treatment: This is a place where … (e.g., You can use the toys to show us what happened and how you feel, and your mommy and daddy can show you what they are doing to keep all of you safe.)

Triangles can be constructed not only for the child but also for the caregiver and cultural group (Fig. 19.2b) as we consider how experiences may intersect and historical forces may interact.



Lieberman & Ghosh Ippen 2014

Fig. 19.2 The child–parent psychotherapy triangle of explanations

Phases of Treatment: Core Intervention Phase

While most CPP treatments involve predominantly dyadic sessions during the core phase, the treatment formulation may also call for individual caregiver collateral sessions. For example, in families dealing with significant trauma (e.g., sexual abuse and murders), caregivers may need a space to process their own reactions, so they can better support their children. Parents of older children who have significant ghosts may also benefit from a private space where they can freely share their experiences and emotions without unduly burdening their child. We differentiate this from individual therapy, in that the focus is a relational one where the caregiver is supported in differentiating their childhood history from their current experience as a parent, freeing the parent–child relationship from the ghosts of the past.

The core intervention phase typically begins after the feedback session when the child is “introduced to treatment” as the therapist and caregiver share a developmentally tailored version of the triangle that includes an acknowledgement of the child’s experience. This triangle is often shared using a child-friendly modality (e.g., play or drawing for older children) to scaffold the child’s ability to communicate and enable the child to contribute by showing with toys or through art what they might not be able to share with words. Even in our work with babies, we set the frame by connecting experience and reactions and establishing what we might do together. The presentation of the triangle is intended as much for the parent as for the child. In listening to the clinician speak to their child, the parent learns about the importance of “speaking the unspeakable” protectively and supportively and also learns about the equal role we give to protective factors. Samir’s therapist began with the following:

> Hello Samir. Your mama told me that when you were born, you had a rough start. You were so small, and the doctors had to do so many things to your little body to help you. Your mama thinks it was scary for you. It was scary for her [looks at mom who nods]. Yeah … and now you’re sitting peacefully in your mommy’s lap. It’s such a good place to sit…Your mama wants you to feel safe. She knows that sometimes you worry when she touches you, or when you have to eat…You had so many pricks and pokes…Mama and I are going to think about what scares you and what she can do to help you feel safe. Your mama has figured out so much, and we’re going to learn more and more together.

Following the introduction of the triangle, interventions flow from ports of entry (Stern, 1995), clinical moments where the therapist sees an opportunity to further the goals of treatment. Ports might come in the form of the child’s play or behavior, the parent’s behavior, interactions between parent and child, or the child or parent’s representation of themself or each other. This flexible intervention unit is responsive to the needs of young children who may need a more unstructured space to be able to spontaneously share their internal experiences. Moreover, for parents of young children, spontaneous interactions offer opportunities to honor strengths, to deal with the reality of a hard moment, and to reflect on the origins of challenging interactions.

Clinical Vignettes

Sonia During the foundational phase, Sonia’s father, Nick, described that 5 months before the referral, the family’s home was threatened by a wildfire that started very quickly. The fire turned so that their house was not in serious danger, but Nick felt guilty that he had been at work while Sonia’s great aunt cared for her. His aunt told him that they had smelled the smoke, and as they looked out the window, they could see the hills in the distance burning. She knew it was far away but she was still scared and she called Nick, who left to come home right away but was delayed due to traffic. Although the family was referred due to wildfires, consistent with procedural fidelity, the therapist used a comprehensive trauma assessment tool to guide dialogue about Sonia and Nick’s full history. When the therapist inquired as to whether Sonia had ever “experienced the death of someone close,” Nick responded “no,” but he looked away and his affect shifted. Rather than move on to the next question, the therapist said, “I wonder if this question brought up something for you.” Nick whispered, “I try not to think about it, but when I was three, my dad died in a car accident.” Nick talked about how alone he felt. “After that no one ever talked about dad or what happened. That’s why I want Sonia to get therapy.” The therapist nodded. “You were just about Sonia’s age, so you really understand how things like this can affect a little one.” “Yeah,” said Nick. “It hurts to see that she’s not the same.” “Mm,” responded the therapist. “She’s been through something scary, and so have you. You mentioned that she talks a lot about the fires.” “Uh huh,” said Nick “I tell her it’s over, no more fires, but she just keeps bringing it up.” “I imagine that’s hard,” responded the therapist. “I do wonder though if we might see it as a sign of hope.” Nick looked confused. “Well,” said the therapist, “as you noted, Sonia has a lot of worries. She’s trying to figure things out, and she’s sharing her worries with you, but it can be hard to hear these things, which is why I’m here to support you. This way, neither of you are alone with your worries. You mentioned that when you were little, you were alone with your experiences. I imagine you are giving Sonia a different experience.” “Wow,” said Nick. “I hadn’t thought of it like that before.”

Later in the session, the therapist returned to the theme of Nick’s past. “I wonder if Sonia being almost three may have brought things up for you.” “You know,” responded Nick, “It did. I’ve always felt like bad things can happen, that your life can change in an instant, but after the fire, it’s been so much worse.” As the foundational phase unfolded, Nick began making important connections. The potential life threat to his child and aunt awakened his fears of death and separation and triggered a major depressive incident. This caused intense guilt because Nick’s mother was unavailable to him due to her depression after his dad’s death, and now he felt he was not the dad he wanted to be for Sonia. His partner, Jason, traveled a lot for work. After the fire, they began arguing because Nick did not want Jason to travel. He worried about Jason’s safety, and he felt unable to care for Sonia. He felt history was repeating. He also shared that as a gay dad, he worried that people would question his parenting ability if Sonia was not doing well. This added pressure, feeling like his family was not valued by society, also affected his mood. The therapist validated his response and opened the door to a conversation about his sense of safety in his community and in the larger society.

Nick recognized that Sonia had been affected by the fire, his mood change, and the fighting at home. During the first core treatment session, he and the therapist told Sonia that on the day with lots of smoke and noise from the fire trucks, dad had been very worried about her and Auntie, and after that, he’d been sad and sometimes, he got angry with Papa, Sonia’s other father. He said he was sorry about getting angry. Sonia took the doctor’s kit and checked him. Nick told her that he was feeling better and was getting help. In future sessions, Sonia would bring the fire truck and ring the siren. Together she and Nick would put out the fire. Nick noticed that the fire people always took care of the fire, and the daddies always came together at the end for dinner in the house. “We do come back together,” he smiled. “Your daddies love you very much.” Outside of sessions, Nick talked to his partner about his father’s death and his fears that something like that could happen again, especially as Sonia neared age 3. His partner responded supportively. He called more often when he was on business trips. They began looking at old family photos, and his aunt shared stories of her brother so that Nick was able to hold on to precious memories to share with Sonia, so she could know about her grandfather even though she could not meet him.

For this family, the focus was more on the parent’s triangle than the child’s but the core of treatment remained a relational approach, where the parent was supported in repairing a rupture he had with his child and the therapist acknowledged and made space for the parents’ feelings about society’s biases of their same-sex partnership. This approach resulted in improvements in the parent’s well-being as well as the child’s, changing the child's family circumstances and interrupting a cycle of trauma that had begun in the dad's childhood.

Kai As the therapist began working with Kai, a question emerged. Which caregiver would engage in CPP? Andrea, the current resource parent or Eileen, Kai's mom, who was continuing to seek reunification and was currently sober? A foundational goal was to stabilize the child's placement and consider his future living situation. To do this, the therapist collaborated with the child welfare worker to understand the reunification plan and the relationship between mom and the resource family. Together they decided to offer CPP to both Andrea and Eileen. They reasoned that treatment might help stabilize Kai's current placement, which was in jeopardy due to his behaviors, and could potentially build a bridge between Eileen and the resource family to alleviate some of their conflictual interactions. The social worker reasoned that Eileen would need additional support after reunification due to ongoing challenges with depression. He had placed Kai with Andrea because she was known to be supportive of parents.

During the foundational phase, Eileen brought up her mixed Indigenous heritage.[4] She had recently joined a culturally concordant parenting focused on traditional ways of raising children. She noted there was a lot she did not know because she had been raised in foster care. She felt she had lost so much. Eileen and the therapist talked about what she knew about her cultural group, the legacy of stolen lands, boarding schools, and restriction of ceremonies and language. They considered the potential impact of historical trauma on her family as well as Eileen's hopes for Kai. Eileen wanted Kai to know it was not his fault that he had lived in so many places. She wanted him to learn about the strengths and traditions of their cultural group because this was something she had not had.

Eileen also openly shared her own and Kai's experiences with the therapist and gave permission for this information to be shared with Andrea. The therapist told Andrea, "Eileen wants you to know what Kai went through. She's shared that when he was little, she had a lot of problems. She didn't know how to keep herself safe, and she didn't know how to keep Kai safe. There were times when he was hungry and when people, including Eileen, were fighting. She said she used to yell at Kai and leave him because she didn't know how to be with him, so she totally gets why he doesn't trust her." Andrea breathed deeply and said, "I wasn't expecting she would be so honest about this." The therapist nodded, remembering what Andrea had shared about her own brother's substance use challenges and how this had affected her. "She's made a lot of changes. She wants Kai to know it's not his fault that he doesn't live with her and that he's been moved around so much. We've talked about how he's been walking around with a volcano inside him, and she wants him to get help because she knows that pain."

Before this conversation, things between Eileen and Andrea had been tense, but the therapist felt Andrea shift after this. When Andrea brought Kai to the clinic for an observational session, Kai ran to the toys in the waiting area. When Eileen tried to encourage him to go to the therapy room, Kai ignored her. During a previous meeting, Andrea had sat back and watched when Eileen had difficulty with Kai, but this time she leaned in and commented, "Your mama really wants to spend time with you." She gave Eileen a little smile, and Eileen smiled back. "I wonder if we might walk down the hall together to show Andrea where you're going to be," said the therapist. Eileen and Andrea nodded. When they got to the room, Andrea looked around and said, "This looks like a lovely place to play with your mama." She pointed to a chair in a nearby nook outside the room. "I'll sit here and wait for you." At the end of the session, Eileen greeted Andrea, "Kai

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[4] We have chosen not to specify Eileen's Indigenous background. As this is a chapter for the World Association of Infant Mental Health, we hope that practitioners will reflect on the histories of the specific Indigenous groups displaced in their area to reflect on the strengths of that group, the ways that histories of oppression have impacted them, and the way we might acknowledge this on the path towards repair.

drew you a picture and told me about your dog." They laughed about the dog and how much Kai loved him. "He has a good heart," said Andrea. "Yes, he does," answered Eileen. While they still had minor conflicts, things in their relationship shifted, and as they did, they noticed that Kai's challenges lessened. Kai was very sensitive to conflict. Improvement in his relational context resulted in improvements in his sense of safety and his behavior.

Although the therapist, Eileen, and Andrea decided that Kai would have separate treatment sessions with Andrea and Eileen, they decided to introduce Kai to treatment and present the CPP triangle together. They met in a room where the therapist had set up multiple boxes representing different houses. They told Kai they were going to talk about his family, and they picked animals to represent family members. Kai chose animals as they asked about the different people who lived in the different houses. He picked a big lizard for Jerry, his grandma's boyfriend, crashed it around the house, and threw it against the wall. "Well," said the therapist looking at Eileen and Andrea, "we are here to talk about how sometimes things were scary, especially with Jerry." Eileen nodded and looked down. The therapist continued. "Mama told me that when you were little in some of the places where you lived, people would fight and yell." Kai picked up a big lion and put it in Eileen's face and roared. "Be nice Kai," said Andrea. "Yes," said the therapist, "Andrea and mom want to help you learn to be nice…I wonder though if Kai is showing us that some of the grown-ups he lived with before roared kind of like that." Eileen nodded. She looked right at Kai, "Kai, mama used to roar too. I had lots of problems, and I'm sorry. That's why you live with Andrea right now while I learn to do better." Kai turned away from Eileen. He had the lions fight, and his play became chaotic and hard to understand. Then he began running around the room. It was a tough session, but it was a beginning.

In future sessions, Kai had very different ways of being in sessions with Andrea than with Eileen. With Andrea, he played with the babies and cared for them. Sometimes, the lizard would roar at them, but there was generally a theme of the lizard being chased from the home and grown-ups being able to care for the baby. Andrea noted his behavior at home had changed, and they made a plan to close treatment shortly after the eighth session. With Eileen, Kai's play was chaotic, hard to understand, and difficult for the therapist and Eileen to tolerate. When he played aggressively, Eileen and the therapist would encourage him to play nicely. They would try to keep the babies safe, but this just made him upset. One day, when the lion was eating the baby, Eileen grabbed the baby and said, "No, you can't hurt my baby. I'm going to keep the baby safe." She covered the baby with kisses. As she did this, Kai wailed, "I want the baby the baby." "No," said Eileen "You don't play nice with him." Kai broke down sobbing. The therapist left confused and drained and later consulted with her supervisor.

As they reflected about the session, the therapist was able to consider how she had joined mom. She wanted mom to feel good and protective. "That makes sense," said the supervisor. "I can see how much you care about her. Do you think we might be able to hold that and also think about what Kai may be showing and needing." As they thought about Kai's experiences and connected it with his play, they began to think about the chaos he had experienced, the feeling that babies were living in terror. The therapist came to wonder if Kai was showing us a world filled with fear and confusion, a world he had been a part of. They wondered if perhaps Kai was different with Eileen because she served as a reminder of this time they had shared together.

During the next session when Kai grabbed the lizard and had it push the baby, Eileen commented, "Not again with that lizard Kai. You need to knock it off." The therapist breathed and thought about how to support mom and child in understanding each other. "I know," said the therapist. "It's so frustrating. The lizard keeps coming back. We want the lizard to be gone, but it keeps coming back, and we have to keep fighting it …What do you think Kai is showing us?" "I don't know," said Eileen. "What do you think?" "I'm not sure," responded the therapist, "but when we started, you told me how you felt stuck. Things were scary and confusing for you and for Kai for a long time." Eileen looked softly at Kai, "Things were scary for a long time, and I'm still battling my demons. He's not wrong." Kai continued to play and the therapist noticed that this session he seemed to be able to focus longer on the play in the dollhouse.

This session marked a shift for Eileen and for the therapist. After this, they were better able to receive what Kai was sharing. When the lizard attacked the house, they sat with how scary it was. Eileen said that she wished she could stop the lizard and was so sad to think about all that Kai had been through. When she said this, it was as if she were truly resonating in her body with what Kai was sharing. In time, Kai let her begin to take a more protective role, and his play became less chaotic.

In the later phase of treatment, the therapist noted that Kai played less with the lizard. They were cooking, playing ball, and telling stories. Eileen taught him words from their traditional language. She sang songs and shared stories she was learning in her parenting group. Treatment with Eileen and Kai continued to include moments of crisis and dysregulation and moments of repair and hope. They were able to reunify with Andrea serving now as "family" in their words. She saw Kai a couple of times a month and was able to have Kai visit and stay over when Eileen was going through a tough time. There were challenges in that Eileen continued to have conflictual relationships with partners that negatively affected Kai. Still, the therapist, Eileen, and Andrea honored the changes that Eileen made.

Phases of Treatment: Closing

The Closing Phase was formerly termed "Recapitulation and Termination" until our Norwegian colleagues pointed out the harshness of the word termination as they were translating the training materials. This phase involves acknowledging the ways that the therapist's and the family members' histories, including experiences of loss and separation, may influence the way they approach this phase and their emotional reactions to ending. After considering both the family's history and the course of treatment, the therapist thoughtfully plans the closing with the caregiver, honoring the relationship that was built, considering and responding to reactions that may arise in the face of a goodbye, supporting ongoing treatment gains, and attempting to have a goodbye different from the more painful goodbyes of the past.

For Nick and Sonia, the closing was brief encompassing four sessions. The therapist completed an evaluation and Nick reflected on the positive changes in himself, Sonia, and their relationship. They let Sonia know about the ending and planned the goodbye session. During that session, they talked briefly about the fire, Sonia kissed the fire truck, and the therapist and family drew pictures for each other. After this, Nick and the therapist had one final session to think about the ways treatment had supported Nick in processing the loss of his father and to say goodbye. For Kai and Eileen with their significant histories of loss and separations, the therapist broached this subject alone with Eileen during the core phase, suggesting that someday they might end treatment. Eileen reacted angrily saying that people were always leaving her and the therapist was just like them. The therapist noted that it might feel like a betrayal. Eileen agreed and missed the next two sessions. Fortunately, the therapist was well supported by their supervisor and continued to reach out to Eileen acknowledging that Eileen might be hurt. The therapist shared a wish to have a different goodbye both for Eileen and Kai, one that was thoughtful and planned. They both deserved something different. Eileen reluctantly agreed. They thought about the rest of the treatment, with Eileen being able to say that she needed support through the winter holidays as that was a time when she had often relapsed. In January, they began the process of saying goodbye. They planned a thoughtful goodbye for Kai and counted down the last four sessions. Kai brought back the lizard and showed how he wrecked the house. He and mom jointly spoke to him and told him they did not want him to hurt anyone anymore. After the goodbye with Kai, the therapist and Eileen met monthly for two more sessions, so Eileen could see how she did "on her own," and the therapist could support her as she got other services in place. As they ended, Eileen said, "I'm mad at you for leaving, but I know you care." The therapist nodded, honoring how hard it is to say goodbye to those we have come to care for and noting that we continue to be connected in our hearts.

The Data Suggest We Have Reason for Hope

Data from five RCTs as well as effectiveness and feasibility studies conducted in the USA, Israel, Sweden, Norway, and Australia (David & Schiff, 2015; Hooker et al., 2022; Norlén et al., 2021; Pernebo & Almqvist, 2019; Weiner et al., 2009) provide further evidence that CPP results in significant positive change across the early childhood developmental span. Because measures of treatment efficacy vary depending on the child's age, it is not possible to assess for intervention effects in a consistent way across this developmental span. However, across studies core measure of early childhood functioning including attachment classification, cognitive scores, behavior problems, trauma-related symptoms, caregiver functioning, and representations of self and caregiver all showed significant change in a direction that supports the utility of CPP for promoting repair in parent–child dyads who have experienced multiple stressors.

CPP with Infants

Two studies examined the efficacy of CPP in infancy. The first involved anxiously attached infant–mother dyads. All mothers were Spanish speaking, identified as recent immigrants from Mexico or Central America, and had experienced multiple stressful events (average = 12.09). When compared to a control group on coded parent–child interactions, CPP resulted in greater partnership and less avoidance, resistance, and anger on the part of children as well as higher maternal interaction and empathy (Lieberman et al., 1991).

A second study involved infant–mother dyads recruited through a review of CPS records following verified reports of maltreatment to either the infant or a sibling. CPP dyads showed significant improvements in attachment classification (3.1% secure at intake and 60.5% at post) compared to a community standard (0% secure at intake and 1.9% at post). An alternate psychoeducation parenting intervention (PPI) also showed improvements in attachment pre to post (0–54%). However, by the 12-month follow-up (Stronach et al., 2013), only the CPP group maintained improvements in attachment security (CPP: 55.6% secure; PPI: 22.7% secure), suggesting that CPP resulted in more stable improvements in relational safety.

CPP with Toddlers

The Mount Hope team has published numerous studies based on a RCT that examined the efficacy of CPP for children of depressed mothers. Positive CPP intervention effects were found related to enhancing secure attachment (Cicchetti et al., 1999; Toth et al., 2006) as well as protecting cognitive development (Cicchetti et al., 2000). Moreover, longitudinal data provide support for CPP-related benefits 6 years later in that children in the CPP group were more likely to show secure attachment, and these children were in turn more likely to have positive peer relationships at age nine (Guild et al., 2017).

CPP with Preschoolers

In a study of preschoolers exposed to interpersonal violence and other traumatic stressors, CPP children showed greater reductions in behavior problems and traumatic stress symptoms, while their mothers showed significantly greater reductions in avoidant symptomatology (Lieberman et al., 2005b). Six months later, improvements in behavior problems were maintained and additional improvements were seen in CPP mother's global symptomatology (Lieberman et al., 2006).

Toth et al. (2002) examined the efficacy of CPP versus a parenting psychoeducation model to alter maltreated preschoolers representations of their mothers and themselves. They reasoned that these representations, also known as schema or internal working models, represent an important outcome as they form the basis of children's future relationship expectations. CPP was found to be more effective in decreasing children's negative representational models of themselves and their mothers, increasing their positive self-representations, and increasing their positive mother–child relationship expectations as measured by narrative story-stems.

New Directions

The evolution of CPP continues as we explore and manualize the extension of this model to the critically important perinatal period in the form of Perinatal Child-Parent Psychotherapy (P-CPP) (Lieberman et al., 2020). Preliminary studies suggest that P-CPP results in decreases in maternal depression and posttraumatic stress symptoms and improved child-rearing attitudes (Lavi et al., 2015). Our team has begun offering Learning Collaboratives to support CPP providers in implementing P-CPP within this critically important period.

In 2020, with the COVID-19 pandemic, our community was pushed to explore the delivery of CPP via telehealth. What we thought was not possible was now essential. Our experience over the next 3 years, as practitioners, supervisors, and consultants, showed us that for some dyads it was not only feasible but also improved access to care. We continue to explore CPP telehealth best practices and are developing guidelines for this application.

Summary and Key Points

Child–Parent Psychotherapy is an evidence-based treatment with five randomized trials supporting its efficacy. It is one of the few trauma treatments for children under the age of 5 and has been found to be effective for families who have experienced multiple complex traumas. CPP is now being conducted in 43 states and 6 countries. This chapter began with a story and a family because opening the door to a family's stories is truly the heart of CPP. Our work is grounded in clinical and ancestral wisdom, and in the wisdom of young children. Through their play, questions, and behaviors, young children show us that they grapple with their experiences. They are "meaning makers" (Tronick & Beeghly, 2011). They are not too young to do this, but they are too young to do this alone. They need a reliable, consistent relationship and accompaniment as they make meaning. In CPP, our role is to support their parents or caregivers so that they can support their child. Parents and caregivers are the co-creators of memory and healing and repair happen within the context of relationships and benefit all members of the family. As one mother wrote, "In time we started to see … it's ok we can trust people, to be honest in therapy, to talk about the bad things that happen to feel … our sparkle inside that we thought we lost; with help we are finding out just how bright our sparkle really is."

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When Does a Baby Need a Psychoanalyst? Psychodynamic Approaches to Infant Mental Health

Kai von Klitzing

When we treat young children with “disturbing” symptoms, it makes a difference whether we primarily aim at getting rid of the symptoms or whether we understand the symptoms as an expression of unsolved conflicts in the child–caregiver relationship and/or unsatisfied needs of the child. This chapter delineates concepts of psychoanalytic developmental theory, especially psychoanalytic reflections on the maturing object relationship during infancy and on the developmental significance of triangulation. Starting from findings of clinical studies and a clinical case example, I elaborate on my psychoanalytic understanding of early development and draw conclusions for psychotherapeutic strategies.

Introduction: Some Results of Clinical Studies

There are several clinical studies which have shown that psychodynamic parent–infant psychotherapies are astonishingly effective. For example, Salomonsson and Sandell (2011) compared, in a randomized controlled trial, two groups of mother–infant dyads in a Stockholm sample. One received exclusively Child Health Centre care, while the other additionally received mother–infant psychoanalytic treatment (29 treatment sessions on average) as described in Salomonsson (2014). Eighty mother–infant dyads (infants under 1.5 years of age) where the mothers had serious concerns about themselves in their role as mothers, their infants’ well-being, or the mother–baby relationship were randomly selected for either of the two groups. The primary outcomes were self-reported depression of the mother, mother-reported infant functional problems, and interviewer-based relationship assessments, all carried out at 6 months after joining the project. Intention-to-treat analyses significantly favored the treatment group for maternal depression, mother–infant relationships, and maternal sensitivity, but not for the infants’ symptoms. When the children were 4.5 years old, the children in the psychoanalytic psychotherapy group had better results on global functioning and the researchers also found lasting effects on maternal depression in favor of mother–infant psychoanalyses. The authors concluded that the treatment seemed to have helped the mothers to recover more quickly on personal well-being, to become more sensitive to their babies’ suffering, and to better support and appreciate their children throughout infancy and toddlerhood (Winberg Salomonsson et al., 2015).

In addition, psychoanalytic informed child–parent psychotherapy (CPP), a treatment focusing on early traumatic experiences of the infant

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and the mother–child relationship as the vehicle for child improvement, proved to be efficacious for preschool children (age 3–5 years) who had experienced multiple traumatic and stressful life events (Ghosh Ippen et al., 2011, alse see Chap. 19, this volume). CPP usually comprises around 30 sixty-minute sessions in diverse settings, mainly with the child and mother present. In a study of 75 high-risk children, the intervention group showed significantly greater improvements in symptoms of posttraumatic stress disorder and depression compared to those in the comparison group that received regular consulting and case management by experienced clinicians.

Even very brief psychodynamic interventions have shown astonishing effects. For example, Georg et al. (2021) applied a brief (four sessions) psychodynamic-based focused parent–infant psychotherapy (fPIP, Cierpka et al., 2017) to treat early regulatory disorders (excessive crying, sleep dysregulation, and feeding problems). fPIP targets the mother's internal representations of her infant, which may be affected by her own attachment experiences, and explores links between these internal images and her current relationship with her child.

The aim of addressing this kind of "focus" in each mother–infant pair is to strengthen the parent–infant relationship and to positively influence the infant's development. According to the treatment manual (Cierpka et al., 2017), the therapists primarily use supportive strategies when parents exhibit deficits of their mentalizing capacity and an expressive, interpretative strategy when parents exhibit good mentalizing capacities. In a randomized controlled trial ($n = 154$; infants age 4–15 months), fPIP proved to be superior to treatment as usual (pediatric routine examinations and development-oriented education, and counselling) in reducing infants' overall symptoms, night-waking disorders, and mothers' psychological distress and depression (Cierpka et al., 2017).

The results of these kinds of randomized controlled trials show that psychoanalytic informed psychotherapeutic interventions work. They all have in common that well-trained psychoanalytic psychotherapists work with mothers (sometimes also with fathers) and their infants. They talk to the mothers and to the babies, they address the interaction which they observe during the sessions, and they try to relate the observations to important relational themes in the parental histories. In longer interventions, a broad spectrum of conflictual themes usually comes up and can be addressed and worked through. In shorter interventions, therapists and parents try to identify a core conflictual theme (so called "focus") if possible already in the first few sessions in order to focus the following therapeutic work on a limited set of themes. With their interpretations, the therapists address the parents and they also talk to the infant. By addressing the infant directly, they try to communicate with the child via an emotional message that they are an important and active part of the therapeutic process. The parents can listen to the words that the therapist directs at the baby, and usually they grasp the meaning of these words in an especially intensive way. The empirical studies described above show that this kind of intervention can lead to an improvement of the relationship and of the mother's as well as the infant's health. Mostly as the parents develop a better feeling of their parental role, their own depressive symptoms decline, leading to an improvement of the quality of the parent–infant interaction and a reduction of symptoms.

Case Example

In order to demonstrate how psychodynamic parent–infant therapy works, I will present a clinical vignette of a therapeutic session with a mother and her infant (excerpt from a longer version in Klitzing and Schlensog-Schuster (2021), pp. 99–101)

> *Laura* is a 12-month-old girl who was failing to thrive as result of feeding problems present since she was born. Her mother had only been able to breastfeed her for a single week. The mother said in the initial interview: "She did not like to drink from my breast, I had to force her." Mother and infant received a short-term psychodynamic psychotherapy (12 sessions) during her stay in the psychosomatic in-patient unit of a paediatric hospital. None of the paediatric examinations

yielded any result to explain her vomiting and her failure to thrive. The developmental tests showed a retardation of two months in cognitive and motor development. After several unsuccessful interventions, the paediatricians had even proposed placing a percutaneous endoscopic gastrostomy tube ("PEG tube") into her duodenum to ensure enough food intake to enable her to thrive. However, after three weeks of therapy the girl slowly started to eat. The therapeutic sessions were held with the mother and Laura present, in line with the principles of parent-infant therapy as described in more detail in an earlier paper (Klitzing, 2003). Later on, also the father participated in the therapy. Here is an excerpt from one of the first sessions around two weeks after admission to the unit:

> The (male) analyst and the mother sat on the floor; Laura was crawling around. In the beginning she seemed to be in a good mood, explored the room and the toys, and approached the therapist without any signs of stranger anxiety. She vocalised but did not speak any words.
>
> The mother was focused on the analyst and told him: "I enjoy staying in the hospital. Finally, I am receiving the support I need. And Laura has started eating, it is like a miracle!"
>
> Analyst: "Your daughter is receiving the support you haven't had as a child."
>
> Mother: "My childhood was a complete disaster! There was nothing but fighting in the family. My mother was so absorbed by her problems that she didn't care about me much. I don't remember anything before I was eight. I had been hoping I could do better with my daughter. But it didn't work. I couldn't nurture her and she didn't eat the food that I gave her."
>
> The child repeatedly turned to the therapist and approached him. Her play was quite sensorimotor… While talking with the mother, the analyst built towers with toy blocks and the girl had fun knocking them down. The mother appeared to have difficulty responding adequately to the infant's needs, for example taking her on her lap abruptly to stop her moving around. She apparently had difficulty sharing her attention between the analyst and her daughter. She seemed to lose interest in the child when she moved away from her. There was no play between mother and daughter and no eye contact.
>
> The analyst asked: "What are your thoughts about why your daughter has such difficulties eating and drinking?"
>
> Mother: "I think it's because of me, because of my anxiety. I am scared she'll bite me. I am also scared that she won't survive. My own anxiety has led to a tension in her organs. Because of that, her organs have tightened up and therefore cannot absorb any food."
>
> Analyst: "Oh, you must feel guilty when you attribute all the faults to yourself."
>
> Mother (smiling): "Yes, I really feel bad."
>
> Analyst: "It is difficult for you as the mother to feel so guilty, although you try to do your best *for* her. Look, she enjoys playing and exploring! Do you sometimes play with her?"
>
> Mother: "Oh yes, I like that."
>
> She took the blocks and started to build a tower exactly as the analyst had done before. But the girl did not show much interest and the mother seemed to be disappointed.
>
> At the end of the session, the analyst and the mother talked about her efforts as a mother, her uncertainty about how to be a mother, and her disappointment that she seemed to be so unsuccessful.

The outcome of the therapeutic intervention was positive. After 3 months (12 sessions), Laura had developed age adequate ways of food intake but was still slightly underweight compared to the age norm. Her mother developed a sensitive way of caring for her, and her father committed himself more fully to Laura and the family life. With the support of a family doctor and some relatives, the young family lead an independent life and Laura developed well.

In the following section, I outline two essential aspects of psychoanalytic developmental theory which can help to understand the relational problems which seemed to be the background of the girl's symptoms, as well as the success of the psychotherapeutic intervention: contemporary concepts of early dyadic object relationships and early triadic development.

Psychoanalytic Reflections on Early Dyadic Relationships

There is overwhelming evidence that the quality of early parent–infant interaction, especially in the first year of life, is a most important factor for the child's cognitive and emotional development. Furthermore, scholars agree upon their observations that early interaction is actively shaped by two active partners, the parent or caregiver on the one side and the infant on the other side. The interaction is bidirectional. The infant expresses his/her emotions and needs on a pre-verbal level (by facial expression, body movement, vocalization, etc.). The parent (or other caregiver) reacts with her or his own emotional responses and actions, which again lead to actions on the part of the infant.

Associated with these observable actions, there are movements of mental states which are influenced not only by the interactions but also reciprocally influence the actions. On the side of the baby, the mental states, which exist from the beginning, seem to be quite holistic. Freud (1900) defined early internal images as "thing-presentations" (in contrast to word-presentations). Stern (1994) spoke about "protonarrative envelopes," from which slowly emerges a move toward self-other differentiation, more autonomy, sense of self-efficacy, and social competences.

The child's action evokes movements of the mental states of the parent ("object") which evolve on a more mature level. Usually, the parents develop internal concepts of possible mental states which might be the background of the child's action. These concepts are shaped by the parents' own inborn capacities and past experiences. There is an intensive exchange between the parent's own mental states and the way he or she conceptualizes the mental state of the infant.

For example, when the child cries, the parent reflects: Is she hungry? Does she feel bad? Did I make her angry? Is she despaired? These ideas and concepts shape the parents' reactions toward the child—and these reactions, in turn, influence the child's mental state and his/her slowly developing concept of the mental state of the other.

In contemporary theories, these circular movements on interpersonal and intrapsychic levels are often subsumed under the term "mentalizing" (Fonagy et al., 2002; Fonagy & Target, 2000). Psychoanalysts try to theoretically capture how the observable interactions—on the interpersonal level—are transformed into intrapsychic experience of the individual child, and how changes in the relationship shape changes in the intrapsychic world.

Let us think about the newborn baby in the first weeks of his/her life. In the case example of Laura, this was the time when the girl's mother, who had been full of hope after the birth of her daughter, tried to nurture her. At that time, the child's inner world was functioning on the level of the "primary process": her emotions and her needs were quite basic. Psychoanalysts assume that she had overwhelming feelings of love, whenever she was in a good state, and overwhelming feelings of hate, when she was hungry, felt unsatisfied and overwhelmed by negative body sensations.

How can the baby get rid of the negative feelings? She acts in a way that the caregiver pays attention to her and becomes concerned. One can observe the concern in the face of the mother or the father before he or she starts to calm the baby down. If the process succeeds, the father or mother is temporarily troubled, sad, angry, or full of concern, but succeed to calm the baby. It looks as if the baby can rid him or herself of negative emotions by moving them into the parent.

Psychoanalysts call this process on the interpersonal and intrapsychic level "*projection*." Something unbearable in the subject's own mind is projected into the other, the object, and when the object identifies with the projected elements (that means the parent's inner world becomes forcefully shaped by the babies emotions), we talk about "*projective identification*" (see Kernberg, 1987; Ogden, 1979). This is a deep intrapsychic interpersonal process on the edge of the interpersonal and intrapsychic level. This pattern plays an important role not only in the parent–infant relationship but also in the process of psychotherapy with adult patients. It seems that the parent has psychologically "digested" the negative emotions of the baby (Fig. 20.1).

When the parents have "digested" the problematic unintegrated emotions of the infant, it is important to consider how they manage to move the transformed and now tolerable state back into the child's inner world. On an observable level, we see that this happens via the parental action of calming the baby. On the level of intrapsychic representations, we can say that the baby takes the transformed states back into his/her own inner world. In psychoanalytic terms, we call this

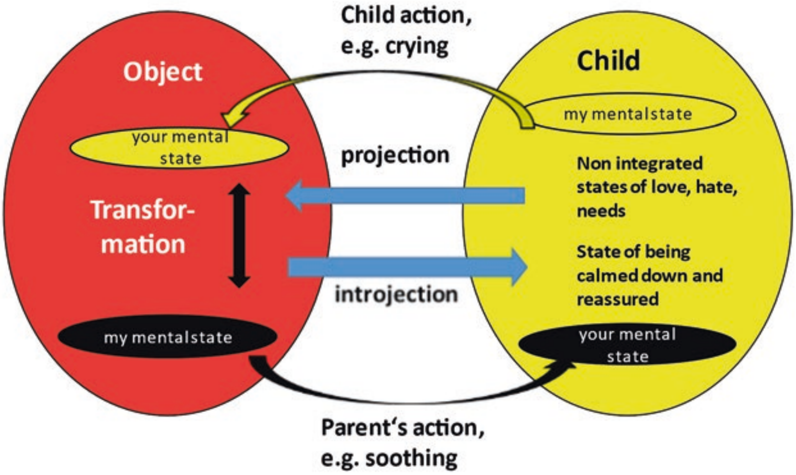

Fig. 20.1 Parent–child relationship; intrapsychic transformations

in-taking movement of the baby "introjection." The British psychoanalyst Winfried Bion (1962) called the unbearable not integrated, "unthinkable," and unmentalized states in the baby "Beta-elements." Beta-elements are somatic and inchoate emotional sense impressions or sensations which cannot be mentalized. In contrast, "Alpha-elements" are "manageable" and thinkable thoughts, emotions, impressions, phantasies, and perceptions in our mental world. The Alpha-function is defined as the process which digests Beta-elements and, in that way, makes them available for thoughts and for mentalizing processes. Bion (1962) hypothesized that a healthy mother (or other caregivers) is able to enter into a state of reverie in which she can take up the Beta-elements of her child and "digest" them psychologically so that they are transformed to Alpha-elements which she then can project back to the baby. This emotional movement between the inner states of the mother and the inner states of the baby leads to an observable calming of the previously alarmed baby.

To return to the case of Laura

> It seems that something went wrong in the first weeks of Laura's life. The mother was troubled by an internal world characterised by aggressive inner concepts of relationships as result of experiencing neglect and abuse in her own childhood. She could not remember many details of her childhood. Against this background, her only wish was for her daughter to be better off than she had been as a child. Because of this wish, she tried to protect her daughter from her own inner intimidating concepts and associated archaic aggressive emotions. Therefore, she split off her affects and did not allow herself any conscious ambivalence towards Laura, and tried to attune herself positively towards her. However unconsciously she projected the bad parts of herself into her child and so became afraid of her (for example, of her biting). Hypothetically, this situation caused her to fear the threatening parts of herself that she experienced in the other.
>
> In Laura, this process was experienced as a bodily threat and she was afraid to incorporate anything orally from the caregiving mother. To protect herself she emitted the introjected bad parts of the mother's nurture, a process expressed on the concrete physical level by regurgitating all food. In early development, we see a correspondence, possibly even sameness, between the psychic processes of introjection and projection on the one side and the corporal intake and ejection of nourishment on the other. There was no easing of the parental burden by the father.
>
> The wording of the mother about the supposed aetiology of her daughter's symptoms seemed to be based on some evidence. She felt her own tension and anxiety, but her feelings of hate stayed unconscious. She realised that her inner states were not only transferred to her daughter but that parts of her internal world even intruded into the girl and influenced her organs. She imagined that Laura's organs tightened under the tension and pressure and therefore became unable to ingest her

mother's food. For the mother this was an easily comprehensible theory. However, she had to isolate these thoughts from the corresponding emotions of despair and guilt. (Adapted from Klitzing & Schlensog-Schuster, 2021, p. 99ff)

Psychoanalytical Concepts of Triadification and Triangulation

In Laura's case, we can see that the process of calming the baby by transforming the baby's unbearable emotions, which had been projected into the mother, into bearable emotional states had been severely disturbed by the mother's own anxieties, which had been originated through her experiences of neglect and trauma in her own childhood. However, in the course of psychodynamic parent–infant psychotherapy, the girl started to eat and after a relatively short time, the relationship improved and the symptoms decreased. How can we explain such a process of change?

In order to understand how psychoanalysts generally think of mechanisms of change in psychotherapy, we have to consider developments in the theory of the psychoanalytic process. In the beginning, starting from the early works of Freud, psychoanalysts understood the effectiveness of psychoanalytic interventions within the framework of psychic energy ("drives") and a one-person psychology. The patient (primarily an adult person) has fixed his/her cathectic energy to a position of defense, which might have been useful in earlier times, but is now dysfunctional and leads to the formation of symptoms which inhibit development. Through the psychoanalyst's interpretations, the drive slowly detaches from this rigid constellation and the freed energy is now available for progressive development.

Over the years, psychoanalysis has moved from this kind of one-person psychology to a two-person approach of modern object relation theory. In this theory, we understand disorders and symptoms as an expression of disturbed relationships. For example, the borderline pathology of an adult person is characterized not only by primitive internal defense mechanisms but also by distorted relationships with important others. The intrapsychic defense mechanisms primarily present themselves in problematic relationship constellations. In the case of Laura's mother, her own intrapsychic misery expresses itself in her relationship with the baby and the baby becomes severely affected. In the psychotherapy of the mother, the relationship with the therapist would be moved into the focus of the interpretative work because we would assume that the mother would "transfer" her own distorted inner world (probably originated in her relational experiences during infancy) into the relationship with the therapist.

In a further step, our psychodynamic concepts have moved to a three (or more)-person psychology. When we look at the relationship between the baby and the mother, we also think about the role of the third person (or several thirds). The third can not only be the father (in real life and/or in the mind of the mother) but also the therapist in the parent–infant therapy. Following Stern (1995, p. 146), we call the interpersonal process of forming a triad "triadification" and the intrapsychic process of experiencing a triad, "triangulation." The third person can be regarded as a disturber of the intimate twoness between mother and baby, but he/she can also help to regulate the dyadic relationship if it has got stuck because of rigid behavioral patterns. There is evidence that infants can develop meaningful relationships to more than one caring person and that fathers as well as other meaningful adults can serve as important supporters and regulators in the mother–infant relationship (see for example Abelin, 1971; Fivaz-Depeursinge et al., 2005; McHale et al., 2008). Our own research group developed the concept of the triadic capacity which is the capacity of an individual (for example, the mother) to integrate a third person (for example, the father) into his/her relationship to the person opposite (for example, the baby). The results of our prospective studies on the transition to parenthood support the hypothesis that the triadic capacity of parents predicts essential qualities of the parent–child relationships and of children's development (Klitzing et al., 1999a, b). Consequently, parent–infant psychotherapy can be understood as an opening process of triadification and triangulation, especially when we attach value to involve the fathers in the therapeutic work (Baradon, 2019).

Psychoanalytic parent–infant psychotherapies represent processes of triadification and support the internal experiences of triangulation in the parents as well as in the infants. This support seems at least partly to explain the positive therapeutic effects of these therapies. The psychotherapist often steps into the function of an important third person who helps to regulate and stabilize the relationship between mother and infant and who grants more flexibility and age adequate autonomy. The fact that a three- (and more-) person theory has found its way into psychoanalytic thinking of the psychotherapeutic process is probably due to the many analysts who do not only think about infancy in the past of their adult patients but also work with real infants and their parents. Even when we work in individual child psychotherapy settings, the children's parents are always present either as real persons in the accompanying parent sessions (Novick & Novick, 2005) or in the minds of the child as well as the therapist during the child sessions.

> In Laura's case, the aim of the psychoanalytic parent infant therapy was "to help the mother to deal with her own feelings of hate and handle her aggressive feelings in her relationship to her daughter in a non-destructive way. It was also important to include the father in the parent-infant therapy. As a real person, he was partially available, but it was also important to include him as a fantasized third object in the representations of the mother and the child." (Klitzing & Schlensog-Schuster, 2021, p. 101) "In the session described, the analyst entered into the role of a meaningful third. First, he let the mother feel that he understood her negative feelings of aggression and guilt. Second, he looked after her daughter and showed how to play with her so that she could try to identify with his attitude. Third, he did not gloat about doing better than she did, bud understood her pain about the repetition of elements of her childhood in the relationship with her daughter. He presented himself as someone who was ready to have a relationship with her daughter without excluding her as the mother, and who tried to help regulate her relationship with her daughter." (p. 100)

The presented case is an example of a psychodynamic mother–infant psychotherapy. The father was included toward the end of the therapy. The therapist had contacted him, and it needed much effort to motivate him to participate. Most reports on early psychotherapeutic interventions present mother–infant psychotherapies, but of course, when we consider our triadic approach, we have to move toward settings in which fathers and other important caregivers are included from the beginning of the therapeutic process (see Baradon, 2019).

The indication of psychodynamic parent–infant psychotherapies comprises a broad spectrum of infant disorders (feeding disorders, crying disorders, anxiety, depression disorders, etc.) as well as problems of the parent–infant relationships and parental depression or anxieties. Before starting therapy, it is essential to evaluate the parent–infant relationship in cooperation with the parents and to agree with them that the symptoms are at least partly associated with their own psychological wellbeing, relational conflicts in the family, and/or their own experiences during their childhood. Without such a joint accordance, psychotherapy should not be started. Such kind of relation-oriented diagnostic evaluation and preparation of a working alliance often needs several joint sessions with all involved persons before the therapy starts. Severe parental psychiatric disorder like substance abuse or psychosis often limits the effectiveness of psychodynamic parent–infant therapies because the capacities of the parents to reflect and to do enter into a process of change may be limited. In such cases, the parental condition should be treated effectively before parent–infant therapy can achieve positive outcomes.

Summary and Key Points

The baby, or more precisely the parent–infant relationship, needs a therapist when unsolved conflicts or sequelae of their own traumatic experiences in the parental intrapsychic world intrude into the interpersonal parent–infant relationship in a way that the early emotional development of the child is jeopardized. This kind of constellation is usually marked by a substantial suffering of both, parents and infants, and may lead to the production of many symptoms: feeding problems, emotional dysregulation, depression, anxieties, etc. Early psychoanalytic parent–infant therapies have shown to be effective in working on the intrapsychic background of the symptoms within the parents and in helping to regulate the parent–infant relationship. Our psychoanalytic theory and experiences help us to develop an understanding of early disorders by conceiving them as an expression of burdened early relationships and to initiate a process of change by using the role of the therapist as a significant third person.

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21

Trauma-Informed Mental Health Interventions for Young Children

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Young children are exposed to trauma in many ways including abuse and neglect that can also be related to substance use and intimate partner violence, exposure to natural and technological disasters (Osofsky & Osofsky 2018; 2020), wars, and parental and caregiver loss (Osofsky, et al, 2020). There is much evidence that traumatic exposure affects brain and biological development (De Bellis & Zisk, 2014) as well as social, emotional, and cognitive development (Shonkoff, 2023). Studies have shown that children who are exposed to adverse life experiences (ACEs) early in their lives are at significant risk for developing serious and long-term problems later in development (Felitti et al., 1998). As is emphasized in Chap. 24 of Volume 1, the impact of trauma on young children is affected by the parenting that they experience. Parents who have experienced trauma themselves earlier in their lives may have more difficulty with some of their children's negative behaviors that they interpret as intentionally hurtful. Therefore, it is important to help parents recognize how their earlier experiences can affect interactions with their children and provide support that may be helpful. Consistent with general parenting data on young children, caregivers' level of functioning and the related care of their children are critical for outcomes for children exposed to trauma. For example, there is an abundance of research suggesting that sensitive and responsive caregiving can attenuate the effects of trauma on young children's functioning (McLauglin & Lambert, 2018). In contrast, compromised parenting (e.g., punitive, detached, and maltreating) can intensify the adverse effects of trauma on outcomes for children.

Trauma-informed and trauma-responsive interventions and evidence-based mental health treatments', like those described in this chapter, have been developed to help young children exposed to trauma. Recovery from trauma when supported in meaningful, consistent relationships will also help a young child become resilient (Masten, 2014, 2019; Osofsky & Lieberman, 2011).

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Review of the Problem: Effects of Trauma on Young Children

Trauma for young children has been defined by the National Child Traumatic Stress Network (NCTSN) as an exceptional experience in which powerful and dangerous events overwhelm a person's capacity to cope (NCTSN (2022), retrieved April 10, 2023). In the USA, more than two-thirds of children reported at least one traumatic event by age 16. Traumatic experiences include individual events such as child maltreatment, including physical, sexual, and emotional abuse, child neglect, and being witness to domestic violence. Approximately 1 in 8 children under 17 years lived in homes with a parent who had a substance abuse disorder (Lipari & Van Horn, 2017). A recent Child Trends report (Dym Bartlett & Steber, 2019) stated that infants and young children are at greatest risk for trauma exposure. Those under 3 years of age are more likely to experience abuse and neglect with those under 5 years at increased risk for witnessing domestic violence. When young children are exposed to traumatic events, the normal trajectory of development may be impacted, increasing risk for developmental regression and/or not meeting typical developmental milestones (Shonkoff and Phillips, 2000; Shonkoff, et al., 2009) Further, abuse and neglect during early development can permanently alter brain functioning which can also affect later development (https://developingchild.harvard.edu/media-coverage/how-trauma-and-stress-affect-a-childs-brain-development/, retrieved May 22, 2023). Early intervention and care can make a substantial difference in outcomes for a young child exposed to trauma, especially if support is available from a consistent caregiver. Further, they are more likely to recover and be resilient if child-serving programs and systems are trauma-informed.

Young children may also experience additional traumatic events in their communities including exposure to natural and technological disasters that occur throughout the world. For example, in the USA in 2005, many young children and families lost their homes and were forced to evacuate from their communities following Hurricane Katrina. Just a few years later, young children and families were again influenced by personal and economic impacts following the Deepwater Horizon Oil Spill. Tornadoes, earthquakes, tsunamis, and even nuclear disasters that have occurred around the world impact young children and families (Masten & Osofsky, 2010; Osofsky & Osofsky, 2013). In 2010 in Japan, many families suffered losses because of the earthquake and tsunami followed by the significant damage to the Fukushima Daiichi Nuclear Power Plant that raised many concerns and fears about radiation exposure for children and families (Mizuki et al., 2021; Watanabe et al., 2019) resulting in separation of families. Disasters expose thousands of young children and families to potentially adverse outcomes. Studies have shown that these negative experiences can exacerbate other trauma challenges experienced within the family (Osofsky et al., 2015). Exposure to war is another example of large-scale events affecting young children and families (United Nations, 1996). Other examples of traumatic events for young children that can be overwhelming and disrupt development include historical trauma, racism, hate crimes, and exposure to community violence. It is important to recognize that if the child has a consistent caregiver who can be emotionally available and supportive, they are likely to recover and do well.

Young children are more likely to recover and be resilient if child-serving systems understand the impact of trauma on young children and how to provide both support and trauma-informed care (Bartlett & Sacks, 2019). Trauma-informed care includes increasing adults' knowledge of childhood trauma, helping them recognize the symptoms, and giving them the resources to support and refer children who have experienced trauma to appropriate services (Osofsky & Osofsky, 2013; Osofsky et al., 2017). It is also important for trauma-informed systems to promote self-care for caregivers including childcare providers, mental health professionals, and others providing support to prevent and address secondary trauma among adults working with children who have experienced trauma.

Ways to Support Resilience for Young Children Impacted by Trauma

Resilience has been defined as the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands. Ann Masten (2014) has defined resilience as "Ordinary Magic." For young children, emotional availability in addition to just "being there" is crucial. Listening to children is very important as children exposed to trauma may find it difficult to share what they have experienced. Knowing about the traumas that they have experienced is essential in order to provide the best support. It is also important to recognize the increased emphasis on the supportive nature of the social infrastructure at the community level in addition to a supportive relationship (Masten & Obradovic, 2008; Osofsky et al., 2010, 2015). Young children who have been exposed to subsequent traumas may show periods of temporary increases in symptoms with further exposure (Osofsky et al., 2015). Overall patterns of recovery depend upon both developmental factors and interactions with supportive caregivers and others in the environment (Osofsky & Osofsky, 2018). Fostering resilience at the individual and community levels is crucial to this work (Bonanno et al., 2011). Interventions and support for young children following disasters have provided helpful information about ways to promote resilience in young children. Traumatic experiences leading to increased risk that seem to affect young children the most are displacement, separation from caregivers, lack of social support, and previous traumatic experiences. The risk for adverse outcomes following childhood traumatic events can be moderated by the presence of protective factors—especially supportive family members and environmental consistency. Trauma-informed care requires comprehensive, multi-pronged support from adults in all aspects of children's lives. The strongest protective factor is consistent, caring, supportive, for the child which adds to their sense of safety, predictability, and control (Bartlett et al., 2017). Early childhood and community settings can play a key role in providing a caring environment to support resilience for young children through listening and being emotionally present for them.

Different Approaches to Support and Help Infants, Young Children, and Families Exposed to Trauma

There are different types of trauma-focused supportive strategies for parents and caregivers that will be described before elaborating on the evidence-based dyadic therapeutic treatments that have been developed to help heal young traumatized children and their parents or caregivers.

CARE and PriCARE

Parent education and parental guidance strategies are also utilized following trauma exposure for young children. One group approach for older children, Child Adult Relationship Enhancement CARE (Gurwitch et al., 2016), has been implemented in the USA and in Japan. CARE has been modified for preschool children, PriCARE, and implemented in pediatric clinics. PriCARE is a modification for use with preschool children and is being implemented in pediatric settings.

Another group intervention approach has been developed by professionals in Finland and implemented in several European countries (Trauma Centre Finland, 2019). The approach, "Daring to Care," focuses on the parents who have experienced trauma. The developers suggested that the group approach may help to prepare the parent to tolerate their own emotions and their children's needs. The intent is to lower the obstacle for other needed, more intensive interventions such as child–parent dyadic therapy, involving joint work with the parent or caregiver and the young child.

Descriptions of these approaches will be followed by a review of several widely used and evidence-based dyadic treatments for young children—Attachment and Biobehavioral Catch-Up, Child–Parent Psychotherapy, and Parent–Child Interaction Therapy. Before describing these dyadic therapeutic approaches to help infants and young children exposed to trauma, it is important to recognize that parent and/or caregiver support is essential. If the parent or caregiver has also experienced trauma either earlier in her/his life or more recently as the child has, they may need support in order to be emotionally available to the infant or young child to help them heal. A consistent, dependable relationship is crucial, and adults who have been exposed to trauma may have difficulty providing the support that the young child needs. The following approaches being described address child and parent issues as part of the treatment.

Child Adult Relationship Enhancement (CARE)

Child Adult Relationship Enhancement (CARE) is a trauma-informed program specifically designed to strengthen positive and responsive relationships between any adult who interacts with youth ages 2–18 years of age. CARE skills are designed to complement mental health programs (Gurwitch et al., 2016). Relating CARE skills to an understanding of the impact of trauma on youth and cultural considerations, CARE training uses adult learning principles and practice with live feedback to improve uptake of the program as this component has been found essential for best skill retention (Kaminski et al., 2008). The evidence base for CARE continues to build, showing improved relationships, improved child behaviors, increased caregiver confidence, and a decrease in parental endorsement of corporal punishment (Schilling et al., 2016; Messer et al., 2018). CARE has been used successfully in childcare settings, including a state-wide dissemination in early childhood programs in the USA. In addition, CARE for Families who Serve has been used successfully with military families in the USA as infants and young children (0–5 years) account for approximately 38% of all dependents in US military families.

PriCare

Other CARE adaptations serving primarily infants and young children include PriCare in primary care settings (Schilling et al., 2016) and Integrated CARE in medical settings (Scott et al., 2020). CARE is being disseminated across Japan in a variety of settings as prevention for risk as well as trauma exposure. With the overall goal of CARE being positive relationships, the outcome is expected to be a reduction of children exposed to trauma needing more intensive interventions. This objective is particularly important for infants and young children who are at risk for mental health problems due to problematic attachment issues and exposure to maltreatment. More focus in this chapter is on the PriCARE adaptation that is primarily used for infants and young children and is integrated in primary care and other medical settings (Schilling et al., 2016). The overall goal of CARE and PriCare is to support positive relationships which is particularly important for infants and young children exposed to maltreatment and at high risk for problems related to attachment relationships.

Daring to Care: An Intervention for Parent Survivors of Childhood Abuse and Neglect

For parents who have experienced childhood abuse and neglect, it can be more difficult, especially without helpful interventions, to provide sensitive parenting to their own children. In addition to the parent potentially experiencing posttraumatic stress disorder (PTSD) symptoms, such developmental and interpersonal trauma can disturb the parent's self-organization, manifesting as affective dysregulation, negative self-concept, and disturbed relationships (Cloitre et al., 2013; Courtois & Ford, 2009; Ruismaki, et al, 2019). Survivors of childhood abuse and/or neglect also tend to display dissociative symptoms, such as derealization, depersonalization, and amnesia (Vonderlin et al., 2018). Comorbidity with other psychiatric and somatic disorders is common (Karatzias et al., 2019; Murphy et al., 2021). Survivors have a narrow "window of tolerance" (Corrigan et al., 2011; Siegel, 1999; Ogden et al., 2006) contributing to a low threshold for triggering hyper- and/or hypo-arousal. Individuals will often avoid triggering inner and environmental stimuli as an attempt to maintain a tolerable state. These characteristics can compromise coping with everyday stressors (Cook et al., 2005; Ford et al., 2005).

These trauma-related difficulties can compromise the primary dyadic regulation functions that are important for "good enough" parenting (Beeghly & Tronick, 2011; Feldman, 2007) as well as parental mentalization capacity (Fonagy et al., 2007; Slade, 2005). The demands of caregiving and interacting with their children can trigger intolerable affect and dissociation in survivor parents (Benjamin et al., 1998; Moldawsky Silber, 2012; Schechter & Rusconi Serpa, 2014), preventing mentalization and benevolent, realistic interpretations of children's behaviors (Luyten & Fonagy, 2019; Mitchell & Steele, 2021; Schechter et al., 2008). From the child's perspective, triggered or withdrawn parents are not helpful and, in the worst case, can show disorganizing responses to their children's needs (Hesse & Main, 2000). According to this author, the group treatment model called "Daring to Care" was developed in response to the International Society for Traumatic Stress Study recommendation about developing group models for trauma recovery. The Daring to Care group model was developed in Trauma Centre Finland during the years 2012–2016 (Trauma Centre Finland, 2019).

The first stabilizing phase of treatment of complex trauma focuses on psychoeducation about trauma symptoms and stabilization skills that help individuals to stay present and regulate arousal and affect (Ford et al., 2005; Reddemann & Piedfort-Marin, 2017; Steele et al., 2017). Aims of the stabilization phase include developing a sense of safety and working alliance, reducing phobic avoidance of difficult mental states and close relationships, and increasing control over symptoms (Cloitre et al., 2012; Boon et al., 2011; Steele et al., 2017). Peer support serves to reduce trauma survivors' isolation and hopelessness and to provide a sense of being understood (Evans et al., 2013; Jennings, 2004; Muzik et al., 2013).

The intervention is manualized, and there are two versions: a 24-session full version and a 13-session short version which is more applicable to communal settings. During 2012–2016, six 24-session pilot groups were carried out. There was an attempt to recruit fathers as well as mothers, but not enough were identified to participate. Research on the pilot groups' impact on mothers' psychosocial functioning, mental health symptoms, parenting experiences, and parent–child interaction is ongoing (Friberg et al., in preparation). In addition, the authors have developed a Daring to Care group leader training and a certification program for healthcare professionals. Group leader training and supervision has been ongoing since the project.

Survivor parents often know what they don't want to transmit to their children from their childhood experiences (Morelen et al., 2018). However, they lack the secure attachment experiences from which to derive how to differently parent their children. Normative parenting difficulties and imperfections may elicit fear that they are repeating the maltreatment they experienced with their own children. This can lead to perfectionism and harshness toward themselves as a parent, age-inappropriate expectations toward children, or to repetition of unhelpful childrearing practices (Trauma Centre Finland, 2019). One parent verbalized this in the following way: "I don't want to be scary like my parents when I'm angry… but if I don't yell at them, what am I supposed to do? Without discipline they will grow up to become menaces."

The Daring to Care model addresses this problem by providing education about trauma-related difficulties in parenting and skills training. It is integrative in combining elements of cognitive and trauma-focused psychotherapy to attachment and mentalization-based understanding. It has been greatly influenced by the skills-training manual for dissociative patients (Boon et al., 2011). The focus is not on processing past traumatic experiences but instead on how the experiences impact current parenting. However, the intervention exposes parents to thinking about previously avoided or dissociated trauma-related difficulties in an indirect and tolerable way through receiving information, making observations about oneself, group discussions, and home assignments.

Six to eight parents can participate in a closed group which is led by two trained professionals. There are no age limits for the children, but interventions may vary depending on the age of the children. Inclusion criteria are that parents (1) live with or co-parent their children (e.g., children are not in custody); (2) are able and willing to think about how their trauma history impacts their parenting; (3) do not have active substance abuse problems; and (4) are not currently undergoing a crisis. Parallel to the group, parents are required to have a regular treatment contact that they can utilize to discuss the experiences that are activated by the group.

Prior to admission, parents undergo a thorough interview and fill out questionnaires about symptoms and parenting to assess whether the intervention is suitable and realistic for them. Leaders provide information about the group to support predictability, working alliance, and safety. Rules emphasize parents' responsibility for their own reactions and safety for all participants (e.g., no touching; no scary behavior; no disclosing details about trauma). Parents are informed that thinking about trauma-related themes can increase symptoms early in the intervention, but that this is part of the experience.

Each 90-minute group session is highly structured and always similar so that attending will be tolerable and predictable for the parents. Coffee, tea, and snacks are served to model self-care. The sessions always start with an anchoring exercise, which aims at increasing parents' presence in the here and now utilizing the five senses—paying attention to a sensory, auditory, olfactory, visual, or taste stimulus. For example, parents can narrowly focus on a rock they hold in their hand, a tree they see from the window, a spicy candy in their mouth, or the sound of the clock ticking in the room. Although not easy, exercises serve to "reprogram" parents' hyper- or hypoactive fear responses (Ogden et al., 2006), and there is no expectation of this step being successful. Parents engage in a variety of stabilizing exercises (e.g., guided imagery, focusing attention, grounding, and taking a time out) throughout the group in order to find the most helpful self-regulation means through experience-based learning.

In the first half of each group session, parents discuss their home assignments. Following a break, the leaders introduce a new topic, encourage parents to talk about it, and possibly lead an exercise. The themes include understanding the challenges of parenting; trauma symptoms; arousal and the window of tolerance; triggers; identifying and understanding emotions; mentalizing; beliefs; boundaries; building a sense of safety; self-care; and preparation for difficult times. The group leaders monitor the arousal of the parents, and if needed, intervene to increase the parents' regulation and presence in the group.

According to participant feedback, the mothers experienced all aspects of the intervention (psychoeducation, discussion, exercises, and home assignments) as beneficial (Trauma Centre Finland, 2019, p. 238). Listening to other parents who were struggling with similar challenges was experienced as utmost important, increasing the mothers' compassion toward their own difficulties. Psychoeducation decreased shame and fear toward one's trauma-related symptoms. Parents commented, for example: "Maybe I'm not going crazy after all" and "These symptoms are not a choice that I've made."

Arousal, boundaries, and beliefs were rated as the most useful topics. The mothers noted that, although mentalization was an important theme and helped them in understanding their unmet needs in childhood, it was also very challenging to mentalize parenting of their own children. As expected, mothers reported increase in their symptoms early in the intervention. Participation was experienced very demanding at times—there were difficult emotions to face that the mothers had previously been avoiding. However, the mothers reported that this exposure benefitted their parenting. One mother commented as follows: "I act in a more thoughtful way in challenging situations. I have more self-confidence as a parent. Checking my arousal levels and anchoring myself are now my go-to's" (Trauma Centre Finland, 2019, p. 239).

In conclusion, the Daring to Care group model seems promising as a first-phase treatment for parents experiencing complex trauma. Research is still needed on its efficacy in general and about its applicability to fathers in particular. Parents suffering from the consequences of complex trauma need to be met where they are and helped in building resources for staying present and regulating themselves. Parenting interventions that require sensitive attunement and mentalization may be too far off from these parents' zone of proximal development without this first step.

First-phase trauma interventions such as the Daring to Care group can help parents in widening their window of tolerance. As a consequence, parents can start observing their arousal and feelings; identify trauma triggers, and prepare for challenging situations. In this way, they may be more ready to consider the effects these have on their children. The approach may help parents become better able to take care of themselves and to form more balanced and realistic expectations about parenting and about their children, thus decreasing their overall burden. A successful consequence of this first-phase intervention may be that it helps parents be more motivated to engage themselves and their children in the more intensive dyadic therapeutic interventions described below.

Trauma-Informed Intensive Dyadic and Triadic Mental Health Treatments for Young Children

The last few decades have seen much advancement in recognizing that infants and young children are exposed to trauma and intensive mental health treatments for those exposed to trauma can be helpful (Osofsky and Lieberman, 2011; Osofsky et al., 2017). Three of these programs which have strong evidence for reducing trauma symptoms in young children include: Attachment and Biobehavioral Catch-up (ABC), Child Parent Psychotherapy (CPP), and Parent–Child Interaction Therapy (PCIT).

Attachment and Biobehavioral Catch-Up (ABC)

Attachment and Biobehavioral Catch-up (ABC) is a 10-session home visiting program designed for infants and parents who have experienced trauma or other challenges (Dozier & Bernard, 2019). The program was initially developed for parents of infants between the ages of 2 and 24 months. Several adaptations have now been developed and tested, including a newborn model (currently being tested), an early childhood model for parents of 2- to 4-year-olds, and a model for parents who are adopting internationally. ABC has a strong evidence base, with support for its favorable outcomes extending across many behavioral and biological domains and at least into middle childhood.

ABC is a manualized intervention that targets three key parenting behaviors: nurturing the distressed infant, following the infant's lead when the infant is not distressed, and avoiding harsh and frightening behavior at all times. The rationale and intervention approach for these behaviors follows.

Nurturance In our earliest work in this area, we found that when infants who had experienced early trauma did not have nurturing parents, they were likely to develop disorganized attachments. The long-term sequelae of disorganized attachment are more problematic than the long-term sequelae of avoidant attachment (e.g., Lyons-Ruth & Jacobvitz, 2016). Therefore, our finding led us to reason that young children who had experienced early trauma (such as maltreatment and/or separations from parents) needed nurturing care in order to organize their attachments around a new caregiver.

Nurturance is readily elicited when infants show their needs clearly and when the parent has had experiences of being nurtured consistently by him or herself. However, two things can interfere with parents responding in nurturing ways. First, when infants or young children have had traumatic early experiences, they often fail to show their needs clearly, turning away from their parent or behaving in resistant ways (Stovall & Dozier, 2000; Stovall-McClough & Dozier, 2004). These behaviors are powerful in pushing the parent away, even when parents would be expected to be nurturing to children under other conditions (Stovall-McClough & Dozier, 2004).

Second, nurturance does not come naturally to all parents. For parents who have experienced trauma themselves and for those who did not have experiences with nurturing caregivers, nurturing their distressed child is challenging and often at odds with their natural propensity (Main & Hesse, 1990).

Therefore, the first target of ABC is to help parents behave in nurturing ways when their infant or young child is distressed, even if the child fails to elicit nurturance and even if nurturance does not come naturally to the parent. The manualized content focuses on helping parents see why nurturance is so important. Most important, the clinician acting as parent coaches making "in-the-moment" comments when parents nurture their child during the session has been identified as the active ingredient of ABC. In-the-moment comments describe the behavior link to the intervention target and link to a child outcome. In early sessions, ABC parent coaches only make positive comments because we want parents to feel empowered and strengthened rather than criticized. Even when parent coaches are later allowed to comment on parents' not behaving in nurturing ways, the proportion of positive comments remains high.

Following the Lead As we studied the effects of disruptions in care and maltreatment on children's neuroendocrine functioning, we found that children who had experienced trauma often showed disrupted patterns of diurnal cortisol production (Bernard et al., 2010). Cortisol is an end product of the hypothalamic–pituitary–adrenal cortex (HPA) axis and is involved in regulating the sleep–wake cycle. Children who had experienced the most traumatic conditions showed the greatest perturbations to their diurnal patterns of cortisol production. These perturbations to the system led us to recognize the importance of helping children develop adequate biological regulation as well as behavioral regulation.

The second intervention target of ABC is therefore to help parents learn to follow their child's lead. The manual content provides parents practice with following their child's lead, with videos providing examples of other parents following or not following their child's lead.

Avoiding Frightening Behavior The third target for ABC was identified as important through our observations in homes. We observed that some parents behaved in harsh and even frightening ways with their children. Sometimes parents seemed to behave in frightening ways as a way to control their children's behavior and sometimes as their customary mode of playing with their child. Frightening behavior serves to undermine young children's ability to regulate physiology and behavior and makes the parent unsafe as an attachment figure, and parents are often unaware that they are behaving in frightening ways (Lyons-Ruth & Jacobvitz, 2016; Main & Hesse, 1990).

Helping parents avoid behaving in frightening ways was therefore incorporated as ABC's third intervention target. Given the sensitive nature of dealing with frightening behavior and ABC's emphasis on being a strength-based approach, frightening behavior is dealt with quite differently than the other two targets. For the most part, frightening behaviors are addressed through session content rather than through in-the-moment commenting. Parents are helped to recall times from their own childhood when a parent or other adult behaved in an intrusive fashion and, in a subsequent session, a time when a parent was frightening. They are then helped to think of times when they have behaved in intrusive (or frightening) ways with their children and discussion of conditions that elicit such behavior are discussed. These issues are considered sensitive and are approached very carefully, with parents' strengths emphasized.

In addition to the intervention components discussed above, "voices from the past" are addressed in sessions 7 and 8. The focus of these sessions is on helping parents recognize influences from their past that are affecting their current parenting behaviors. The intent is for parents to gain the capacity to recognize their voices from the past so that they can then override these voices when the voices interfere with providing nurturing, sensitive care.

Evidence Base for ABC

The efficacy of ABC has been tested in multiple randomized clinical trials. The effectiveness has also been assessed through pre- to post-intervention assessments in the community. In efficacy and effectiveness studies, ABC has been shown to enhance parental sensitivity and to decrease parental intrusiveness among parents involved with child welfare, foster parents, and parents adopting internationally (Bick & Dozier, 2013; Raby et al., 2019). A systematic review reported a small to medium effect size for sensitivity and intrusiveness (O'Byrne et al., 2023), with larger effects shown in our lab and in dissemination sites (Roben et al., 2017).

Attachment Quality In the randomized clinical trial that has allowed us to follow families the longest, families were enrolled who had involvement in the child welfare system because of known risk factors. These families from a large Eastern city in the USA were mostly Black or Latino/a. They were randomized to the ABC intervention or a parenting intervention of similar structure and duration targeting cognitive and motor development. Fewer children in the ABC group developed disorganized attachments than children in the treatment control group (Bernard et al., 2012). Children in the ABC intervention showed significantly lower rates of disorganized attachment (32%) and higher rates of secure attachment (52%) than children in the control intervention condition (57% and 33%, respectively).

Cortisol Regulation Children whose parents received the ABC intervention showed higher wake-up values and steeper slopes than children in the control intervention group, which represents a normative pattern (Bernard et al., 2015a). These results were seen soon after the intervention with differences sustained 3 years later (Bernard et al., 2015b). At age 9, ABC children continued to show more normative patterns of cortisol production than children in the control group, an effect fully mediated by parental sensitivity (Garnett et al., 2020).

Other Early Childhood Outcomes Children whose parents received the ABC intervention also showed better receptive vocabularies than children whose parents received the control intervention (Raby et al., 2019).

Middle Childhood Outcomes In middle childhood, children whose parents received the ABC intervention indicated that they felt greater trust in their parents than children in the control intervention condition on the Kerns Security Scale (Zajac et al., 2020). They also showed more normative autonomic nervous system regulation (Tabachnick et al., 2019) and more optimal neural activity and brain functioning (Bick et al., 2019; Valadez et al., 2020).

Change in Parents We have also studied changes in parents carefully because they are surely the mechanism for changes in children. In addition to changes in parents' sensitivity, differences in brain activity, assessed with event-related potentials (ERPs), were seen between parents in the ABC intervention and those in the control intervention several years post-intervention, with ABC parents showing neural responsiveness to infant emotional faces not seen among control parents (Bernard et al., 2015c). Parents in the ABC group also showed greater sensitivity to attachment issues (Zajac et al., 2020).

Intervention Fidelity and Dissemination

In addition to evidence for the efficacy of ABC, there is strong evidence of effectiveness when ABC is disseminated into the community. Pre- to post-intervention differences in parental sensitivity have effect sizes in community settings that are as large as those seen in RCTs (Roben et al., 2017). We attribute community effectiveness to use of a strong fidelity assessment tool that involves tracking parent coach (home visitor) behavior at a micro-analytic level.

International Reach of ABC

ABC was developed in the USA and first implemented in English with English-speaking parents, parent coaches, and supervisors. As time went on, we implemented the program with Latino families in the USA. ABC has been implemented in about 25 states in the USA, in several European countries (Germany, Norway, Sweden, and Russia), Asian countries (South Korea, China, and Taiwan), one African country (South Africa), and in Australia.

Up to this point, training and supervision has been provided in English and Spanish only. It will be important as we move forward that we make cultural adaptations for different cultures and/or countries and that we fully translate intervention materials and provide supervision in native languages (Mohamed et al., 2023).

In summary, Attachment and Biobehavioral Catch-up is a 10-session home visiting program that was designed for parents and infants who had experienced trauma and other adversity. The evidence base supports the intervention's effectiveness in enhancing parental sensitivity as well as neural and representational correlates of sensitivity. Children whose parents have received the ABC intervention are more likely to develop secure attachments to parents and to show enhanced behavioral and biological outcomes for at least 10 years following the intervention relative to children who received a control intervention. The ABC intervention is being disseminated internationally with plans for cultural adaptations.

Child–Parent Psychotherapy

Child–Parent Psychotherapy (CPP) (Lieberman et al., 2015) (see Volume 2, Chap. 15) is a widely used evidence-based psychotherapeutic approach to help young children under the age of 5 years who have been exposed to trauma. The attachment systems help organize the young child's response to danger and safety. Emotional and behavioral problems often relate to attachment and relationships issues and CPP works with the child and caregiver to support and strengthen the attachment relationship with focus on restoring a sense of trust, safety, and affect regulation. For young children exposed to trauma, CPP works to normalize trauma-related responses and return the child to a normal developmental trajectory.

Parent–Child Interaction Therapy (PCIT)

Parent–Child Interaction Therapy (PCIT) is a strong evidenced-based mental health treatment for young children (2–7 years of age) and their caregiver, defined as any adult in a primary caregiving role (i.e., biological, kinship, adoptive, and foster parents) (Gurwitch et al., 2017). PCIT has received the highest rankings on scientific databases (e.g., California Clearing House for Evidence Based Practices, National Registry of Evidence-based Programs and Practices; Kauffman Foundation Best Practices Report) and has been endorsed by the US Families First Prevention Services Act.

PCIT, developed in the mid-1970s by Sheila Eyberg, PhD, is heavily based on attachment theory, with strong elements of behavior management, play therapy, social learning theory, and an understanding of the coercive cycle of behavior (Gurwitch et al., 2017). With these underpinnings and grounded in developmental theory, the short-term treatment consists of two phases, Child Directed Interaction (CDI) and Parent Directed Interaction (PDI); each assessment-driven, criteria-based phase lasts approximately 6–10 sessions. PCIT, like other dyadic treatments, see the child and caregiver together for the majority of the treatment. In PCIT, the child and caregiver are seen together for all but two sessions throughout the treatment that are for the caregiver(s) only to teach them the skills that will be stressed in each phase. An important aspect of PCIT consists of in vivo coaching such that the caregiver is given live feedback and support on treatment implementation each week; the therapist is behind a mirror/in an adjacent room with feedback for this coaching allowing for the interaction to be between the young child and caregiver. Then, the dyad is encouraged to work on their skills in the home environment during 5 minutes of proscribed daily practice (i.e., Special Time). Kaminski et al. (2008) found that providing this live feedback is associated with best outcomes of treatment. For each session, the caregiver–child interaction is coded using an empirically validated system, the Dyadic Parent–Child Interaction Coding System (Eyberg et al., 2013) to guide session goals and coaching as well as to assess treatment progress. As the therapist and the caregiver work in partnership, all coding and observations are shared with the caregiver and then progress and next steps are discussed at the conclusion of each session, setting goals for the coming week (Eyberg & Funderburk, 2011).

The primary goal of CDI is to strengthen the caregiver–child relationship, creating a strong sense of a secure attachment, which is often disrupted by extreme stress and/or traumatic events in the life of the child (and caregiver) (Lieberman et al., 2015). Skills coached in CDI are referred to as PRIDE skills: Labeled *P*raise of appropriate behaviors, *R*eflections of the child's appropriate speech and demonstration of active listening, *I*mitation of appropriate behaviors as one way to increase the child's self-confidence, and Behavior *D*escriptions designed to focus on the child's play and improve attention, all with a goal for *E*njoying the dyadic relationship. With CDI, research studies have found improvements in the child's positive behaviors, social skills, self-esteem, attention, speech/language skills, frustration tolerance, and anger management (Gurwitch et al., 2017). The CDI phase includes a focus on consistency, predictability, and follow-through, which are strongly emphasized in the PDI phase. PDI works to change a coercive cycle of negative behaviors (Patterson & Snyder, 1982) and teaches the caregiver a positive discipline program coached with continued relationship-building skills. Use of PCIT skills begin in a clinic or telehealth setting (Gurwitch et al., 2020) and are implemented during Special Time, gradually moving to use in all settings (e.g., home and any public setting). At the conclusion of PCIT, caregivers have the skills and the confidence to engage in an Authoritative parenting style, with high warmth and high demand considered best for overall child well-being and development (Masud et al., 2019).

In addition to improved parent–child relationships, studies of PCIT have also found a reduction in parenting stress and negative parent behaviors Ho (2004) found a reduction in maternal depression. Significant reductions in both externalizing and internalizing behaviors (i.e., anxiety) are seen. Other findings include improvements in attention and hyperactivity, speech/language skills, and overall compliance. Longitudinal studies over 6 years have shown that gains are long-lasting. Gurwitch et al. (2013) found positive results with military families. PCIT is equally effective in settings outside of the clinic such as in-home (Abrahamsen et al., 2021) and via telehealth, the latter being critical during the height of the COVID-19 pandemic (Gurwitch et al., 2020). PCIT has been implemented in Australia, China, France, Germany, Greece, Hong Kong, Japan, Israel, Netherlands, New Zealand, Taiwan, and South America.

Although PCIT was initially developed for use with young children, a downward extension, Parent–Child Interaction Therapy with Toddlers (PCIT-T) is being used for children 12–24 months. This developmentally appropriate treatment focuses on attachment and emotion regulation in both the child and the caregiver. As with PCIT, PCIT-T utilizes live coaching of skills designed to bring the caregiver closer to the child, assist and reassure the child, validate emotions, and soothe distress; caregivers are also coached to manage their own emotions. PCIT-T includes developmentally appropriate ways to help the very young child learn to follow directions through an interactive approach of tell-show-try again-guide with PRIDE skills also used. While the results of this evidence-based treatment are impressive, the question has been raised about whether PCIT is appropriate for children with a history of trauma (Gurwitch & Warner-Metzger, 2022). There have been numerous studies of PCIT with children who have experienced trauma (Messer et al., 2022). To address concerns raised about PCIT as a treatment for young children exposed to trauma, Trauma Directed Interaction (TDI) was developed (Gurwitch & Warner-Metzger, 2022). This adaptation creates a uniform application of PCIT to children who have experienced trauma. TDI is four sessions placed between CDI and PDI that includes (1) psychoeducation about the impact of trauma on young children, caregivers, and their relationship; (2) understanding the difference between upset and distress; (3) using consistent responses to trauma reactions including SAFE skills (naming emotions, addressing safety, implementing a coping skill, and returning to relationship building skills; and (4) teaching and supporting coping skills to aid both the child and caregiver to manage these activators. COPE skills include relaxation exercise, feeling identification, positive actions, and talking to the caregiver. PCIT with TDI is bi-directional, assessing both the child's and caregiver's trauma reactions and coping. Early research shows promise in improving behaviors, reducing trauma symptoms in child and caregiver, and improving parental sensitivity and understanding of the child's needs (Gurwitch et al., 2022; Warren et al., 2022).

Summary and Key Points

When focus on very young children—the field of infant mental health—began, it was difficult to help others understand that trauma can impact on even the youngest children. When observing very young children witnessing violence in their neighborhoods, much explanation and examples were needed to help others understand that young children witnessing violence in their homes and neighborhood would have a negative impact on behavior and development. The thinking was that they were "too young" to understand and be impacted. In this chapter, we review the effects of interpersonal and environmental traumas on young children. It has now been well accepted that infants and young children impacted by trauma can have effects on their development ranging from negative impacts on brain development to language, cognition, and social and emotional development. We now know and have much evidence indicating that exposure to trauma can affect young children negatively and, as is elaborated in this chapter, different evidence-based approaches and treatments are available to help the young child and their parent or caregiver recover, repair, and heal from traumatic experiences. We also have learned about ways to support young children exposed to trauma not only in their homes but also in their communities including preschools, childcare centers, and other community environments. We also have learned much about ways to support resilience in both young children—by being emotionally available to listen and talk to them—rather than just physically present. To support resilience is very important to listen to children when they are exposed to trauma in order to learn more about what they know and what they understand. By listening to young children and trying to understand their experience from their perspectives, we can be most helpful. In a previous publication, Osofsky et al. (2017) considered ways to decide between these three dyadic treatment approaches to address and provide treatment for young children impacted by trauma. We developed a treatment selection framework that included the following criteria: (1) age of the young child; (2) traumatic exposure; (3) sequelae of traumatic experience; (4) who is the client; and (5) the caregiver's capacity to participate in dyadic therapy. All of these considerations should be taken into account related to helping both the young child and parent or caregiver move forward following a traumatic experience. It is not always possible to have answers to these questions when the therapeutic intervention begin but rather more information becomes evident over time. An issue that the first author has found to be very important in choosing which treatment may be most effective in helping a young child exposed to trauma relates not only to the child's trauma history but also the parent's early experiences with trauma that can also impact on the progress of dyadic and triadic treatment. On the positive side, it is important that there are several therapeutic approaches to help young children exposed to trauma so that there is an opportunity to prevent future difficulties for the child that will likely become more complex over time.

Conflict The authors have no conflicts of interest.

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22

Addressing Trauma-Related Needs of Young Children with Developmental Delays and Disabilities

Juliet M. Vogel

Young children with developmental delays and disabilities are overrepresented among those who experience two major categories of trauma—maltreatment (Casanueva et al., 2008, 2012) and medical trauma (Schieve et al., 2012). Providers of trauma treatments for young children need to be able to address the trauma-related needs of those with delays and disabilities, and providers of early intervention (EI)/preschool intervention services also need to be aware of and responsive to the trauma-related needs of many children with whom they work. This chapter provides information about these needs and how to address them.

The DC:0-5 diagnostic system for early childhood defines trauma as "exposure to a frightening/terrifying event or series of events" which the infant/young child "may experience… directly, witness as it occurs to others, or learn that it occurred to a significant person in the infant's/young child's life" (Zero to Three, 2016, p. 115). Among potentially traumatic events are accidents, injuries and frightening medical procedures, disasters, exposure to violence or warfare, maltreatment (abuse or neglect), or loss of a parent or other loved one. Traumatic experiences can involve a single event or a cascade of events, as in a disaster resulting in losses and displacement, or ongoing or recurring events as in many cases of maltreatment. Exposure to trauma is common in the preschool years, with heightened likelihood for children living in poverty (Osofsky et al., 2017).

This chapter considers both young children with developmental delays and those with diagnosed developmental disabilities. Developmental disabilities refer to lifelong conditions that begin in childhood, generally involve intellectual or physical issues or both, and significantly impact everyday functioning (National Institute of Child Health and Human Development, n.d.). A significant proportion of developmental disabilities are not yet diagnosed in the preschool years (Zablotsky et al., 2019). One factor is fluidity in early developmental scores (Cheng et al., 2014; McManus et al., 2016), leading to caution making some diagnoses in the early years. Thus, intellectual disability (ID) refers to significant delays in both cognitive and adaptive functioning (American Psychiatric Association, 2022), but because of the plasticity of early development and the possibility of catch-up in functioning, DC:0-5 (Zero to Three, 2016) recommends use of the term "global developmental delay" instead during the preschool years. In addition, relationships between some early delays (e.g., language delay) and later learning disabilities are complex (Duff et al., 2015), and some disabilities become apparent only when children face formal school

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demands. Nevertheless, even delays that ultimately do not result in diagnosed disabilities can have significance. For example, the association between early developmental issues and maltreatment is not specific to children with diagnosed disorders.

The next section of this chapter will provide more detail about the association between trauma risk and developmental delays or disabilities for young children. The following section will address trauma interventions for young children with disabilities. Although most preschool trauma interventions are developmentally sensitive in terms of considering the developmental stage of the child and issues important for healthy development, there has been more limited discussion of considerations when the children have significant developmental delays, unevenness, or diagnosed disabilities. Promising interventions for children with delays or disabilities will be discussed, together with issues and adjustments. Finally, there will be a brief discussion of considerations for developmental intervention providers and systems of care.

Co-occurrence of Developmental Delays and Disabilities with Early Childhood Trauma

Child Maltreatment

Population studies of frequency of maltreatment of children with disabilities Population studies have examined the relationship between developmental disabilities and child maltreatment by linking disability and maltreatment databases for populations such as all children born in a location over a multi-year period (Spencer et al., 2005; Maclean et al., 2017) or all children enrolled in public schools in a large community in a specific year (Sullivan & Knutson, 2000). Studies in locations that include England (Spencer et al., 2005), Western Australia (Maclean et al., 2017), and mid-western United States (Sullivan & Knutson, 2000) have shown higher incidence of maltreatment for youth with developmental disabilities compared to others from the same populations.

Higher rates of maltreatment are consistent for three types of disorders commonly diagnosed in preschool and young school-age children: ID (Maclean et al., 2017; Spencer et al., 2005), language delays/disorders (Spencer et al., 2005; Sullivan & Knutson, 2000), and learning disabilities (Sullivan & Knutson, 2000). Associations are attenuated but remain when studies statistically control for key environmental factors known to contribute to the likelihood of both maltreatment and developmental issues, such as living in an impoverished area or having a young, single mother with limited education (Maclean et al., 2017; Spencer et al., 2005).

Early linkage studies had relatively small populations of children with autism or birth defects and, when background risk factors were controlled, did not find elevated risk of maltreatment for these groups (Maclean, et al., 2017; Spencer et al., 2005). Recent studies of carefully diagnosed populations of children meeting current criteria for autism spectrum disorder (ASD—formerly, autism) have found heightened maltreatment reports (Fisher et al., 2019; McDonnell et al., 2019), but only the latter study found higher rates of substantiation compared to community peers.

Regarding birth defects, a pair of linkage studies used the Texas state birth disorders registry and state maltreatment database to analyze the rates of maltreatment reports for children with spina bifida, cleft palate, and Down syndrome. From birth to 2 years, children with spina bifida and cleft palate were more likely than the general population to have substantiated maltreatment reports (Van Horne et al., 2015). These reports tended to be for medical neglect. Reports were particularly elevated in the first month of life. Associations were attenuated when demographic risk factors were controlled. Children with Down syndrome tended to have older mothers and come from families with more resources, both of which were protective. New reports declined with age from 2 to 10 years (Van Horne et al., 2018). Only the cleft palate group had higher overall reports (again reduced when neighborhood risk factors were controlled), although medical neglect remained higher for birth defect groups. These studies reflect current US expectations for parental role. Prior to the 1970s, parents often were given advice to institutionalize children at a young age if the child was seen as at risk for ID (Trent Jr., 2017).

With the exception of the birth defect studies, the population studies described above provide little information specifically about young children. However, two of the studies provide information about the age of the first maltreatment report. In one study, the average age for children both with and without disabilities was in the late preschool years (Maclean et al., 2017), in another, most frequently in the preschool years for children with communication issues and evenly divided between preschool and elementary school years for those with ID (Sullivan & Knutson, 2000). The early age of first report for children with disabilities or delays is consistent with the general age distribution for maltreatment reports. In the United States, by far the greatest number of first-time substantiated reports are for children under the age of 1 year followed by ages 2–5 years, with steady decreases over the preschool years (Children's Bureau, 2023).

Assessed developmental status of young children who are subjects of maltreatment investigations Two extensive longitudinal studies provide direct information about the frequency of developmental delays and disabilities shown by children who have undergone investigations by US child welfare agencies because of maltreatment allegations. The National Survey of Child and Adolescent Wellbeing (NSCAW) I and NSCAW II were longitudinal studies of nationally representative samples of children referred to child welfare agencies. Both involved direct assessment of the children's cognitive, language, and adaptive skills with reassessment approximately 18 and 36 months after initial evaluation. They also obtained information from caregivers about formal diagnoses the children had received.

NSCAW I followed children who were ages 0–14 years at entry to the US child welfare system (Biemer et al., 2010). NSCAW II followed a cohort ranging in age from early infancy to 17.5 years when first reported for maltreatment (Casanueva et al., 2011). Both studies oversampled infants in order to allow better analysis of this group.

Varying strategies have been used to identify young children with high developmental need in the NSCAW samples. The most stringent criteria are based on those most frequently used by US states for children to qualify for EI services: (a) scoring 2 standard deviations below average in at least one major developmental area such as cognition, language, or adaptive behavior, (b) scoring at least 1.5 standard deviation below in two areas, or (c) having a diagnosed condition with high probability of resulting in developmental delay, such as Down syndrome. (Cognition was assessed by the Battelle Developmental Survey up to the age of 4 years and Kaufman Brief Assessment of Intelligence Test over the age of 4 years. Language was assessed by the Preschool Language Scale, and adaptive behavior by Vineland Daily Living Skills scale.)

For NSCAW I, analysis of initial assessments from 1845 youngsters aged 0 to 36 months found that more than 35% were at high developmental risk: 1.5% had an established medical condition associated with developmental problems, although they did not reach criteria for significant developmental delay; 32% had low scores on the developmental screens; and 2% had a medical condition and low scores (Casanueva et al., 2008). At 18-month follow-up, 39.2% showed high developmental needs.

For NSCAW II, at initial assessment, 3766 children were under the age of 6 years. Based on the criteria discussed earlier, at baseline 32.2 percent showed high developmental need: (a) 1.4% had a medical condition associated with developmental problems, although they did not show significant developmental delay; (b) 26.1% had significantly low scores on the developmental screens; and (c) 5.4% had a medical condition and low scores (Casanueva et al., 2012).

Pathways of risk connecting early maltreatment and developmental delays For older children, the assumption is often made that children's developmental disabilities lead to their maltreatment. However, studies often do not provide evidence of causal pathways (Leeb et al., 2012) and authors of some of the population studies are careful to point out that some risk factors may contribute to both higher incidence of maltreatment and developmental issues (Spencer et al., 2005; Maclean et al., 2017).

For young children, the evidence suggests multiple, interacting causal pathways connecting developmental delays and early maltreatment. Background factors such as family poverty, lower education of mother, and mother's impairment were associated with consistency of low functioning over a 36-month period for young children with substantiated maltreatment reports in NCSAW I (Scarborough et al., 2009). These variables are associated with both increased likelihood of biologically based developmental issues (based on factors such as genetics and prenatal care) and environmental risk.

Neglect is the most common maltreatment reported for children under the age of 3 years, including in the NASCW studies (Casanueva et al., 2008, 2011). There is substantial evidence that severe neglect leads to developmental delays and deviations, although improvement in functioning can be achieved if children are removed by age 2 from the depriving environment and given high-quality care (Nelson et al., 2019). The research, based on children in under-stimulating orphanages, also was relevant to many of the children who in the first six decades of the twentieth century were institutionalized in US facilities for the intellectually disabled. Although the original intent of the institutions was benevolent, with changes in structure, support, and belief systems, the positive programming often was lost (Crissey, 1975; Trent Jr., 2017).

For a subset of children with early severe neglect, symptoms mirroring many of those of autism may occur (Levin et al., 2015; Rutter et al., 1999), and while these symptoms may abate to some extent in nurturing environments, they may have long-term sequelae (Kumsta et al., 2015). Although much of the literature on the impact of severe neglect comes from studies of children who have spent time in depriving institutional settings, the impact of severe neglect on both developmental skills and relatedness is not limited to children who have experienced institutional care. Langenfeld et al. (2021) discuss diagnostic issues that developmental pediatricians encounter when a child presents with delays and behaviors suggestive of ASD after severe neglect in the family during the early years, but subsequently presents as well related, without the disordered behaviors apparent earlier, after living in a stable home and receipt of both developmental and trauma-specific treatments.

The multiple and interacting pathways that can contribute to the developmental impact of neglect have been described by deBellis (2005) and are likely to also pertain to some other early forms of maltreatment, such as physical abuse. Studies of impact of both abuse and neglect on development have been reviewed by Osofsky et al. (2017, Chap. 1).

Medical Trauma

Children with developmental disabilities have higher rates of other healthcare needs (Schieve et al., 2012) including injuries (Lee et al., 2008; McDermott et al., 2008), and they have more medical visits (Schieve et al., 2012), emergency room visits, and hospitalizations (Lingdren et al., 2020; McDermott et al., 2008).

Medical visits and procedures can be stressful for any young child and the child's family. For very young children, the visits can be hard to explain. Issues are heightened when the child has increased reactivity (e.g., children with sensory processing issues) and/or greater comprehension difficulties than most children their chronological age. Relevant issues are discussed by Liddle and colleagues (2018), and for ASD, by the Boston Medical Center (n.d.) Autism Friendly Initiative.

Tailoring Early Childhood Trauma Treatments for Youth with Developmental Delays and Disabilities

Overview

Discussions of tailoring trauma treatments for youth with developmental disabilities have focused primarily on school age children and adolescents (D'Amico et al., 2022; Grosso, 2012; Peterson et al., 2019) and have focused on use of Trauma-Focused Cognitive Behavior Therapy (TF-CBT). Although TF-CBT can be used with children as young as 3–5 years, the child needs to have memory of the trauma that they can access verbally and language skills sufficient to create a short trauma narrative (Pollio & Deblinger, 2017) which would preclude using this treatment with a significant proportion of preschool children with cognitive and language disabilities.

Pollio and Deblinger (2017) note that the role of non-offending parents in children's post-trauma adjustment, while generally important, is especially so for young children. The trauma treatments developed specifically for preschool children focus on the parent–child attachment relationship as central to young children's trauma recovery. For older preschool children, these treatments often include emotion-related skill-building components like those described by Pollio and Deblinger for TF-CBT but have greater emphasis on play as a mode of expression, relationship building, and trauma processing.

Although limited, there has been consideration of issues involved in use with children with delays and disabilities of trauma treatments specifically designed for young children. Indeed, Child–Parent Psychotherapy (CPP) is included in recent reviews as one of the few trauma treatments with published evidence regarding usefulness for youth with ID (Keesler, 2020) and ASD (Rumball, 2019) because of the publication of two case studies using CPP with children with disabilities, cases with careful assessment of treatment fidelity and impact as well as documentation of special considerations in work with these children (Harley et al., 2014),

The discussion of treatments will focus primarily on CPP, the treatment for which there is the most explicit discussion of addressing trauma for young children with disabilities (Ghosh Ippen et al., 2014; Harley et al., 2014; Willliams et al., 2014). In addition, in contrast to other trauma treatments for young children, it is appropriate for the full age range from birth up to age 6 years.

CPP is a relational trauma treatment of the child with their parent(s)/caregiver(s). The premise is that the attachment relationship is a key resource for the young child to be able to cope with stressful events and recover from trauma. CPP is derived from Fraiberg's (1980) Infant–Parent Psychotherapy. The developers of CPP (Lieberman & Van Horn, 2008; Lieberman et al., 2015) describe drawing on the psychodynamic framework and grounding in knowledge of development from which Fraiberg approached her work, as well as incorporating trauma theory and components from cognitive behavioral and social learning theory. Like Fraiberg, the developers of CPP consider that when needed, it is important to help address problems of daily living that can be critical to family functioning, such as linking families with needed services. CPP looks at the child and family in their social and cultural context (See Handbook Chap. 19, vol, 2, for more information about CPP).

CPP is a lengthy treatment, taking up to a year. Three structured, time-limited parent–coaching interventions will be discussed more briefly. Parent–Child Interaction Therapy (PCIT) (McNeil & Hembree-Kigin, 2010) and Parent–Child Care (PC-Care) (Timmer et al., 2023) both are structured dyadic treatments designed to address parent–child relationships and behavior dysregulation in young children. Both are for children with some verbal skills. Attachment and Biobehavioral Feedback (ABC) (Dozier & Bernard, 2019) is a brief trauma intervention for infants and toddlers and their caregivers.

Both PCIT and PC-Care have been applied in situations in which children have experienced trauma and are showing disruptive behaviors, and for both, recommendations are available concerning use with children with intellectual and developmental disabilities (IDD). PC-Care is being used for cases involving both trauma and IDD issues (S. Timmer, personal communication 7/21/23). It is likely that PCIT is being used for this combination, but the writer has not been able to locate any reports of such use. (Wallace & Glick Sly, 2018, describe adjusting PCIT for ASD issues of a child who also had a trauma history but do not report explicitly addressing the trauma issues.) Attachment and Biobehavioral Catch-up (ABC) is a trauma treatment for infants and toddlers and their caregiver (Dozier & Bernard, 2019). A recent pilot study has explored application to infants with significant delays (Mohamed, et al., 2022, 2023). (See Handbook Chap. 21 Vol 2 for more information about the PCIT and ABC interventions.)

Child–Parent Psychotherapy in Relation to Developmental Disabilities

Precursor: Fraiberg's work with blind infants As noted in the previous section, CPP traces its origins to Fraiberg's work with blind infants and their parents (Fraiberg, 1971, 1977; Fraiberg et al., 1969). That work led Fraiberg (1980) to develop Infant–Parent Psychotherapy (IPP), from which Lieberman (who had worked with Fraiberg) and colleagues developed CPP. Fraiberg's work with blind infants provides information helpful in informing specific aspects of use of CPP with children who have disabilities and their families.

Fraiberg's work with blind infants and their parents grew out of a request to consult regarding the clinical problems of a series of blind young children whose behavior closely resembled autism in sighted children. This led her to do research about the development of infants who were blind from birth but without other identified disabilities or brain damage and to develop a dyadic intervention for them and their parents. Central to her work was seeing the relationship and interaction with the parent as key to both the infant's motivation to interact with the world and the infant's skills development.

In *Insights from the Blind* (1977), Fraiberg described a phase of detective work and exploration—observation and analysis—that at times is needed to understand the behavior and interaction/response patterns of a young child with disabilities. In the earliest stages, she used her observation skills and detailed (and constantly being updated) knowledge of normal development to test hypotheses about ways in which the disabilities impacted the children's engagement with the world—at times learning that her preconceived expectations were incorrect.

Fraiberg (1977) translated for parents as she learned—pointing out what she was seeing and helping to structure settings to facilitate the child's competence and interactions so that the parents could see both the child's developing skills and the importance of the parent for the child (as well as strategies to help facilitate the child's use of touch to compensate for the absence of vision). As she gained more knowledge of the development of blind babies, she was able to do more prediction of likely sequences and timing of emergence of skills and of facilitating circumstances. The blind infants' disability posed challenges for the parents, which Fraiberg and her colleagues addressed, but the focus was on the infant, with the clinician serving as the parents' co-observer, interpreter, and guide.

Fraiberg (1980) then moved to address the needs of a broader range of infants. Based on the referrals, she realized a need to adapt her intervention for infant–parent dyads for which impairment in parenting was a major component of the concerns. She incorporated consideration of parents' historical and intergenerational experiences that impacted the parent's portion of the parent–child "dance." IPP thus came to focus equally on the issues of the two members of the dyad.

Fraiberg demonstrated the importance of close observation, developmental understanding, and in-the-moment developmental guidance for facilitating parent–child relationships and when a disability is present, helping to facilitate the relationship even when the child's developmental limitations interfere both directly (reducing the developmentally typical cuing from the child) and through the meaning of this for the parent. CPP builds particularly on this relationship-building component. CPP adds a trauma lens—often involving interpreting for the parents the way in which the young child's behavior may reflect emotional issues and trauma reactions and helping the parent develop supportive responses.

CPP with young children who have developmental delays and disabilities:general considerations For children with significant developmental delays and disabilities who have experienced trauma, CPP provides trauma-focused mental health treatment that complements developmental interventions needed to address skills deficits in areas such as language and motor skills. Indeed, Fraiberg's (1980) work with IPP included developing the role of infant mental health specialist, who could address the emotional and relational needs of infants in coordination with providers addressing other issues. When medical issues are involved (for children with identified medical trauma and/or ongoing medical complexity), coordination by CPP therapists with medical providers also can be important, as emphasized by Williams and colleagues (2014).

When child maltreatment is involved, there are special considerations for CPP therapists regarding understanding and coordinating with the child welfare system while also considering potential impact of this involvement on the parents' engagement in treatment—issues for which guidance is provided in CPP training materials (Lieberman & Van Horn, 2008). In the United States, an issue pertinent specifically to young children with delays involved in the child welfare system is the mandate that children under the age of 3 years with substantiated child maltreatment be referred for evaluation of need for EI services—though states vary in the extent to which they have systems in place to do this (Shannon, 2021).

As is the case in planning trauma treatment for older children with developmental disabilities (Hoover et al., 2023), adjusting CPP for young children with delays and disabilities involves considering the specific nature and severity of a child's impairments as well as child and family strengths.

Harley et al. (2014) discuss the use of CPP for two cases with substantial child developmental impairment and family/situation complexity. Treatment benefitted from the resources of an academic medical center that provides early childhood trauma treatment training as well as interdisciplinary training in developmental disabilities. However, there are children with both trauma and developmental issues who are receiving treatment in less specialized community agencies. When surveyed about providing evidence-based preschool treatment, including both CPP and PCIT, 5 out of 20 Los Angeles County community agency program managers mentioned that their clinicians needed to make modifications for individual child factors such as developmental disabilities (Skale et al., 2020). A London team working with family court involved young children (Lamb & O'Sullivan, 2021) reported successfully using CPP with a 4-year-old of normal intelligence who had a history of severe maltreatment and co-occurring ASD.

The reports cited above indicate that some CPP therapists are already working with children with disabilities and may be making some of the adjustments to be discussed below. This is likely to be similar to the situation for certified TF-CBT providers documented through a recent survey about the use of this treatment with youngsters with disabilities (D'Amico et al., 2022). The survey indicated varying clinician comfort with this population, in part based on experience with neurodiversity, and identified specific conditions that they found more challenging. This led the authors to discuss the relevance of increasing resources and training for dealing with neurodiversity in trauma treatment. The discussion below is meant to add to the supports for trauma clinicians working with young neurodiverse children and for the other professionals coordinating with them.

The cases described by Harley et al. (2014) are discussed as examples that involved high levels of child impairment, complexity of family and resource issues, and need for integration with other disciplines. This is followed by a discussion of some general issues in applying CPP to a wider range of children with disabilities and delays.

Harley et al. (2014) describe Harley's use of CPP with a 14-month-old ("James"), who had medical trauma (a stroke subsequent to cardiac disease and surgery) resulting in substantial loss of skills/developmental delay, and 6-year-old ("Juan"), a child with ASD who had a history of maltreatment and exposure to domestic violence. Both lived in immigrant Hispanic families. Both cases involved:

1. Helping parents with their own reactions. In James's case, a major focus was on his mother's grief about her baby's regression. In Juan's case, a major issue was the father's guilt that he had been a perpetrator of domestic violence his son witnessed.
2. Helping parental understanding of their child's issues—trauma-related and developmental—and facilitating a sense of hope. For example, James's mother came to recognize the impact of trauma reminders, such as frequent medical appointments, on her son and herself. In both cases, parents were able to better understand the child's issues and see developmental progress during the treatment period.
3. Supporting improved parent–child interaction. In James's case, it involved helping the mother to re-engage with him and see her child as responding to her. In Juan's case, it included helping his caregivers be able to help Juan with regulation strategies. In both cases, it involved working to facilitate activities within the session that fit the child's interaction and developmental skills—and thus made developmental progress more apparent.
4. Interdisciplinary collaboration. For James, consultation with the child's speech-language pathologist and occupational therapist helped the therapist to develop activities appropriate to use in the CPP therapy. In Juan's case, the child's occupational therapist eventually co-led sessions with the CPP therapist in order to help improve Juan's regulation.
5. Assisting with access to supportive resources. For James, this included helping the family access additional developmental therapy services and helping them with applying for disability benefits. For Juan, it included getting an updated assessment of his ASD and functioning and helping the father advocate for more appropriate school supports for Juan.
6. Honoring cultural factors. The therapist spoke Spanish and was knowledgeable about cultural issues for the families.

In their commentary on the work with these two cases, Ghosh Ippen et al. (2014) provide the following summary:

> In both the cases of James and Juan, Child–Parent Psychotherapy seemed to have helped the caregivers in: (1) making meaning of the children's disability; 2) increasing their competence in reading and responding to their children's cues and needs and supporting their developmental progression; 3) being able to identify and develop appropriate coping strategies to manage the feelings and thoughts evoked by their children's condition, and their own and the children's trauma triggers; 4) increasing their attunement and the possibility to take protective role in the care of their children; and 5) developing a more realistic positive and developmentally appropriate view of their children….(p. 208)

A treatment issue with any child who has delays/disabilities is to help the child resume/obtain a personal optimal developmental trajectory—not necessarily a "normal" one (also noted by Willliams et al. (2014), regarding CPP). As discussed earlier, in the preschool years, that trajectory often is unclear. A source of tension for many parents is dealing with the ambiguity—maintaining hope but hope that is realistic while getting needed services.

A second issue is overlap between trauma and disability symptoms, such as perseverative behaviors that could reflect either ASD fixed interests or posttraumatic play, or hypersensitivity to some stimuli that could have a sensory base or be responses to trauma triggers. Sometimes, it is unclear if delays might reflect trauma-related regression, neglect-related lack of skills development, other developmental issues, or a combination. A careful analysis of behaviors and triggers may provide some clarification. A timeline of skill development and regression can also help—but for children in the child welfare system, historical information often is not available. As in the case discussed by Langenfeld et al. (2021), treatments to address both developmental and trauma issues at times are needed to clarify long-term implications of early delays and deviations in children with trauma histories.

When doing CPP with children who have ASD diagnoses, there are special considerations. Some children, like Juan, present with considerable behavioral dysregulation. When the dysregulation interferes with treatment, there is a need to determine ways to structure treatment to help with regulation—often with consultation from others on the child's treatment team—in Juan's case, his occupational therapist.

The extent of perseverative behaviors and fixed interests and nature of play skills can impact the way the child uses the treatment. This is illustrated in work with two young children, both with generally normal intelligence, both diagnosed with ASD in the course of CPP treatment. For one, a three-year-old girl, the therapist suspected the presence of ASD from the time of intake because of language abnormalities (pronoun reversals) and the extent of perseverative behavior. Initially, it was unclear to what extent she would be able to use play to address her medical traumas. She readily engaged in medical play, but initially, it was a very brief, perseverative, and literal reenactment. However, over the course of treatment, her medical play became more elaborated. She accompanied her play with questions to her mother that were pertinent, if also perseverative. Mother provided simple answers to the child's questions and served as interpreter of the relationship between the child's play and the specific events they reflected. With time, the girl condensed play about the initial medical themes and developed others. She also showed a shift in session in proximity to her mother, increasingly spending time on her mother's lap or leaning against her. However, perseverative tendencies continued both in her medical play and her other activities. The therapist helped the mother anticipate and prepare the child for medical visits when they occurred during treatment and also suggested additional materials related to dealing with emotions. Therapy also involved other play and dealt with other issues that came up during the treatment, using both child-parent sessions and developmental guidance sessions with both parents. Possibility of ASD was discussed during feedback from intake and periodically; after evidence emerged of relevance to preschool functioning, ASD was assessed and confirmed.

In contrast, a second child showed more stereotyped play throughout the treatment. He had been referred for oppositional defiant disorder and attention-deficit/hyperactivity disorder, was showing some language-based learning issues in kindergarten and had an early trauma history in relation to his estranged father. Much of the treatment focused on the relationship between mother and son. The mother shared that she came to realize that when her son had a tantrum in response to school-related tasks, this was likely to reflect his frustration rather than indicating that he was turning into one of the abusive males she had experienced, including the child's father. There was considerable work in sessions on emotion vocabulary and identification, using materials of interest to the child, such as Pokémon feeling faces. Over the course of treatment, the perseverative nature of the child's interests became clearer, with play typically reflecting contents of videos or shifting fixed interests, but with little thematic development. Mother and therapist both began to wonder about ASD. Autism Diagnostic Observation Schedule and neuropsychology evaluations confirmed ASD and provided a clearer picture of learning issues than the school had been able to obtain before the treatment.

Some considerations by CPP treatment phase In the *foundational phase,* major goals are to form a treatment alliance with the parents and assessment to get sufficient understanding of issues to guide trauma treatment. One of the elements of assessment is getting developmental history—of trauma and of developmental/behavioral issues and strengths. When a child has had formal evaluations, it is important to ask permission to review them. If the therapist does not have experience in interpreting such evaluations, one strategy is to use a consultant with that expertise (a role I had for several years for the social workers in a trauma-focused child psychiatry department).

In understanding and addressing the parents' concerns, it is important to assess parental understanding of the child's developmental issues as well as their understanding of the impact of trauma and to begin to understand their emotional reactions to each of these issues. At times, the clinician may consider suggesting further evaluations to clarify issues, may make recommendations regarding developmental supports (such as EI), or may provide practical assistance regarding how to access such services (as was done in Harley's cases). The review of development at times can raise concerns that the therapist and parent discuss and decide do not need immediate attention but to monitor. Over the course of treatment, this monitoring may lead to referral for evaluation and diagnosis, as happened for the three-year-old girl discussed earlier.

During the *core intervention* portion, the therapist should be mindful about the child's developmental profile and, as pertinent, use simple language and visual supports for a child with language delay or facilitate activities that will fit motor skill development even when this is limited (as noted by Harley in her work) and in doing so plan for toys and materials appropriate for the child. At times, this can be educational for the parent. For children with special interests, trying to find ways to bridge therapy goals and interests, such as the Pokémon feelings faces discussed above, may be helpful. Adjustments should be ongoing and should take into account the therapist's observations in the course of treatment as well as any new formal assessments.

CPP developers note that reflective developmental guidance includes assisting parents with information about development. For a child with a delay or disability, this may mean the kind of guidance discussed by Fraiberg in her work with blind infants—noting patterns and then helping to facilitate interactions that strengthen the attachment relationship and facilitate the child's development and in CPP, processing of trauma-related issues at the child's developmental level. Clinician skill in doing this may vary depending on knowledge of development and disabilities. A consultant or reflective supervisor with expertise in this area can be helpful for some clinicians. As discussed further below, providers of another attachment-based intervention, ABC, have described the importance in their work with infants who had significant delays of a supervisor who could help the providers see subtle positive behavior changes that could be pointed out to the parents (Mohamed et al., 2022, 2023).

Understanding of pertinent service systems and coordinating with other providers can be important across phases of treatment but may be particularly pertinent in this phase. As Harley's cases illustrate, children with disabilities may be working with numerous providers dealing with the child's developmental, medical, and daily care needs; and these professionals may have information relevant to the CPP therapist's work with the child and family. In addition, educating other providers about trauma-related needs often is an important role for the trauma therapist.

Ideally, the CPP clinician working with a child with delays or disabilities will know about access to and functioning of other service systems that may be relevant, such as EI, preschool special education, or medical systems. Practically, a substitute may be access to a consultant with that expertise. As Harley notes, the CPP therapist may be in the best position to help the parent integrate the differing perspectives the parent is encountering—but that requires that the therapist understands these perspectives.

In my experience, special considerations during the *termination phase* include helping the parent consider future service needs. When I have played a role in helping parents obtain and integrate services, at times I have been asked later for occasional follow-up meetings to discuss perspectives on shifts in services, particularly as the child faces developmental transitions.

An additional consideration pertinent across treatment phases: Age range As Williams and colleagues (2014) suggest, CPP may be helpful for children older than the conventional CPP age range if the child's cognitive functioning is at a preschool level. It may be particularly relevant when there is a need to strengthen the supportive relationship with the parent.

Grief work and resilience Ghosh Ippen et al. (2014) emphasize the role that CPP can play in supporting parental grief work related to their child's disability, whereas Williams and colleagues (2014) emphasize the resilience of many families in which a child has a disability, with each citing pertinent literature. Both issues can be important, not mutually exclusive, and can shift in balance over time. Patterson's (1988) family resilience theory, derived in part from work with families in which a child had a chronic illness or disability, provides one framework for considering such issues. Patterson described families' shifting balance of stressors and capabilities/resources. She discussed that when there is need for re-stabilization of the balance, both practical resources (consistent with William's stressing the importance of access to such supports) and meaning-making have important roles.

Culture Ghosh Ippen and collaborators (2014) and Williams and collaborators (2014) stress the importance when doing CPP of taking into account cultural considerations. For children with disabilities, this includes cultural variability in understanding disabilities and responding to them. Ghosh Ippen and colleagues note a model by Kapitanoff et al. (2000) of cultural influences on the relations between disabilities and child abuse and that this model may be useful even when there is no maltreatment. In addition, the developmental niche theory of Super and Harkness and its application to developmental disabilities (Harkness et al., 2007) provides a framework for thinking about child disability issues in the context of different cultures—considering how customs about child rearing, settings in which the child functions, and caregiver psychology combine to impact family coping with a child's disability and developmental services.

Training and settings Fraiberg (1977, 1980) discussed the importance of both extensive developmental training of staff and use of interdisciplinary teams for carrying out her work, and Williams and colleagues (2014) discuss the importance the resources an interdisciplinary training setting afforded for the cases seen by Harley et al. (2014). While this seems optimal, consideration needs to be given to how to support work with children with disabilities being seen in the community by clinicians without the same degree of training or built-in access to interdisciplinary resources. Some agencies have some interdisciplinary supports, and some communities have good referral supports for preschool intervention services. At times, however, clinicians may need to develop their own sources of information and/or network of referrals.

Williams and colleagues (2014) recommend qualifications for CPP clinicians to work with children who have developmental disabilities. They include (a) knowledge about developmental disabilities and their impact, (b) knowledge about the impact of pediatric medical trauma on young children and caregivers, (c) knowledge about systems of care and entitlements, (d) skill in supporting families in navigating service systems, (e) knowledge about the roles of different professionals/care providers and skill in working collaboratively with providers from other disciplines, and (f) skill in communicating a trauma-informed perspective to the professionals in other service systems such as EI and medical care. These are ideal qualifications.

In order to meet community need, for cases with milder levels of disability, one might consider adequacy of: (a) good basic knowledge of development, (b) good observation skills, (c) some knowledge of “red flags”—major indicators of possible problems concerning development, (c) good systems collaboration skills, and (d) access to a consultant with the skills that Williams described. Clinicians should include good developmental screening as part of their clinical intakes and have knowledge of basic developmental resources. Good basic developmental knowledge is likely to be important for mental health specialists working with young children and their parents regardless of whether the children have disabilities. Indeed, a recent discussion within the Zero to Six Collaborative Group of the US National Child Traumatic Stress Network has been of materials and strategies members have developed to enhance knowledge about early development for therapists (pertinent for the interventions discussed below as well as CPP).

Parent–Child Interaction Therapy (PCIT)

PCIT is a dyadic treatment for young children and their caregivers, originally developed to treat disruptive behavior in children between 2 and 7 years old. It draws on work on parenting styles, play therapy techniques, and social learning theory—particularly ways to avoid negative escalation cycles between parents and children.

PCIT has two phases. For each, after an initial didactic session, the therapist provides in-the-moment coaching of parent’s play with the child. Parents are asked to practice skills during brief daily “special time” between sessions. A phase continues until the parent reaches criterion on coached behaviors. First, parents learn to follow the child’s lead in play, providing supportive verbalization while avoiding criticism and questions. Then, parents are coached in giving effective commands and consequences. Duration is approximately 12–20 weekly sessions.

PCIT has had extensive application for young children who have experienced maltreatment and are showing disruptive behaviors (Urquiza & Timmer, 2014) and also has been applied more generally when disruptive behaviors are a major component of children’s responses after trauma (Gurwitch et al., 2017; Gurwitch & Warner-Metzger, 2022). Adjustments recommended to address trauma include adding a screen for trauma exposure at intake to allow consideration of potential impact of specific traumas, providing psychoeducation about trauma, and teaching emotion regulation skills for parents and children. The University of California, Davis PCIT Training Center (2012) online free training program for the use of PCIT with trauma addresses a range of such issues, and Gurwitch and Warner-Metzger describe a brief additional treatment module to enhance addressing trauma. Although PCIT can lead to trauma symptom reduction, Gurwitch et al. (2017) note that some children completing PCIT may need referral for further trauma-specific treatment such as TF-CBT. PCIT is sometimes used for behavior stabilization before such treatment.

PCIT has been used with children who have ASD or ID to address their disruptive behaviors (see review by Timmer et al. (2018) and discussion for ASD by McNeil and Quetsch (2018)). McNeil and Quetsch state that the child’s language comprehension needs to be at least at a two-year level. Timmer and colleagues summarize some of the ways clinicians working with ID have taken the child’s language functioning into account during each of the phases of PCIT. McNeil and Quetsch summarize a range of strategies and tools that can be used to support PCIT with youngsters with ASD. Timmer and colleagues report that for high-functioning youngsters with ASD, at times the only modification needed is mindfulness about when and how to use materials that fit the child’s specific “special interests.”

McNeil and Quetsch (2018) and Timmer et al. (2018) recommend that clinicians doing PCIT with children who have IDD have solid training in PCIT plus some experience with IDD. They note the importance of good developmental assessments of the youngsters to help guide treatment. Timmer and colleagues suggest that to handle youngsters with ID and ASD in community agencies, many clinicians need more training regarding recognizing atypical development and strategies for adjusting treatment for youngsters with such development. McNeill and Quetsch discuss the importance of understanding and coordination with other services a youngster is receiving.

Parent–Child Care (PC-Care)

PC-Care is a time-limited intervention with one presession and 6 treatment sessions. It was developed to provide a brief intervention that could be used in a variety of settings. As with PCIT, the therapist provides parent coaching concerning both relationship enhancement and behavior management skills (Timmer et al., 2023). However, PC-Care differs from PCIT in several important ways. The age range is 2–10 years. During the pretreatment session, the therapist provides psychoeducation on factors that can influence dysregulation, choosing from several options, including psychoeducation about trauma. The number of sessions and agenda for each session are fixed rather than depending on skill mastery. The relationship-enhancing skills are similar to those used in PCIT. In contrast, the therapist introduces and coaches the parent on a wider range of behavior management strategies with two new strategies introduced in each of the first five treatment sessions. Because of the limited number of sessions, "time out," which may require considerable coaching to be effective, is not included as a strategy. Skills for emotion regulation are introduced as a regular component of treatment.

The developers of PC-Care report that for children referred to a community agency, participants in PC-Care showed better retention in treatment over a 7-week period and faster improvement during that period than participants in PCIT (Timmer et al., 2023). They recommend PC-Care for children with mild-to-moderate dysregulation and provide a decision tree on the PC-Care website regarding use of PC-Care vs PCIT (https://pcit.ucdavis.edu/wp-content/uploads/2022/01/PCIT-vs-PCCARE-Decision-Grid-Steps.pdf).

For children with ASD or ID, an appendix in the PC-Care treatment manual (Timmer et al., 2022) provides a modified session-by-session outline, psychoeducational materials about ways in which issues related to these diagnoses can contribute to dysregulated behaviors, and modified treatment handouts. Included is guidance regarding when to use play materials related to a child's special interests, being mindful about language complexity, and use of visual supports and shaping of behaviors. As noted previously, Timmer has reported the use of the intervention for children with ID or ASD who have experienced trauma, although information is not currently available separating outcomes for these youngsters.

Attachment and Biobehavioral Feedback (ABC)

ABC is a dyadic attachment-focused treatment for infants up to 2 years who have been exposed to trauma (Dozier & Bernard, 2019). It focuses on enhancing the parent–child relationship through 10 brief, home-based parent coaching sessions with the child present. Goals include increasing parent sensitivity and responsiveness to their child's distress, increasing "synchrony"—parents' following the child's lead accompanied by genuine, positive affect, and decreasing parental frightening and intrusive behaviors. Coaches use psychoeducation and in-the-moment coaching. Each session has a structured focus. Sessions are videotaped for review with the participants as well as for supervision. Because of the brevity and specific session goals, there is an emphasis on maintaining treatment focus rather than addressing other ongoing family problems. In spite of treatment brevity, Dozier and colleagues have demonstrated impressive long-term impact (Dozier & Bernard, 2019; Grube & Liming, 2018; Osofsky et al., 2017).

Dozier and Bernard (2019) discuss work with high-risk birth parents, foster parents, and parents adopting internationally. Issues of developmental delay have not been a primary focus, but their work has involved child populations at high risk for delays and deviations. Their case example of ABC with parents of a child adopted from a foreign institution illustrates handling of some issues related to delays and deviations. They describe work with a parent whose adopted son had both language and gross-motor delays. The ABC coach helped her shift from using most interactions with the son as attempts at directive teaching to being more nurturant and more frequently following the child's lead. This included expanding on the child's verbalizations and describing in words what the child was doing in a supportive way—an approach facilitative of language development as well as of a positive relationship. ABC follow-up studies document a positive impact on receptive language development (Bernard et al., 2017; Raby et al., 2019).

A pilot study in South Africa used ABC to facilitate the relationships between three infants with global delays and their parents (Mohamed et al., 2022). Parental sensitivity and child attachment security increased according to "visual analysis," but without statistical significance. Qualitatively, coaches and parents noted child and parent gains.

The parents and coaches, as well as "experts" (therapists and other parents/caregivers) were interviewed about ABC use in this context (Mohamed et al., 2023). The coaches, both psychologists, discussed the importance of working with a supervisor who helped them see subtle changes in the children's behavior on which they could focus with the parents. Experts noted the compatibility of ABC with the approach used in speech-language therapy, and that it could help parents better understand their children's idiosyncratic communications. Recommendations included (a) incorporating more psychoeducation about development and developmental delays to help parents be more realistic in their expectations, (b) more training about development and ID for coaches, (c) adapting activities in session to better allow successful interactions, (d) training coaches when and how to access referral networks, and (e) guidance to coaches of how sensitively to address cultural issues such as coaching to follow a child's lead when this does not fit cultural messages about parent–child interactions.

Summary of Treatment Approaches

The four interventions discussed share emphasis on the key role of parent attachment for young children coping with trauma. They differ in age group, treatment structure and length, extent of processing of traumatic events, and extent to which they take parental history into account. CPP, the longest treatment, also addresses the widest range of issues. It has the most (if limited) published data concerning application when there is both disability and trauma. PCIT and PC-Care are most likely to be recommended when behavior dysregulation is a major presenting symptom.

Regarding recommended adjustments for children with delays or disabilities, a recurring theme is the importance of good developmental information as well as trauma history as part of clinical intakes, clinician understanding of development and developmental disabilities—or regarding the latter, at least knowledge of key features plus access to a knowledgeable consultant. Experts recommend mastery of treatments before applying them to children with disabilities. All note the importance of good clinician observation skills—needed to adjust treatment to fit the specific child and family. A recurring (if not universal) theme is understanding the multiple systems of care in which these children may be involved, so the trauma clinician can make developmental therapy referrals when needed and can coordinate care—both learning from and educating other providers.

For all the treatments, there is a need for more systematic information about the extent of delays and disabilities among children currently being treated, how adjustments are being made for these children, and what the outcomes are. Important questions include which children can be treated effectively as part of community treatment programs with some support to clinicians and what supports are needed and which children require more specialized settings with higher level of expertise and interdisciplinary involvement.

Trauma-Related Issues in Early Intervention and Preschool Services for Young Children with Delays and Disabilities and Cross-System Needs

Developmental service providers for young children with disabilities need to know how to respond when trauma has affected the children and families with whom they work. This pertains to children with any of the traumas they may experience prior to or during enrollment in developmental services—although attention to this need has been increased with the mandate for referral to EI of US children up to age 3 years who have had substantiated maltreatment.

Issues that have been identified for teachers/providers include discomfort by some regarding how to respond when a child brings up trauma-related issues or when a child in foster care is dysregulated in an educational setting after a distressing encounter such as upsetting visitation with a biological parent, lack of experience/training for staff on how to respond when overwhelmed parents are not responsive to program paperwork or other requests (Ward et al., 2009) or staff not knowing how to engage parents who are guarded about sharing information because of concerns about stigma or fear that information could lead to their child being taken way (Gilkerson et al., 2013).

Issues also include need for sensitivity regarding situations with EI services or in a preschool setting that may serve as trauma reminders. These include ones that can readily be anticipated, such as issues around separation from caregivers of a child recently placed in foster care, as well as more child-specific trauma-related stimuli (Gilkerson et al., 2013). At times, both a good trauma history and problem-solving with a caregiver may be needed to figure out when a young child's reactions are trauma related, such as toilet training issues for a child with a history of medical trauma that impacted toileting.

In 2013, a group of seven experts in early childhood mental health and trauma presented recommendations for trauma-informed EI programs (Gilkerson et al., 2013) and provided brief descriptions of two model programs. The Baltimore Infants and Toddlers Program is a collaboration between the Baltimore City Department of Health and an infant and preschool mental health program at the University of Maryland School of Medicine. It involves trauma and social/emotional development screening for EI referrals, including those from child welfare, and mental health consultation or treatment as needed. New Mexico Infant Teams focus on needs of young children in state custody, include transdisciplinary work between infant mental health and developmental specialists in areas such as occupational therapy and speech/language development, and provide integration with family court and child welfare systems. Both programs involve mechanisms for cross-consultation and, when needed, co-treatment. Both include mechanisms that allowed not only support for developmental service providers regarding trauma but also support for infant mental health specialists about developmental issues.

Although not focused on disability issues, Bartlett and Smith (2019) provide information regarding programs that have been developed to make preschool programs more trauma-informed, while providing the caveat that there tends to be less evidence-base for these programs than for the early childhood trauma treatments. They discuss not only programs that can be incorporated in schools and those provided by some specialized schools but also ones that involve mental health consultation and community-wide programs designed to facilitate family access to resources—either specific to mental health or more general.

The need for trauma sensitivity also pertains to autism-specific treatments. Applied behavior analysis is widely used with children with ASD. There has been recent discussion by some applied behavior analysts about how to be trauma-sensitive in their work, such as a discussion by Kolu (2022) of contraindicated behavioral procedures after trauma. In terms of integrating consideration of parental history into developmental intervention with children with ASD, Kalmanson and Seligman (2021) describe the integration of Fraiberg's IPP with Greenspan and Wieder's DIR/Floortime (Wieder et al., 2008) approach.

Recommendations for trauma-informed programs have included: (a) training for staff regarding early childhood trauma, its impact, and how to deal with it in the education/intervention settings, (b) more emphasis and resources related to social-emotional development in services/programs for young children, (c) more connection and collaboration between early childhood mental health and other early childhood development providers, (d) actively involving caregivers, (e) and support for staff regarding secondary traumatic stress. The EI programs discussed highlight the importance of structures that provide cross-system collaboration and thus provide support for both mental health and developmental service providers, as well as facilitating access to resources for families.

Summary and Key Points

Young children with developmental delays or disabilities are at heightened risk for experiencing maltreatment and traumatic medical procedures, as well as being at risk for the range of traumatic experiences that young children may encounter. Four treatments have been discussed as relevant for addressing the impact of these experiences on young children and their caregivers. Key differences between treatments were discussed, but there is considerable agreement on the importance of the parent–child relationship, some key adjustments for children with delays and disabilities, the need for knowledge about development for early childhood trauma therapists, and some of the training and/or resource needs for therapists working with this population. There is also a need for more research to support these recommendations.

Both developmental service providers and trauma treatment providers need to approach their work with children who have developmental delays or disabilities from a framework that tailors to the child's developmental level and individual pattern of strengths and needs while taking into account possible trauma-related issues for the children and their families. Collaboration between developmental service providers and early childhood trauma specialists can help both groups. The providers and the children and families they serve benefit from programs (whether in one agency or across agencies and service sectors) that facilitate cross-consultation across disciplines and locating of resources for providers and families.

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23

The Importance of Relationships to Help Young Children, Parents, and Caregivers Impacted by the COVID Pandemic

Joy D. Osofsky and Howard J. Osofsky

The Importance of Relationships for Infants, Young Children, and Families During the COVID Pandemic

In order to thrive, infants and young children need predictability, consistent schedules, and dependable and emotionally available parents and caregivers who can take sensitive care of them that includes listening to them, playing with them, and planning experiences they can count on and expect. The COVID pandemic changed many of these expectations as children and families were living with "indefinite uncertainty" about when the pandemic would end and their lives would return to normal. First, they had to adjust to the "stay at home" orders so that they could not participate in the usual activities of going to childcare centers, preschools, or schools. For parents who were essential workers, there were many worries about childcare and also stress related to concerns about losing their jobs. For others who could work virtually, balancing providing both childcare and/or virtual schooling for their children was challenging. While advice to practice social distancing was designed to help protect children and families from COVID, it also meant that young children were not able to visit their friends, go out to play, or see their grandparents and other close relatives who meant a lot to them. From a mental health perspective, it would have been more advisable to require physical distancing for safety and encourage virtual social contact with friends or family using technology if possible. If families did not have access to video technology, and many throughout the world did not, telephone contact could be encouraged as a way to stay in touch and to visit friends and family. It would have been important during this time of isolation that a "new normal" be created to find ways to help families keep up with close relationships that are so important for young children (Lyons-Ruth et al., 2017). Virtual contact is also important for parents and caregivers for support to help them be able to provide better care for their children. At the same time as lockdowns were required, for the first time in many countries, wearing face masks for protection was recommended or required in many settings when around other people. For many children and families, masking was uncomfortable, different, and also interfered with them trying to feel "normal."

In summary, the COVID pandemic experienced around the world has had a significant

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impact on many infants, young children, and families, especially those living with fewer financial and other resources and support. The ordered lockdowns, social distancing mandates, closure of schools, childcare centers, and preschools that were part of the lives of most infants and young children, and the continually changing regulations, without clarity of when the pandemic would be contained, contributed to a situation of "indefinite uncertainty" for young children, parents, and caregivers including all preschool and school personnel. As mentioned, consistent schedules and routines are very important for young children to feel secure and learn during the early years. They also thrive with consistency in relating to family and friends. When school authorities decided it was safe to reopen schools, some preschool or kindergarten children hesitated to go back to school not understanding why it was interrupted unless they had a supportive parent or caregiver explain in a way that they could understand. Some were hesitant to go to school and fearful that they might become sick and spread the virus. They also did not understand why the childcare center or school was closed and what it would be like for them now. It was also a time for parents and caregivers to reassure them with a new schedule so that they would have regularity in their lives, even if different from before. Further, if they were either too young to understand what was happening or were not told in a language they could understand, young children may have heard people around them talking and worrying. They also might have had a family member get sick with COVID and, for that reason, feared going to school where they thought they could become infected and then make another family member become sick when they came home. It is very important to talk to and listen to young children about their concerns and worries and to learn about what they know and may have heard. Then it is helpful to share with them what has been happening using words they can understand. They also need reassurance that their parents or caregivers will keep them safe. The data from the Sesame Street workshop study done during COVID are supportive of this approach (Wong Chin et al., 2021). The study gathered data from a group of diverse families with children of different ages coming from different socioeconomic groups and geographic areas in the United States. Most children stated that parents were their "heroes" and would be there for them and keep them safe during the COVID pandemic.

Background and History of the COVID Pandemic

The COVID pandemic experienced around the world has played a significant role for many infants, young children, and families, especially those living in poverty with fewer financial and other resources and support. A cluster of cases of COVID was reported in Wuhan, China, by the Chinese government on December 30, 2019, and confirmed by the World Health Organization on January 4, 2020. By mid-January, there was evidence of possible human-to-human spread. On January 30, with 7818 cases identified, the Director General of the World Health Organization, with the guidance of the Emergency Committee, declared the virus outbreak to be a Public Health Emergency of International Concern. Most of those infected had mild to moderate respiratory disease (https://www.who.int/publications/m/item/covid-19-public-health-emergency-of-international-concern-(pheic)-global-research-and-innovation-forum, accessed August 15, 2023). However, especially among the elderly and those with underlying conditions, such as cardiovascular disease, diabetes, and chronic pulmonary disease, illness could be much more severe and even fatal.

Concerned both about infection, and the rapid spread, WHO declared COVID to be a pandemic on March 11, 2020 and continued to track the spread around the world (WHOCOVID Dashboard, https://covid19.who.int/sueif, accessed June 18, 2023). Many countries closed borders temporarily. During the spread of COVID in the United States and with each new variant, People of Color including Blacks, Latine, American Indians, and Alaska Natives had the most illnesses and fatalities. On February 22, 2021, the United States reported 500,000 deaths from COVID. On April 17, 2021, the international tally of deaths reached 3 million. Around the world, significant losses occurred, especially in India, Africa, and several Asian countries (https://www.economist.com/graphic-detail/coronavirus-excess-deaths-tracker, accessed June 18, 2023).

Beginning in March 2020, 42 states and territories in the United States issued mandatory stay-at-home orders, affecting 73% of the counties with others, rapidly following. Many countries closed their borders (https://www.cdc.gov/mmwr/volumes/69/wr/mm6935a2.htm, accessed August 15, 2023). On April 28, figures were released by Johns Hopkins University indicating that 1 million people worldwide had contracted COVID and 2 million confirmed cases were reported on July 2 (https://coronavirus.jhu.edu/, accessed June 19, 2023). The infection rates and death toll were staggering contributing to much family stress (Lafarge et al., 2020). On February 22, 2021, the United States reported 500,00 deaths from COVID and on April 17, 2021, the international tally of deaths reached 3 million. In March 2023, it was estimated that almost 80,000,000 people in the United States had been infected and that approximately 1 million had died from the COVID virus. The World Health Organization estimated that approximately 450 million people had been infected worldwide and that approximately 6 million had died because of COVID (https://www.who.int/data/stories/the-true-death-toll-of-covid-19-estimating-global-excess-mortality, accessed August 15, 2023). It is very important to recognize that around the world, there were significant disparities in infection and deaths related to socioeconomic status, ability to provide seclusion, and access to medical care. Lower-income people with fewer resources were more likely to live in crowded circumstances, have jobs that were classified as essential, have fewer opportunities for virtual work, and have less access to healthcare. In the United States, unemployment levels reached almost 15% (US Bureau of Labor Statistics Monthly Labor Report, June 2, 2021) and 35% of households with children reported food insecurity affecting 52 million people (Kakaei et al., 2022; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9335023/, accessed August 19, 2023). A study conducted in 2020 found that many children's socio-emotional development was severely disrupted during lockdown, with a variety of negative impacts including tantrums, anxiety, clinginess, boredom, and under-stimulation (Eagan et al., 2021). In addition, COVID also impacted cognitive, social, and emotional development (Harvard Center for the Developing Child: COVID impact, accessed June 18, 2023).

The issue of inequities with COVID is striking (Shim, 2020). For example, in Louisiana, African Americans represent 32.7% of the population but accounted for 70% of the deaths from COVID. These figures for Louisiana have been repeated across the United States with a much higher incidence of illness and death from COVID for Black/African Americans, Latin, Native Americans, Alaska Natives, and Pacific Islanders among the many groups heavily impacted (Hu et al., 2022). These figures and inequities are likely related to having more limited healthcare that also contributed to a higher percentage of underlying conditions such as heart disease, hypertension, diabetes, and respiratory problems placing them at higher risk if they became sick with COVID. The COVID pandemic is an unmitigated disaster in many ways comparable to but worse than traditionally defined disasters such as hurricanes, earthquakes, tornadoes, and fires. This topic will be discussed below.

Key Findings Estimating Risks and COVID Losses

Hidden Pain: Children Who Lost a Parent or Caretaker to COVID and What the Nation Can Do to Help Them was released in December 2021 (Treglia et al., 2023). This report was among the first that provided estimates of the number of children who lost a caregiver and concrete recommendations to support them. The COVID Collaborative is a group in the United States that came together to mobilize government, nonprofit, and private sector partners to support the children in the United States, who had lost a parent or caregiver to COVID and help determine what the nation could do to provide more help (https://www.covidcollaborative.us/about, accessed February 23, 2023). According to the COVID Collaborative, as of April 2023, at least 204,000 US children and teens have lost parents and other in-home caregivers to COVID which is more than 1 in every 360 youth (Hillis et al., 2022). Further, more than 15,000 children lost their only in-home caregiver to COVID. The losses for young children were significant. Fifty percent of parent or caregiver loss was among children ages 5–13 years. Of particular significance for this book, 20% was among those from birth through 4 years old. As expected with the disparities in COVID losses, differential losses were found by race and ethnicityas non-White children lost caregiving adults at higher rates than their White peers. American Indian, Alaska Native, Native Hawaiian, and Pacific Islander children lost caregivers at rates of nearly 4 times the rate of White children. Black and Latin children lost parents or caregivers at nearly 2.5 times the rate of White children. Asian children lost parents or caregivers at 1.6 times that of White children. While caregiver loss was concentrated in certain racial and ethnic groups, loss was also found in every state in the United States. For example, the five most populous states—California, Florida, Georgia, New York, and Texas—accounted for half (50%) of total caregiver loss from COVID. Arizona, Mississippi, New Mexico, and Texas had the highest rates of caregiver loss, while Maine, New Hampshire, Vermont, and Wisconsin had the lowest rates. The District of Columbia had the widest disparities in caregiver loss with Black and Hispanic children's rates of caregiver loss being 11 and 18 times the rates of loss for White children, respectively.

Beyond the data is the impact of such losses on young children. While grief is a normal process following loss, how it manifests varies as a function of the age of the child, the characteristics of the loss experience, and the quality of the support, especially from the surviving caregiver. The consequences of losing a parent or other caregiver are more often than not traumatic for a child or adolescent and can persist through a child's lifetime. Again, having a supportive adult caregiver who can listen to the child and be emotionally available can be very helpful. Consequences of such losses can include depression, posttraumatic stress disorder (PTSD), anxiety, and, as a result, lower rates of academic attainment. In more extreme cases, the consequences, without sufficient caregiver support, can lead to higher school dropout rates, higher rates of alcohol and other substance use, suicidal ideation and risk, and reduced employment. As mentioned above, disparities were identified in infection and deaths related to socioeconomic status, ability to provide seclusion for safety, and access to medical care. As noted, many countries closed their borders temporarily in an effort to reduce the spread of the virus. In the United States, with each new variant, more people of color, Latine, and AIANs were infected, at least during the early phases of the spread of a new variant. On February 22, 2021, the United States reported 500,000 deaths from COVID. On April 17, 2021, the international tally of deaths reached 3 million (https://www.who.int/data/stories/the-true-death-toll-of-covid-19-estimating-global-excess-mortality. WHO accessed June 18, 2023).

Fortunately, new opportunities emerged for possible prevention of the COVID virus. On December 10, 2020, the Food and Drug Administration (FDA) granted emergency authorization for Pfizer and Moderno vaccines for individuals aged 18 years and older (https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/full-fda-approval-of-a-covid-19-vaccine-what-you-should-know; April 11, 2021, accessed August 19, 2023). Authorization was given for those aged 16 years and older, and on November 2, 2021, the Centers for Disease Control authorized vaccination for children aged 5–11 years. On June 18, 2022, vaccination was recommended for children aged 28 days and older. Children less commonly developed severe infections or death because of COVID. However, some did occur but children rarely developed Multi-system Inflammatory Disease (RSD) following COVID. There was also concern, however, that children could be silent carriers of the virus, a concern that has been supported in recent studies (www.ama-assn.org, accessed July 24, 2023).

In sum, given the "indefinite uncertainty" during the COVID pandemic, especially for families with fewer resources, the environment for infants and young children was unpredictable and not one that was most supportive for growth and development. As described above, a predictable environment includes: (1) consistent schedules; (2) dependable and consistent parents or caregivers; (3) an adult parent/caregiver who is emotionally available to them to listen to them about their concerns, take sensitive care of them, encourage play, and plan life experiences they can count on and expect. The COVID pandemic changed many of those everyday guidelines and expectations as parents/caregivers, children, and families were living with "continuous uncertainty." With all of the required changes in the usual ways that children and families could live, concurrently they still worried and were fearful of the COVID virus disease affecting them or a member of their family which introduced more anxiety for children. All of these alterations in the usual day-to-day lives of infants and young children occurred concurrently with fear of the disease infecting them or a member of the family and continual economic pressures leading to more anxiety and stress for families and for the children (Liu et al., 2020; Rapid Survey Project, 2023). Interestingly and related to concerns about young children becoming infected or possibly spreading COVID if they went to childcare or school, a study by Gilliam et al. (2021) indicated no association between exposure to childcare and COVID in both unmatched and matched analyses. However, these fears of spread in families for both young children and parents or caregivers continued to be a concern.

Children who lose a parent or caregiver are at elevated risk for traumatic grief, depression, poor educational outcomes, and other risks (Briggs-Gowan et al., 2019). The researchers found that separation and loss were significantly associated with symptoms of posttraumatic stress, reactive attachment disorder, or grief disorder, as well as impairment and psychiatric disorders in models that controlled for sociodemographic and contextual risks, including other traumas. Psychiatric disorders were approximately 2.5 times more likely in children who had experienced multiple separations/losses, after accounting for interpersonal violence which was also significant.

All of these alterations in the usual day-to-day lives of infants and young children occurred concurrently with fear of the disease infecting them or a member of the family and continual economic pressures leading to more anxiety and stress for families and for the children (Liu et al., 2020; Rapid Survey Project, 2023).

Supporting Young Children Who Lost Parents and Caregivers to COVID Pandemic

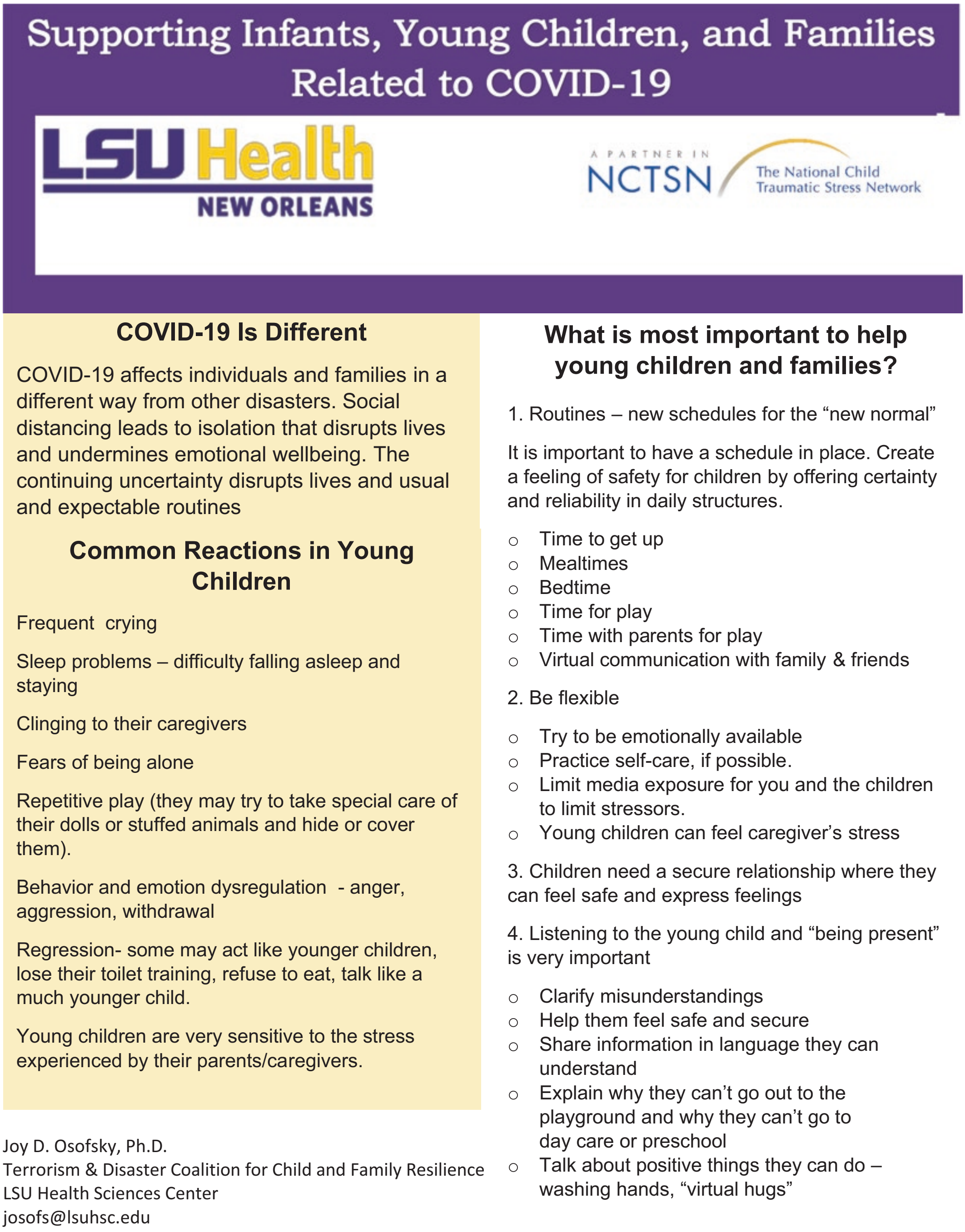
How does a young child feel if a parent or grandparent is taken from the house by ambulance never to return? As they do not understand why they left and did not return, it has not been uncommon for young children to stand by the window or door repeatedly staring and waiting for their return that does not happen. They may become increasingly distressed and dysregulated and will benefit significantly from having a parent or consistent caregiver with them for support. The ambiguity experienced by these children may be a similar feeling to that children experience with parents going off to war (Gorman & Fitzgerald, 2007). And yet, they also had to deal with the confusion of their mother or father coming home from work after working in high COVID risk exposure situations and not being able to hug them or be around them. As in other situations of ambiguous loss and family stress, young children may become increasingly distressed and dysregulated and will benefit significantly from having a parent or consistent caregiver with them for support (Gorman & Fitzgerald, 2007). Internationally, losses of parents, grandparents, and primary caregivers continued to increase during COVID. An international study based on WHO data estimated that 10.5 million children lost a parent or caregiver through May 1, 2022. Further, COVID orphaned an estimated 7.5 million of those children (Hillis, et al., 2022). These were large and rapid increases from the prior estimate of 5.2 million children who lost a parent or caregiver from the start of the pandemic until October 31, 2021 (Belllandi, 2022). As mentioned above, there were many disparities in numbers and rates of infection and deaths related to socioeconomic status, ability to provide seclusion, and access to medical care.

As noted, it is important in providing sensitive support and consistent caregiving for young children for them to have a schedule—with a regular time for waking up, having breakfast, and for those old enough, a time to go to an in-person or virtual childcare program, preschool, or school. Also as noted, often it may have been difficult for parents to implement a consistent schedule as their work schedule was also continually changing. All of these alterations in the usual day-to-day lives of infants and young children occurred concurrently with fear of the disease infecting them or a member of the family and continual economic pressures leading to more anxiety and stress for families and for the children (Liu et al., 2020; Rapid Survey Project, 2023) (Fig. 23.1).

The Impact of the COVID Pandemic Compared with Natural Disasters

While the psychological and social impact of the COVID pandemic shares some similarities to past natural and technological disasters, there are also major differences that need to be considered to support response and recovery for both individuals and communities (Pfefferbaum & North, 2020; Osofsky et al., 2020). One major difference is that natural disasters impact designated regions of a community, county, state, or country allowing those not impacted to be available to help with recovery. A second difference is that it is possible to predict, with some variations, the duration of natural and technological disasters. However, with the COVID pandemic, the duration and, therefore, the recovery process and ramifications, have been far less certain. Third, and perhaps most important, is that recovery from natural and technological disasters is helped to a great extent by supportive in-person relationships that have been unavailable during COVID (Masten & Barnes, 2018; Masten et al., 2015; Osofsky et al., 2014a, b, 2020). When a natural disaster occurred during the pandemic, evacuations were more problematic. Given the need for social distancing, transportation and finding a safe place to stay was more difficult. Health resources may be more difficult to obtain being closed during the pandemic. Further, the impact of the COVID pandemic could be particularly severe for the millions of people whose lives have been previously disrupted by natural and technological disasters over the past several years and who may experience new disruptions after being temporarily or permanently displaced because of disasters. The economic impact of the pandemic may be even more severe for these families and their young children. In addition, preschools and childcare centers that are so helpful for children's recovery and family support are unavailable.

Psychological and social well-being of children, parents, and caregivers has been affected significantly during the COVID pandemic by "stay at home" orders, social distancing, and other safety precautions needed to contain the pandemic that preclude social relationships (Osofsky et al., 2020). Further, the psychological and social impact is influenced by people's fears of becoming sick as well as having to cope with friends and family being sick and dying mostly alone from COVID. The number of fatalities from COVID has also taken a toll on psychological well-being. Following the very destructive Hurricane Katrina, Louisiana experienced an estimated 1700–2200 fatalities. In contrast, as of May 2020, there were already more than 2281 fatalities in Louisiana from COVID. The death rate for the African American population was 2.65 times the rate for all other groups. As with many major disasters, socioeconomic difficulties and preexisting health conditions are contributing to racial disparities in COVID (Gold et al., 2020). The mental health repercussions following destructive natural disasters like 2005 Hurricane Katrina have been significant with both adults and children reporting high incidences of depression, anxiety, posttraumatic



Supporting Infants, Young Children, and Families Related to COVID-19

COVID-19 Is Different

COVID-19 affects individuals and families in a different way from other disasters. Social distancing leads to isolation that disrupts lives and undermines emotional wellbeing. The continuing uncertainty disrupts lives and usual and expectable routines

Common Reactions in Young Children

Frequent crying

Sleep problems – difficulty falling asleep and staying

Clinging to their caregivers

Fears of being alone

Repetitive play (they may try to take special care of their dolls or stuffed animals and hide or cover them).

Behavior and emotion dysregulation - anger, aggression, withdrawal

Regression- some may act like younger children, lose their toilet training, refuse to eat, talk like a much younger child.

Young children are very sensitive to the stress experienced by their parents/caregivers.

What is most important to help young children and families?

1. Routines – new schedules for the "new normal"

It is important to have a schedule in place. Create a feeling of safety for children by offering certainty and reliability in daily structures.

- Time to get up
- Mealtimes
- Bedtime
- Time for play
- Time with parents for play
- Virtual communication with family & friends

2. Be flexible

- Try to be emotionally available
- Practice self-care, if possible.
- Limit media exposure for you and the children to limit stressors.
- Young children can feel caregiver's stress

3. Children need a secure relationship where they can feel safe and express feelings

4. Listening to the young child and "being present" is very important

- Clarify misunderstandings
- Help them feel safe and secure
- Share information in language they can understand
- Explain why they can't go out to the playground and why they can't go to day care or preschool
- Talk about positive things they can do – washing hands, "virtual hugs"

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Fig. 23.1 Supporting infants, young children, and families

stress disorder, and substance abuse that went down slowly over time with growing family and community stability (Kessler et al., 2008; Osofsky et al., 2009, 2015a, b).

The results have been somewhat different with COVID. Reports indicate that COVID in the United States is impacting mental health with increases in anxiety, depression, posttraumatic stress disorder, substance use, and an exacerbation of previous mental health problems (Pfefferbaum & North, 2020; Galea et al., 2020). However, a gradual decline in symptoms was not noted during COVID. For example, anxiety, including social anxiety, remained high. In addition, death from substance abuse overdoses increased during the lockdown with mandated isolation to prevent infection. In June 2023, substantiating mental health concerns in the United States, the US Senate HELP Committee conducted a hearing on the Child Mental Health Crisis. The usual responses following natural and technological disasters that include in-person crisis counseling and Psychological First Aid (Ruzek et al., 2007) was provided remotely. However, with generally limited outreach support for young children and families during the COVID pandemic, parents and families had to deal with the stresses of temporary or permanent layoffs, decline in income, having to provide remote learning for children, and worries about illness and possible death. Mental health support also focuses on the importance of establishing new routines and schedules for daily life including a schedule for meals, self-care, and time with children for not only virtual schoolwork but also for positive play or conversation. The new routines also need to include virtual ways to maintain friendships and family relationships using telephone or social media if available. While systematic reporting has been hampered with Stay-at-Home orders, concerns have been raised about possible increases in child abuse and domestic violence with perpetrators and victims living in close quarters (Campbell, 2020). Additional stress is contributed by family members not being able to be with loved ones when they are severely ill or dying from the virus as well as older adults living at home, in nursing homes, or retirement communities. With such losses, the remaining caregivers have had to find ways to support the young child while also grieving themselves. These figures and inequities are also likely related to having less access to care. Further, limited healthcare which has contributed to a higher percentage of underlying conditions such as heart disease, hypertension, diabetes, and respiratory problems places them at higher risk if they become sick with COVID. The COVID pandemic is an unmitigated disaster in many ways comparable but worse than traditionally defined natural and technological disasters.

It is also important to consider the effects of the COVID pandemic in relation to other natural and technological disasters as the COVID pandemic is considered a disaster, but one of a different type. The COVID pandemic caused much disruption, stress, and tragedy like that caused by disasters and wars which will be considered below. For example, comparing the outcomes for young children and families following a natural disaster like the 2005 Hurricane Katrina (Masten & Osofsky, 2010) and/or the natural disaster or the 2010 earthquake and, tsunami in Japan, and then the consequential technological disaster caused by the damage to the Fukushima Daichi Nuclear plant resulting in much disruption and many fears for those families living near the Fukushima Daichi Nuclear plant in Japan on March 11, 2011 (Harada et al., 2014). Like other natural and technological disasters, these events resulted in separation of families and fears for safety due to radiation in the environment. Much effort was made with families to help relieve the emotional damage of both Hurricane Katrina (Osofsky & Osofsky, 2023) and the Fukushima nuclear power plant accident. After both disasters, efforts were made to support the children. After the nuclear disaster, mothers played a key role in measuring the level of radiation in the air in order to help protect their children and themselves from radiation exposure when living in these areas. Some individuals have shared in narrative reports that many people even 12 years later are still suffering from anxiety and continuing concerns about the level of exposure to radiation (Nakayama et al., 2019). Some have compared their experiences to others who live in war zones due to the continuing worries that mothers and children, as they grow older, share about being exposed to uncontrolled radiation in the environment where they live. Traditional Asian approaches to mental healthcare were put in place with "Narrative Therapy for the Mothers and Children in Fukushima" as a way to provide support and protection for families living in this environment. A Citizens' Radiation Measurement Center was established by mothers who were residents in the Fukushima area to protect the health and livelihood of local children and people against the damage due to radiation exposure (http://fukushimaontheglobe.com/citizens-movement/radiation-measurement-by-citizens, accessed August 17, 2023). Their goal was to help relieve the emotional damage of survivors of the Fukushima nuclear accident, especially the mothers and children still living in evacuation. The group, many of whom were mothers, monitored environmental contamination by radiation that cannot be seen, smelled, or felt and the group establishing a large center continued to carry out activities safely and lessen concerns thinking about the distant future for them and for the children. They felt strongly that they needed to have more information and control the radiation exposure for themselves and for their children. This special space that they established was also a safe space for mothers and for children to tell their stories and to heal through sharing. Interestingly, the Crisis Counseling team in Louisiana and our team from Louisiana State University Health Sciences Center found a similar approach to be very helpful for children and parents following the devastation and losses after Hurricane Katrina and was supportive of the efforts in Japan to build the center.

Young Children's Exposure to War During the COVID Pandemic

Early in the pandemic, the Secretary General of the United Nations issued a proclamation calling for a cease fire in all conflicts during the pandemic. Shortly afterward, the President of the World Health Organization issued a call for peace. Instead, there were increases in armed conflict during the pandemic. Armed conflict increased dramatically in a number of countries including Afghanistan, Nigeria, Sudan, and Mozambique. At the end of 2021, the Save the Children report documented that almost 200,000,000 children were living in areas of armed conflict and that 400 million children were living in areas near armed conflict (Gorman & Fitzgerald, 2007; Keren et al., 2019; Lyons-Ruth et al., 2017). Young children in war zones are impacted by trauma, loss of life—including family members—parental stress, and coping, lack of nutrition, unsanitary living conditions, and water supply, destruction of healthcare and educational facilities, and unexpected and unpredictable sounds of shelling and violence. In addition to health problems and adverse educational impact, they frequently exhibit emotional dysregulation. They may also suffer from the policies of powerful perpetrators. Some barriers for conflict increased in many countries, including Mozambique, Afghanistan, and others. It is important to recognize the importance of protecting children in wartime and during other unpredictable situations as WAIMH has proposed by developing a position paper on infants' rights in wartime (Keren et al., 2019).

In 2022, in the month after Russia invaded Ukraine, over 1/2 of the children were rushed out of the country for their protection. However, this forced deportment resulted in them living in unfamiliar circumstances, frequently with less available resources and money. Children remaining in Ukraine were exposed to the trauma of war, including air pollution from bombings, fires, leaks of ammonia and gas, contamination of water, and destruction all around them. Hospitals, including hospitals in underground bomb shelters, were bombed. During that time, other atrocities occurred to 250,000 women who were pregnant. A delivery room and a neonatal area were bombarded with a loss of life for both mothers and infants. As with other wartime zones, it is anticipated that the incidence of the COVID infection will be greater. However, when the conflict ends, young children will again be innocent victims.

COVID and Pregnancy

During the early phase of the COVID pandemic, there was limited information about questions of concern to the pregnant mother about herself and her baby. After the vaccines were developed, there was also initial concern about whether they should be taken during pregnancy and worry about possible side effects. Multiple studies have indicated that COVID is not more common during pregnancy, but that the infection may be more severe (Allotey et al., 2020). Especially with the Delta variant, more pregnant women with COVID infection required intensive care and ventilation, with death somewhat more likely. Also, infants were more likely to be born prematurely. Neurodevelopmental difficulties appeared to be more common in the infants during the first year of life, but with improvement over time. There is considerable evidence that boys are more likely to have neurodevelopmental problems than girls (May et al., 2019). Breastfeeding appears to be safe, with benefits for neonatal immunity, and without complications, especially if proper precautions for cleanliness were followed, including masking when indicated. We have also learned that Moderna and Pfizer vaccinations are safe during pregnancy. There have been no significant side effects that impacted on the pregnancy or the infant, and they reduced both the incidence and severity of infection during pregnancy. Precautions that were deemed necessary during the height of the pandemic, including restrictions on visitors and spouses or partners, masking and social distancing, created burdens for many pregnant women, with increased anxiety and depressive symptoms and reduced social support.

The Rapid Assessment of Pandemic Impact on Development Early Childhood Survey, that was designed to collect essential information from households and families of young children during COVID, indicated that the level of emotional distress in households for both parents and children was related to the number of material hardships encountered (Zalewski et al., 2023). These concerns contributed to increased stress during pregnancy as well.

Supporting Resilience in Young Children During the COVID Pandemic

Infants, young children, and families around the world have experienced much adversity during the COVID pandemic due to the indefinite uncertainty. Masten et al. (2015) emphasized that some young children, especially with support from parents and caregivers, can adapt and recover showing resilience, while others have a more difficult time adjusting. Response and recovery depend on several different factors including the extent of the impact on the young child and family and especially the support provided by family and others.

Resilience in young children depends on caring, engaged and nurturing family members, close relationships with emotional security and a sense of belonging, planning and problem-solving, family flexibility, ability to self-regulate including emotions, hope and optimism, coherence and understanding of what is happening, routines and rituals. Engagement in school is also important for children who are a little older, as are well-functioning communities that provide support, promotion, and protection for children and families.

One of the factors that made it more difficult for young children to show resilience during the pandemic related to the significant impact on parents and families, especially those with fewer resources. Unfortunately, the usual supports provided by childcare centers and preschools, relatives, friends, and community supports were not available during COVID due to the lockdowns and social distancing requirements to keep children and families safe and healthy. The components leading to increased self-efficacy and resilience with a supportive infrastructure at the community level were generally not available during COVID. To support resilience for young children, it is crucial to provide support for parents and families during any disaster, including the COVID pandemic. Masten (2021) considers risks, assets, and adaptive systems in a multisystem perspective to support resilience. The following components are important to support resilience: (1) caring family with sensitive caregiving (nurturing family members); (2) close relationships; (3) emotional security, belonging (family cohesion, belonging); (4) skilled parenting (skilled family management); (5) skilled parenting (skilled family management); (6) agency, motivation to adapt (active coping, mastery); (7) problem-solving skills, planning, executive function skills (collaborative problem-solving, family flexibility); (8) self-regulation skills, emotion regulation (co-regulation, balancing family needs); (9) self-efficacy, positive view of the self or identity (positive views of family and family identity); (10) hope, faith, optimism (hope, faith, optimism, and positive family outlook); (11) meaning-making, belief life has meaning (coherence, family purpose, collective meaning-making); (12) routines and rituals (family routines and rituals, family role organization); (13) engagement in a well-functioning school; and (14) connections with well-functioning communities.

Summary and Key Points

The COVID pandemic has had a significant impact on young children and families, especially those with fewer resources. Adaptation to the lockdown, social distancing, changing schedules, alternative child-rearing and work schedules, and schooling was easier to adapt to if a family had more resources that included the ability to work virtually, internet access, and virtual platforms for education and interactions. Children of all ages need to be able to communicate with family and friends for positive development. For infants and young children, consistent parental and caregiver relationships are crucial for all aspects of their development including social, emotional, and cognitive development including their behavior and emotion regulation. During the pandemic, virtual resources were important to allow young children the ability to visit with grandparents, family, and friends. Further, those families with more resources were better able to access medical care and experienced fewer losses. In this chapter, we included information about experiences of young children and parents or caregivers during natural disasters and the COVID pandemic, differences in the experience of young children living in war zones during the pandemic, and the different ways that loss of a parent or caregiver impacts on young children and ways to support them. We also elaborated on ways to support resilience and more positive outcomes for young children experiencing adversity. Infants and young children demonstrate resilience with support from parents and caregivers and those with more resources during the pandemic were better able to practice self-care. The COVID pandemic was very different from natural disasters related to having a broader impact in different ways and also not allowing for the usual in-person support that is so important for recovery. To support resilience, what is most important is a consistent emotionally available caregiver to listen to and be with the young child. It is crucial that the needs of young children and families become an important component of disaster planning in order to support resilience. COVID had characteristics of a disaster, and therefore, recovery includes a community approach involving schools, parents, and caregivers (who themselves may be traumatized), community providers, spiritual leaders, schools, and other supportive groups. The focus needs to be placed not only on the expectable and developmentally related regressive symptoms and behavioral dysregulation in young children but also on those factors that will build resilience and inevitably will support recovery. Interventions should focus on efforts that will be universally helpful, those that should be targeted for young children with specific reactions, and those that are useful for children with preexisting and long-term difficulties. It is important to include a community participatory approach in the establishment of supportive services. Respect needs to be given to the strengths and cultures of the impacted communities. To support resilience, more attention should be given to individual and community resilience as well as an effective response to support recovery across systems.

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The Paradigm Shift to Early Relational Health: From Disease Prevention to Promotion of Optimal Development

24

David W. Willis, Kay Johnson, and Nichole Paradis

Over the last century, child health and public health systems across the world have made remarkable progress in advancing child health and survival, including improved obstetrical care, improved infant nutrition, and the elimination of the historically common and often deadly childhood infectious diseases. Universal childhood vaccination initiatives led to worldwide reductions of childhood mortalities. By the late twentieth century, the increasing survival of children from previously fatal illnesses and the rise of children with chronic conditions and disabilities stimulated the development of the medical home model and expanded care coordination to meet the needs of these children with special healthcare needs (CSHCN) (Ziring et al., 1999). This expanded standard of care was largely developed in response to the leadership of families advocating for the needs of their children (McPherson & Arango, 1998). Leaders in pediatrics also began to discuss the importance of broadening the medical home to address the "new morbidities" in pediatrics that included children with developmental and behavioral problems, and the growing awareness of the health risks exacerbated by social, community, and environmental factors, which has come to be called the social determinants of health (Haggerty, 1995).

Child Health System's Role in the Promotion of Social-Emotional Well-Being

During the last three decades, advances in child health care have simultaneously witnessed the shift of its prevention and promotion focus toward optimizing child development (Schor, 2010). As the science of child and neurodevelopment has advanced, there has been a growing consensus in pediatrics of the pediatrician's role in the universal promotion of early brain and child development. In addition, there has been increased focus on the prevention of the disparities that arise from increasingly understood powerful impacts of adverse childhood experiences (ACEs) that arise from poverty, racism, and disadvantaged communities (National Academies of Science, Engineering and Medicine (NASEM), 2019a, b, c; Shonkoff et al., 2021, 2012). The expanded awareness of the impacts of adverse childhood experiences (ACEs) on future health, development, and mental health became a part of

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the trauma-informed movement in pediatric preventive care (Bethell et al., 2017; Felitti, 2009).

In the United States, the American Academy of Pediatrics (AAP) (a private professional organization of over 67,000 pediatricians), in partnership with the US Department of Health and Human Services (HHS) and Health Resources and Services Administration (HRSA), worked to codify, articulate, and standardize this expanding focus on child development, prevention, including the expanded immunization schedule, with its published and iterated *Bright Futures* guidelines (Hagan et al., 2017). Not only do the guidelines help define important promotion and prevention activities for well-child visits in health care, but also they elevate promotion, early identification, and interventions for supporting child development. Specific recommendations for developmental screening within the context of well-child care have become an expected quality standard for pediatric care in the United States. However, they have not yet been fully adopted in practice, despite many years of initiatives and investments at federal, state, and local levels (Council on Children with Disabilities et al., 2006). Many forces have slowed progress, including: no generally agreed upon equitable developmental screening tools; limited access to developmental intervention services; failed referral and intake systems for identified families; insufficient available time in well-child visits; and a child health system designed and reimbursed for the rapid delivery of immunizations and acute and chronic illness healthcare, rather than the promotion of child well-being (Elansary & Silverstein, 2020). Despite these challenges, the child health system in the United States remains a universal population-based system in support of child development with activities within the medical home for the promotion, prevention, and early identification of developmental health. More than 90% of children have annual visits to a health provider in the first 3 years in the states. And other global nations with strong primary care systems for maternal child health, including midwives, doula's, home visitors, and an emphasis on education, show greater positive outcomes (i.e., Norway, the Netherlands, England, etc.) (Tikkanen et al., 2020). And addressing global human development, the World Health Organization (WHO) has articulated its Global Strategy (2016–2030) as a platform to accelerate the health-related Millennium Development Goals, putting woman, children, and adolescents at the heart of the new UN Sustainable Development Goals (SDGs) (Kuruvilla et al., 2016). These efforts to support the well-being of woman have direct impacts on the well-being of their children, though their more positive relational experiences.

Traditionally, the observation and monitoring of child development has been understood and defined by the five developmental domains: gross motor, fine motor, language, cognitive, and social-emotional. Developmental screening tools capture each of these domains. With greater focus on child development and well-being among educators, policymakers, and communities came growing recognition of the vast numbers of young children who demonstrated developmental risks or delays. Many young children arrived at preschool and kindergarten with lost potential and often startling disparities based on race/ethnicity and income status. After more than 30 years of effort where some communities have demonstrated strong developmental screening initiatives and responsive early intervention systems, progress at a population level to advance developmental well-being by school entry remained disappointing. Simultaneously, the United States and other nations witnessed a rise in behavioral, social-emotional delays, and childhood mental health disorders in many communities. Two seminal National Academies of Science, Engineering and Medicine (NASEM) consensus studies *From Neurons to Neighborhoods* and *Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity* identified the key drivers of these disparities: poverty, racism, trauma and community violence, and poor investments for families and communities (Institute of Medicine, 2000; NASEM, 2019b). And with the global leadership of the WHO and UNICEF, family policies and the Sustainable Development Goals are all focused on supporting the well-being of mothers in the care of their infants and children (Richardson et al., 2020). Each authoritative report emphasizes the role of the child health system in addressing the promotion of social-emotional development and the importance of nurturing care for prevention, early identification, and early intervention for social-emotional delays and mental health disturbances. Moreover, child health transformation activities are increasingly focused on fostering social and emotional health, identifying risks to future developmental well-being, and providing early interventions within the medical home (Doyle et al., 2019). This expanded emphasis on social-emotional development and the social determinants of health within the medical home grew further in response to the rising behavioral and mental health challenges post-COVID (Racine et al., 2021).

Global Health: Early Childhood Development (ECD) and Nurturing Care Framework

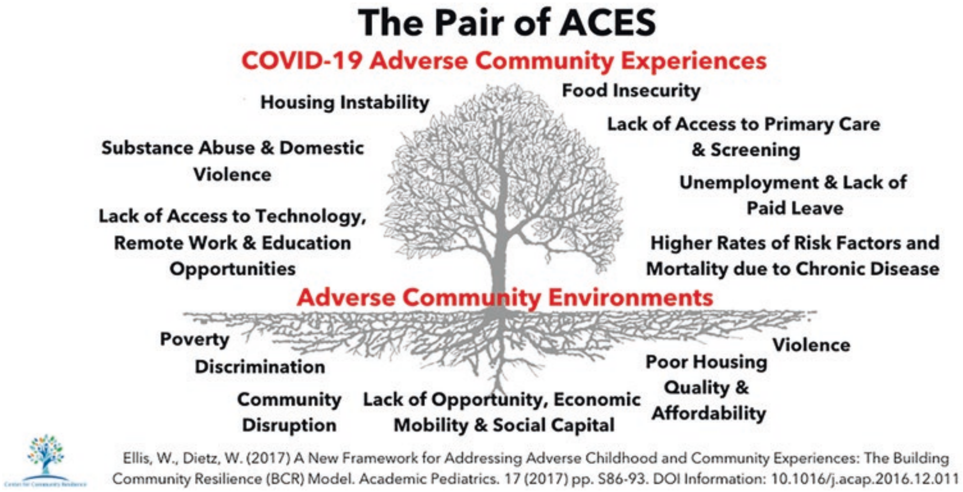
On the world stage, the World Bank, UNICEF, and international economic development leaders began to stress the critical importance of investing in early childhood for developing nations. Building from the known science, they began to articulate the critical and mutually necessary elements for early childhood development (ECD), which has become foundational for the emerging international ECD agenda (World Health Organization (WHO), United Nations Children's Fund (UNICEF), 2018). The G20 workgroup and others have gone on to define the environmental experiences necessary to promote healthy development—the Nuturing Care Framework—and have incorporated them within the Sustainable Development Goals and its global movement (Bernard van Leer Foundation, 2016; McCoy et al., 2021). The Nurturing Care Framework has identified and articulated a global definition for ideal care of young children through five interconnected components: nutrition, health, early learning, responsive caregiving, and safety and security (Britto et al., 2018). Specifically, the responsive caregiving component focuses on the importance of caregiver–child interactions that promote child development including social-emotional development (Jeong et al., 2021).

The Paradigm Shift to Early Relational Health

Child health systems worldwide are increasingly focused on promoting human development within the global Nurturing Care Framework for Early Childhood. And within the domain of responsive caregiving, a new paradigm has emerged that brings greater focus on supporting the foundational early relationships in partnership with families and communities for the promotion of health, development, and well-being (FrameWorks, 2020; Garner et al., 2021). In the United States, a new term and a new emphasis for early childhood systems have emerged—early relational health (ERH)—which is intended to capture the power of the convergence of knowledge, research, and experience from the fields of infant and early childhood mental health (IECMH), neurodevelopment, and related fields on the primacy of relationships, beginning even prenatally for child development and health. ERH has been an emergent and expanding concept over the last decade, elevating the centrality of positive, nurturing, and stimulating experiences as a key driver for the future health and well-being of children (Frosch et al., 2019; National Scientific Council, 2004). The term was first conceived by pediatric leaders on the AAP's Taskforce on Early Brain and Child Development in 2011 and appeared to be an important emerging framework to not only capture the current scientific knowledge of the influence of relational experiences to future health, development, and well-being but also to convey "that relationships are a new vital sign" in pediatric care. The new term was found to be galvanizing for thought leaders, providers, and policymakers in early childhood, and most importantly, meaningful to parents. As the use of this new term spread, it also came to represent an expanded equity framework for promoting health, development, and well-being, starting in early life with safe, stable, and nurturing relationships (SSNR) and an intentional focus on partnering with families and communities to address structural barriers to advance equity. The partnership with families to promote ERH elevated a simultaneous and essential focus on trust-building in the medical home. The ERH framing required too that providers create authentic relationships with families, engage family leaders with broad lived experiences, and develop systems for family partnership. The ERH framework has elevated the parallel contextual environments within which families live (including nonmedical determinants of health), which recognize the reality of racist, social-economic, historical trauma, and other community burdens that still far to often disrupt the flourishing of foundational relationships.

The ERH framework is more than a two-generational and attachment-based concept. It equally emphasizes the simultaneous influences of community context and the social, economic, racial, and cultural realities within which families live (FrameWorks, 2020). The foundational relationships that anchor ERH require safe, stable, and nurturing environments for the family within their neighborhoods, communities, and social networks. Addressing and changing these contexts is also essential for promoting ERH for the many families that live in under-resourced communities (Clark et al., 2022; Ellis et al., 2022).

The ERH framework also builds on the recently described Community Resilience model (Ellis et al., 2022). The Center for Community Resilience at George Washington University has developed the visual metaphor of the *Pair of ACEs Tree* which depicts the interconnectedness of adverse community environments—the soil in which children's lives are rooted—and the challenges to ERH from adverse childhood experiences (ACEs)—the branches that promote and protect the growth of healthy children and families dependent on such roots. *The Pair of ACEs Tree* depicts the interface between adverse community and childhood experiences. It also brings emphasis beyond the family-level relational experiences, including personal and family traumas, to the equally important community-level factors—historical, institutional, and structural—and socio-political factors that continue to exert forces that may disrupt family and child well-being. Further, the *Pair of ACEs Tree* visualizes multitiered solutions that promote better family lives and outcomes. In short, the *Pair of ACEs Tree* model encourages all early childhood stakeholders to think beyond only addressing individual family challenges, but toward enriching community context, changing racist systems, and realizing equity at all levels—the nutrients in the soil that advance ERH.



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-93. DOI Information: 10.1016/j.acap.2016.12.011

The pair of ACEs graphic

Strongly signaling the importance of ERH, the AAP released an updated professional policy statement in August 2021 that called for pediatric care to focus on safe, stable, and nurturing relationships (SSNRs) in order to buffer adversity and build resilience. The AAP statement emphasized that pediatric care is on the cusp of a paradigm shift that will reprioritize clinical activities, rewrite research agendas, and realign our collective advocacy (Garner et al., 2021). This updated statement from pediatric leaders was years in the making and focused on promoting relational health in partnership with communities and families. This call for a paradigm shift came at the same moment as the converging forces surrounding the global COVID-19 pandemic of 2020–2022: the public health emergency, the associated economic downturn, the racial justice awakening, the political upheavals, and the existential threat of climate change. The stress on families, communities, and nations has been well documented and relates to young families, the disruption of some parents' capacities to provide safe, stable, and nurturing relationships (SSNRs) and environments for their young children (Fisher et al., 2021; Racine et al., 2021).

Infant and Early Childhood Mental Health and ERH

The Centrality of Relationships in Infant and Early Childhood Mental Health

The term infant and early childhood mental health (IECMH) is grounded in development and attachment science and used in a variety of contexts. It refers to the developing capacity to experience, regulate, and express emotions, to form close relationships, and to explore the environment and learn (ZERO TO THREE Infant Mental Health Task Force Steering Committee, 2001). It can also refer to the study of the factors that impact an infant/young child's mental health. And it sometimes refers to the relationship-based, two-generation interventions used to treat mental and behavioral health disorders of infants and young children. Its primary definition intersects with the definition of ERH as noted in the position paper on the rights of infants from the World Association for Infant Mental Health (WAIMH):

> Caregiving relationships that are sensitive and responsive to infant needs are critical to human development and thereby constitute a basic right of infancy. The infant therefore has the right to have his/her most important primary caregiver relationships recognized and understood, with the continuity of attachment valued and protected—especially in circumstances of parental separation and loss. This implies giving attention to unique ways that infants express themselves and educating mothers, fathers, caregivers, and professionals in their recognition of relationship-based attachment behaviors. (WAIMH, 2016)

Racism and other systems of oppression are an endemic, global threat to the families of infants and young children with consequences related to IECMH. In her keynote address at the 2022 ZERO TO THREE Annual Conference, Dr. Barbara Stroud encouraged participants to consider the impact of family culture, as well as the impact of systemic racism and inequities on IECMH:

> Family culture is present in all caregiving interactions. It is within culturally informed relationships that all development unfolds. Children learn to experience, regulate, and express emotions as defined by their cultural communities. Children form protective relationships with caregivers that can ensure their safety within inequitable and racist environments.

IECMH-informed approaches can play an important role in dismantling systems of oppression that impact babies and families. The Diversity-Informed Tenets for Work with Infants, Children, and Families "encourage and guide the IECMH workforce to strengthen self-awareness, champion the rights of infants and children, acknowledge privilege and combat discrimination, respect nondominant bodies of knowledge, honor diverse family structures, understand the power of language to hurt or heal, support families in their preferred language, allocate resources that promote systems change, and advocate for policies that support all families" (Thomas et al., 2019).

Both ERH and IECMH center the power of early relationships—that nurturing, sensitive caregiving relationships can offer protection and that the absence of them can cause harm. Both concepts acknowledge the role that culture plays and the impact that racism and other systems of oppression can have on infants, young children, caregivers, and families. There are also some distinctions between the concepts. The presence of the word "infant" in IECMH emphasizes that even newborns experience a full range of human emotions. And although they retrieve memories from infancy differently from memories acquired after language has developed, humans do remember and can be profoundly impacted by their earliest experiences. But what is missing from the term IECMH is the emphasis on relationships and the power they hold to buffer or contribute to the earliest adverse experiences. ERH emphasizes the promotion of nurturing *relationships* between parents and infants. The inclusion of IECMH in broader conversations assures an intentional focus on the experiences of the *infant* in the context of their relationships. And IECMH offers approaches when caregiving relationships are negatively impacted by trauma (including historical trauma), unresponsive caregiving, separation, grief, loss, the presence of disabilities, and the presence of substance use disorders. These approaches also center relationships; practitioners offer a therapeutic relationship to the caregivers addressing the caregivers' needs so that they are better equipped to meet the needs of the infant/young child and buffering the impact of ACEs (Riggs et al., 2022; Weatherston & Tableman, 2015).

In addition, the ERH framework (like IECMH) also emphasizes the bidirectional nature of the parent–child relationship. Parents, too, experience the benefit of an attuned, nurturing, and safe relationship not only subjectively but also at the neurodevelopmental level (Abraham et al., 2016; FrameWorks, 2020). The brain changes for mothers as they develop their nurturing care experiences with their infants (Gholampour et al., 2020). In addition, recent neuropsychological research has begun to show the impact of ERH interventions on maternal intersubjectivity and improved maternal mental well-being (Li & Julian, 2012). A review and analysis of the key components of interventions for mothers with serious perinatal mental health disorders and their infants reported that successful interventions included facilitation of positive mother-to-infant interactions, helping mothers to understand their infant's perspective or inner world, and the use of video feedback (Newton et al., 2020). And it also appears that sensitive and attuned maternal caretaking of her infant, despite her own elevated perinatal emotional distress, is protective to her on her child's development (Grande et al., 2021). The early relational context has positive benefits for both infant and the caregiver, a key perspective captured in the ERH framework.

ERH can open a door in conversations about what babies and families need and then open it further to increase awareness that mental health issues also apply to infants. And that ERH and IECMH-informed approaches exist that can support families faced with adversity and complex circumstances. Both ERH and IECMH offer opportunities to see and understand the relational needs of infants and young children from different, yet complementary, perspectives.

Research and Measurement

Research Supports How the Early Relational Experiences Impact Future Health, Development, and Well-Being

Decades of research within the fields of child development, neurodevelopment, and infant mental health have irrefutably demonstrated that early relational experiences matter for optimal child development, neurodevelopment, and social-emotional development of all children (National Scientific Council, 2004; NASEM, 2019a, b). The impact of adverse childhood experiences on long-term health and developmental outcomes has also been well-established, when such toxic stress within an individual child is not buffered by safe, stable, and nurturing relationships with caregivers (Felitti, 2009). Yet, as research has progressed, our understanding of childhood development has demonstrated the equally important protective effects of positive childhood experiences, even in the face of adversity (Bethell et al., 2019a, b; Sege & Harper Browne, 2017). Population-level survey data also demonstrate the role of family resilience and connections in support of the importance of early relational experiences for a child to flourish (Bethell et al., 2019a, b; Fuentes-Afflick et al., 2021). Similarly, population surveys demonstrate how social risks, relational risks, and their interactions early in life are associated with mental and behavioral health conditions among older children and youth (Bethell et al., 2022).

Advances in research techniques in neuroscience have emerged that bring new understanding to ERH, especially within studies of dyadic synchrony. Synchrony refers to the coordinated interplay of behavioral and physiological signals that reflect the bidirectional attunement of one partner to the other's psychophysiological, cognitive, emotional, and behavioral state (Azhari et al., 2019). A longitudinal study of maternal-newborn synchronous caregiving on later adult brain social processing has shown how the maternal-newborn contact enhanced social synchrony across the life course and predicted the brain's functional sensitivity and core structures for emotional-specific empathy (Ulmer Yaniv et al., 2021). From these early relational experiences, the later adult social brain activities, including the detection and sharing of the affective states of others, are postulated to underpin affective sharing and human attachment. For example, naturalistic studies of infant and adult interactions using simultaneous and continuous measures from functional near-infrared spectroscopy (fNIRS) have shown how parents and infants have time-locked neural couplings and moment-to-moment fluctuations of mutual gaze, joint attention to objects, infant emotion, and adult speech prosody (Piazza et al., 2019). These observed synchronous and dynamic patterns are unique to each dyad and a part of their ERH experiences.

ERH Promotion, Observation, and Measurement

As the concept of ERH spread, the need for scalable observational and measurement tools for ERH monitoring and measuring became apparent. New approaches with screening and monitoring tools for ERH offer opportunities to advance promotion, prevention, and early intervention efforts in partnership with families to improve child well-being and mental health, especially when co-developed with families (Willis et al., 2022). At the same time, many existing tools and questions have serious limitations. Tools that can be utilized for clinical purposes must be not only reliable, objective, and practical for providers, but, equally, they must be meaningful and acceptable to families. Similarly, questions used for population-level surveys must be valid, as well as culturally competent and respectful. Of course, any tools that attempt to screen and/or identify families where greater supports for ERH are needed run the risk of continuing to perpetuate the bias of blaming families for their challenges, or worse. It is the historical structural barriers, like poverty, racism, and discrimination, that deprive families of equal access to opportunity and the needed supports that contribute to their thriving (Dreyer, 2020; Thomas, 2022). In addition, many parent–infant observational tools used in research studies have been developed without family input, may reflect researcher bias, and often lack cross-cultural and population group validations. Most currently available parent–infant interaction tools (often designed for early childhood evaluations and research) are also not focused on observing and coding for the interactive patterns within the dyadic interactions that define ERH.

Recent reports in the literature describe newly designed, early relational observational tools that offer promise for wider adoption for ERH promotion and monitoring (Condon et al., 2022; Hane et al., 2019; Willis et al., 2022). Each has its strength and utility in particular settings, but as yet more study is needed for greater cross-cultural validation, utility in clinical practices, and most of all, acceptability by parents. Clinical application, implementation, and validations studies are underway, including co-design with family partners.

Families Experiences and Cultural Wisdom Advance ERH and Equity

Listening to the Voices of Families to Advance ERH

Listening to the voices of families about their hopes and dreams for their young families and their expectations of the child health system and family supports services is an essential approach to advancing equity and shifting the paradigm of services and caregiver supports in support of SSNRs. A number of studies point to the importance and power of listening to, engaging, and partnering with families (Condon et al., 2022; Thomas, 2022). Experts have called for use of more culturally relevant, strengths-based, and relational approaches. A qualitative study in Oregon with three parent/peer-lead focus groups (African American mothers in inner Northeast Portland; Spanish-speaking Latinx mothers in rural Oregon; and White mothers in an isolated rural community in Southern Oregon) sought guidance from parents about how the child health system might better support their family's ERH. All three groups overwhelming emphasized that families must feel respected, heard, and not judged by the providers of services (Center for Improvement of Child and Family Services, 2020).

Indigenous and Ancestral Knowledge of ERH

As the social and racial justice movement gained the attention of thought leaders, early childhood system leaders, and child development experts, cross-cultural, indigenous, and ancestral knowledge about ERH has begun to appear in the broad literature. As an example, the Indigenous Connectedness Framework advanced an indigenous worldview about the development of child well-being (Ullrich, 2019). Central to this framework is the core concept of connectedness that brings a deeper understanding of indigenous people's determination to restore the historical knowledge and cultural practices that promote child and family well-being. This framework poses that when children are able to engage in environmental, community, family, intergenerational, and spiritual connectedness, not only do children thrive but also a synergistic outcome emerges of the collective well-being for the community. For many indigenous people, ERH is embedded within this connectedness framework. A second example of ancestral knowledge about ERH comes from ethnological research and evolutionary anthropology that has been elevated within the concept of The Evolved Nest (Narvaez et al., 2021). The Evolved Nest perspective proposes an ecological system of care that has evolved within human cultures over thousands of years to potentiate both physical and psychological thriving and considered the foundations of cooperative and egalitarian societies. Interdisciplinary scholarship has revealed that humans functioned within partnership societies for 99% of their history (before about the last 10,000 years), and it is only in the last 1% of time that some societies shifted toward a dominance orientation. Ethnographic studies have also suggested that the societal orientation shift toward dominance over the more recent centuries appears to have brought about significant changes to infant care practices. What has been hypothesized as evolutionarily developed requirements for optimal development, and notably, sociomoral early childhood development, are now divergent from those ancestral practices. Those articulated practices, which current knowledge would say support ERH, include soothing perinatal experiences, breastfeeding, affectionate touch, responsive relationships, free play, positive climate, and social supports. Preliminary research at a cultural and societal level suggests that the preservation of these early relational practices is associated with improved child well-being (Gleason & Narvaez, 2019).

A Broad Policy Agenda to Support Families and ERH

Policies to Advance ERH

To accelerate the paradigm shift toward ERH will require substantial policy advances. Many different types of policies affect the well-being of infants, young children, and their families, including those that promote responsive relationships, health care, learning, nutrition, and safety. The United Nation's Global Strategy for Women's, Children's, And Adolescents' Health proposes an agenda focused on helping children survive (end preventable deaths), thrive (ensure health and well-being), and transform (enabling environments) (Tomlinson et al., 2019; United Nations, 2015). Researchers looking globally at ways to meet the Sustainable Development Goals (SDGs) concluded that comprehensive, multisectoral, and multilevel actions will be required to maximize future human capital, enhance resilience, mitigate adversities, and promote equity and human rights. Defined as a Nurturing Care Framework for all nations, the focus is on efforts that: (1) begin in the earliest years pregnancy to age three, (2) address major threats to early child development, (3) use nurturing care and early relationships to protect young children from the worst effects of adversity and promote development—physical, emotional, social, and cognitive; and (4) support what caregivers need in order to provide nurturing care for young children (Black et al., 2021; WHO, 2018).

This work requires a "whole of-government action" and a "whole-of-society approach" to promote nurturing care for young children (WHO, 2018). Policies include healthcare coverage and access, support for breastfeeding, paid parental leave, adequate income and wages, affordable childcare, quality early learning, effective social service and protection from maltreatment, and environmental health. Family-centered care and policies are recommended. Equity is a central principle, yet no one specific piece of legislation to create a new program is sufficient.

While in many countries, national policy action has a direct impact on the lives of the whole population of children and families, in the US decentralized, federalist policy structures, both national- and state-level changes will be required. Recent US government proposals to invest in families and communities offer unprecedented opportunities to reimagine health, early care and education, economic, housing, and other family-serving systems to reflect what children and families want and need. In particular, the COVID-era funding in FY 2020–2021 represented new investments in programs, services, and supports that can strengthen families and communities. These new governmental resources created the conditions for state and local governments to partner with families and communities in unprecedented ways to advance equity and strengthen ERH through effective policy implementation.

ERH in Health System Transformation

Child health system transformation to advance ERH on a population basis focus on improving families' safety and stability, providing an array of services that reflect ERH principles, developing more integrated systems of care, and advancing equity. The ERH policy agenda in the United States aims to create safe, stable, and nurturing relationships and environments for young children in the context of their cultural traditions and communities. It aims to advance the development of policies and programs that reduce the stressors and remove the structural barriers (e.g., limited time, income, racism, and safety) that affect parents' capacities to develop strong foundational relationships with their infants and toddlers. While the details about which specific policies need change will vary, all of the following ERH policy aims and principles could be used in those countries around the globe that have adopted the Nurturing Care Framework for their SDG early childhood advancements.

The high-level goals of the ERH policy agenda defined for the United States are to:

- Aim to *advance equity* in design, implementation, and practice of all policies.
- Support family *economic security and mobility* for multigenerational success, including paid family leave, child tax credits or allowances, and assistance to address insufficient food, housing, income, and other concrete needs.
- Train the *providers serving families* in ERH principles and best practices, including IECMH-informed, relational, strengths-based, and anti-racist approaches.
- Scale up and sustain *evidence-based interventions and community system innovations* that promote ERH. Currently available interventions have not been taken to scale, largely due to lack of sustainable public funding.
- Develop a diverse and well-trained *relational workforce* to support ERH, including community health workers, doulas, home visitors, physicians, nurses, childcare providers, and others.
- Advance *high-performing medical homes* using team-based, family-driven approaches, with relational care coordination.
- Increase access to *Infant and Early Childhood Mental Health (IECMH)* services, including promotion, prevention, and treatment for parents, infants, and young children together. Too often mental health conditions among caregivers and children birth to three have been left unaddressed by mental healthcare systems largely oriented to adolescents and adults with serious disorders and substance use problems.
- Strengthen *early childhood systems*, with linkages and coordination among health, family support, early care and education, home visiting, early intervention, mental health, housing, child welfare, and other services and informal supports. While no single early childhood system is defined by US public policy, the opportunity exists for all levels of government to support more comprehensive systems approaches.

One example is paid family leave. The United States is the only country among the 38 in the Organization for Economic Cooperation and Development (OECD) without a national paid family leave policy (OECD, 2022). On average across the 38 OECD countries, mothers are entitled to just under 19 weeks of paid maternity leave around the time of childbirth. While payment rates and types of leave vary across the OECD countries, most have created an entitlement for mothers and some for fathers. In recent years, US policymakers have continued to debate the merits of federal paid family leave. The debate has brought forth many facts that make clear how paid family leave is good for the parents and the baby, and yet there has been little discussion of another highly important fact: foundational relationships define the health, development, social, and mental well-being of both the parent and the baby, perhaps for a lifetime. These early relationships translate into ERH, which support a child's ability to learn, experience optimal development, and social-emotional skills. Without paid family leave, many parents miss the opportunities they want and need to nurture connections and develop strong foundational relationships with their newborns, and far too many face the stresses of trying to balance work and caregiving responsibilities. New policies should reflect and respect the value of the foundational early relationships for every family, of every race/ethnicity, and of every socioeconomic level. Paid family leave policy should be part of a social insurance system, that is, provide for all families and workers, be of meaningful amount and duration, and protect workers from discrimination and retaliation in the workplace.

Health policy to advance ERH matters for both parents and young children. In some other countries—particularly those that have signed the United Nations Convention on the Rights of the Child—all children have a right to health care (Rosenbaum et al., 2019). In 2019, the year of the 30th anniversary of the Convention on the Rights of the Child, a global alliance of child health providers and other advocates released a statement entitled "Time to Stand Up for Child Health," which called for greater progress toward the rights of the child to the highest attainable standards of health and for governments and health systems to prioritize sustained investments in children's health. Yet, health care is not considered a right in the United States, slowing progress at many levels.

Unlike many countries, the US healthcare system depends on both public and private, employer-based health coverage. Young children are more likely to have publicly financed health coverage guided by decisions in 50 states and less likely to have employer-based health coverage aligned with that of many parents. Medicaid, together with the Children's Health Insurance Program (CHIP), provides health coverage to more than 40% of all US births and infants and toddlers under age 3. Moreover, because they are more likely to have parents with low incomes or working in a job that does not offer dependent health coverage, six in ten US Black and Hispanic and indigenous infants are covered by Medicaid and CHIP (Artiga et al., 2020). As a result, Medicaid financing is important for health services, mental health services, parent–child dyadic interventions, and workforce development. At the same time, Medicaid is managed by states under broad federal rules and show substantial variation and inequities (Johnson, 2021; Schor & Johnson, 2021).

Policy and program changes are also essential to support workforce development, especially those who can provide relational support to young families. Around the world, community health workers are increasingly recognized as important and effective element of a healthcare workforce to support people in their efforts to seek health care, understand health information, and navigate a complex healthcare system (Crear-Perry et al., 2021). In the United States, however, only a handful of states are using their option under federal law to finance community health worker services for those enrolled in Medicaid. The policy changes adopted in Washington State in 2022 that will allow for Medicaid payment for community health workers in the pediatric medical home who focus on young children and ERH is an ERH policy breakthrough.

Healthcare transformation for young children requires participation of government, public and private payers, and the clinical providers who deliver services, in partnership with families. In creating a roadmap for "vibrant and healthy kids," the US National Academies of Science, Engineering, and Medicine (NASEM) called for public and private sector leadership to promote multidisciplinary team-based care models focused on integrating preconception, prenatal, and postpartum care with a whole family focus (NASEM, 2019b). The NASEM panel also called for more efforts to measure and improve quality, to expand efforts in workforce development, and to advance equity (Recommendation 5-2, NASEM, 2019b).

The High-Performing Medical Home Advances ERH

As discussed above, for decades, the concept of a medical home has been advanced as an approach for the delivery of comprehensive primary care that facilitates partnerships between patients, providers, and families (Agency for Healthcare Research and Quality (AHRQ), 2022) The AAP and key units of HHS all recommend that each child have a patient/family-centered medical home (PCMH). An increasing body of literature identifies the key characteristics of a medical home or PCMH. Today, the shared principles are generally defined as delivering primary care that is: patient- and family-centered, comprehensive, team-based, accessible, coordinated, and committed to quality, safety, and equity (Primary Care Collaborative, 2022).

Despite the documented advantages of having a medical home and its promotion by governmental, professional, and family advocacy organizations, too few US children have care that meets basic criteria for a medical home. The US National Survey of Children's Health (NSCH) criteria for a basic medical home are to have reported: (1) a personal doctor or nurse, (2) a usual source for sick care, (3) family-centered care, (4) few problems getting needed referrals, and (5) effective care coordination when needed (a composite based on 14 survey items). Data from the 2019–2020 National Survey of

Children's Health (NSCH) indicate that parents of children under six reported that 49% of their young children had a medical home that met basic criteria. Among children under age 18 who have publicly funded health coverage (primarily Medicaid), 38% had a medical home, compared to 56% of those with private health insurance and 27% of those who were uninsured (Child and Adolescent Health Measurement Initiative (CAHMI), 2022). A growing number of studies illuminate racial, ethnic, and income disparities in access to a medical home, with many using the National Survey of Children's Health (Barradas et al., 2012; Cordova-Ramos et al., 2022; Guerrero et al., 2018; Perrin et al., 2020). In addition, emerging models point to the importance of a change in design of the medical home. In particular, the paradigm shift to advance ERH will require new approaches to children's primary health care, which includes broadening to a team-based care model.

Recent descriptions of the "high-performing medical home" distinguishes it from common practices and a basic medical home, which focus primarily on medical needs and are limited in scope and impact (Johnson & Bruner, 2018). To advance the high-performing medical home and realize the paradigm shift for ERH, it will require changes and enhancements to practice design, better financing, and measurement approaches. Figure 24.1 illustrates the three areas of change in the design of a high-performing medical home. First, the design builds upon the US Bright Futures guidelines and recommendations to ensure delivery of all recommended screening and more strengths-based and family-driven health care in well-child visits. Second, it expands use of advanced team-based care models that allow for relational care coordination and effective referral, connection, and follow-up with other community resources. Third, child health-care practices and clinics would embed such models as Healthy Steps or DULCE placing an early childhood development expert or community health worker in the medical home team. These medical homes also embed Reach Out and Read (ROR) and may use integrated behavioral health that includes IECMH best practices. All of these changes are aimed at increasing use of strengths-based and relational approaches to address family resource needs, conduct necessary screenings, and ensure effective referrals. As use of the high-performing medical home and team-based care expand, they will be ready to adopt the new promotion, monitoring, and early identification advancements to advance ERH.

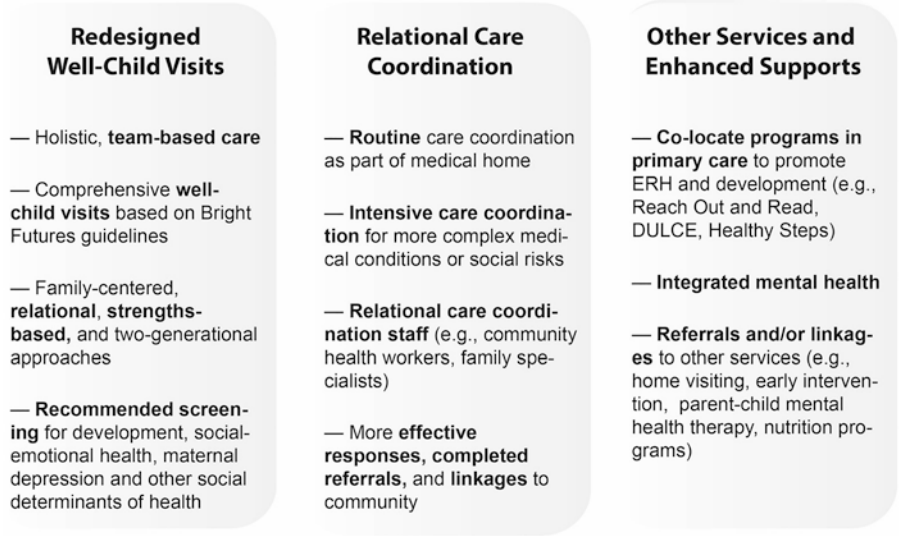
Place-Based Initiatives and Frameworks

The ERH Coordinating Hub at the Center for the Study of Social Policy has also articulated six elements of an integrated, equitable community, and child/family health system, in a Family-Centered Community Health System (FCCHS) model to advance ERH including:

1. A place-based approach for achieving population health with data that inform local decision-making
2. A local, coordinated early childhood system that works to dismantle structural inequities
3. High-performing medical homes that better support families
4. Parent leadership networks that hold programs and services systems accountable
5. Strategies that support ERH for improved life course outcomes
6. Vibrant and robust family- and community-led networks that support positive experiences for children and families

This aspirational model leads with parent leadership and power-sharing with programs, services, and communities all in support of those foundational relationships for ERH.

Place-based early childhood community initiatives are one way to promote community-wide change, working across sectors, and partnering with families in an all-in strategy to advance ERH (Jain et al., 2019; Masten & Barnes, 2018). For example, the *Pediatrics Supporting Parents (PSP) Initiative* (https://www.pediatricssupportingparents.org/) funded by a consortium of philanthropic organizations has identified and



Redesigned Well-Child Visits

— Holistic, **team-based care**

— Comprehensive **well-child visits** based on Bright Futures guidelines

— Family-centered, **relational**, **strengths-based,** and two-generational approaches

— **Recommended screening** for development, social-emotional health, maternal depression and other social determinants of health

Relational Care Coordination

— **Routine** care coordination as part of medical home

— **Intensive care coordination** for more complex medical conditions or social risks

— **Relational care coordination staff** (e.g., community health workers, family specialists)

— More **effective responses, completed referrals,** and **linkages** to community

Other Services and Enhanced Supports

— **Co-locate programs in primary care** to promote ERH and development (e.g., Reach Out and Read, DULCE, Healthy Steps)

— **Integrated mental health**

— **Referrals and/or linkages** to other services (e.g., home visiting, early intervention, parent-child mental health therapy, nutrition programs)

Fig. 24.1 The high-performing medical home advances ERH. (Adapted from Johnson and Bruner (2018))

provided funds for place-based action in five communities in the United States. The five proof point communities (Pierce County, WA; Onondaga, NY; Oakland, CA; Durham, NC; and UCLA, CA) funded within the Pediatrics Supporting Parents (PSP) Initiative are focused on linking child health systems, communities with family engagement to advance ERH over 4 years. The ERH Coordinating Hub is involved in this effort.

Another example of a place-based strategy is the *Bridgeport Baby Bundle*. Bridgeport, CT is a part of the STRIVE Together multiyear collective impact effort to address child and family well-being. Bridgeport is one of the poorest communities in the United States and nearly three out of four 3-year olds are already developmental behind by the time they enter HeadStart. Bridgeport's "baby bundle" represents a unified, cross-sector, neuroscience-informed approach to supporting *all* families with very young children. The bundle framework sought to strengthen and expand specific services at the community level for children, families, and the organizations that serve them. Importantly, the framework goes far beyond a single program or payment, including universal tools and strategies that require community-led design. The building blocks of the work were neuroscience, core community strategies, core community agency supports, and implementation science. Table 24.1 shows the core community strategies that emerged from community and parent leadership and represents the all-in ERH strategy. The first promising population data has emerging from this all-in ERH strategy of the Bridgeport Baby Bundle framework by the demonstration of meaningful improvements in child well-being for the first birth cohort as they enter preschool, 3 years later (Personal communication and government presentations).

The Relational Health Workforce

The relational health workforce includes an array of people whose primary responsibility is to foster relational health, through building relationships of trust, coaching, and modeling empathetic and nurturing relationships with children, youth, and families and increasing positive social relationships (Bruner, 2021). This requires an approach to workforce development across multiple disciplines and service sectors, including health, home visiting, early care and education, IECMH, behavioral health, child welfare, early intervention, and other sectors. Practices are relationship-based, culturally responsive, and

Table 24.1 Bridgeport's core community strategies

Supporting care and parenting (all primary caregivers)	Fostering deep neighborhood engagement and innovation	Strengthening civic engagement: an army of helpers and advocates	Building a resource portfolio (dollars, people, skills)	Tracking change. Measuring impact
The Bridgeport Basics Pregnancy and first year supports (group prenatal care/doulas/community health workers/home visiting) Universal developmental screening (Sparkler) & wellness check Early literacy (ROR) Infant and toddler family childcare (All Our Kin) Maternal wellness (MOMs Partnership)	Better practice: No wrong doo Respectful service Warm handoffs Trauma-informed workforce training Top to bottom (food and diapers) Music together: arts in early learning Seniors rock the babies (engaging elders)	Resilience showings and trauma-to-resilience training Walk for babies: The Bridgeport "Baby Brigade" Building champions: faith, health, higher education and giving sectors Parent leadership Bridgeport Sings	Reports on building the resource investment portfolio, including: (a) Medicaid funding (b) high-wealth donor development Resource analyses of state and local dollars and staff for Bridgeport babies	Demonstration site: National Interoperability Collaborative Bridgeport baby data collection Interagency data partnership Medicaid administrative data Linking developmental screening data to the Child Development Infoline (2–1–1) and pediatric offices

trauma-informed (Michigan Assocation of Infant Mental Health (MI-AIMH), 2017). Services are most often directed not at one member of a family but at the primary caregiving relationships that surround an infant or young child. There are competencies and standards that define best practice for IECMH that can be useful to the ERH workforce. The expansion of a skilled relational health workforce is a key strategy for advancing ERH. Healthcare settings can contribute to a child's and family's relational health while recognizing the importance of social connections, supports, and interactions in overall child and family health. This may be through a fully transformed high-performing medical home or by adopting even one step toward ERH practices along the journey of practice transformation. Additional ERH workforce activities include strengthening the community-based, relational health workforce such as doulas, community health workers, and home visitors. US policy and program change can support transformation especially by including improvements in Medicaid financing because of the scale of potential impact. Other nations committed to achieving the health-related Sustainable Development Goals are finding financing approaches for expanding a workforce with advance nurturing care and ERH, like community health workers (Crear-Perry et al., 2021).

Such efforts offer additional opportunities to emphasize the paradigm shift toward ERH in all training, messaging, and communications with families. The approaches to training and service are designed to enhance family engagement, trust, and partnerships with families and to combat all forms of bias, discrimination, and racism.

- The relational health workforce can be particularly effective in ensuring that young children and their families have a strong start by communicating in that moment of becoming new parents when they are most receptive and eager to learn about most important approaches to the daunting process of parenting, especially when delivered by a workforce of similar lived experiences.
- Partnering with families in their home offers an opportunity to bring a more trusted and equitable approach to promotion and prevention efforts.

- Earning a credential that documents competency, i.e., that specialized ERH and IECMH knowledge, skills, and experiences have been accrued and inform their work.

Advancing ERH Across Early Childhood Systems

In 2020, the ERH Hub conducted a survey of the early childhood field about its knowledge of ERH and its current activities (Willis et al., 2020). Among over 600 survey respondents, 22% noted that ERH, as a concept, was recognized both explicitly and implicitly, even though the term "ERH" was new and unfamiliar. More importantly, survey respondents provided a list of evidence-based and well-developed models and services that they understand to advance ERH (see Table 24.2). The ERH survey also made visible the importance of equity and the importance of engaging families of color, in particular, in co-design of ERH efforts.

Table 24.2 Early relational health-supporting models and services

Home visiting models and enhancements
Healthy Families America (HFA), Parents As Teachers (PAT), Nurse Family Partnership (NFP)`
Family Connects
DANCE in NFP, CHEERS in HFA
Child First
Parent education programs
Circle of Security-Parenting
NCAST
Strengthening Families Framework
VROOM
Talking is Teaching
Play and Learning Strategies (PAL)
Incredible Years
Growing Great Kids Curriculum
Lemonade for Life
Read/talk/sing
MOM Power
Nurturing Parenting
Triple P
Early care and education enhancements
Pyramid Plus approach
Head Start/Early Head Start
FIND
Touchpoints
DIR Training
High-performing medical home augmentations
Reach Out and Read
Promoting First Relationship
DULCE
HealthySteps
Video Interaction Project (VIP)
FAN Training
ERH screening and video feedback

Source: Adapted from Willis et al. (2020)

Summary and Key Points

Advancing early relational health (ERH) in the United States will require a paradigm shift across early care and education, family support, and health services and systems bringing the focus on safe, stable, and nurturing relational experiences to buffer and mitigate environmental stresses and promote well-being and flourishing. By listening to the lived experiences of families served, co-developing new approaches for partnering with families, and applying IECMH principles, the ERH framework also seeks to advance equity and strengths-based approaches. Research efforts are expanding to increase understanding of how to strengthen and support ERH for all families, and implementation research seeks to scale such activities across all child and family serving systems. Measuring and monitoring ERH must be done with due respect to both measurement science and family partnership. The ERH paradigm shift not only means addressing the historical and structural barriers that disrupt the thriving for all young families but also brings new policies, practices, and an expanded workforce to help to achieve the vision for the thriving of all children and families. In those nations around the world where national policies support universal health care and generous paid family leave, e.g., the Scandinavian countries and/or the Netherlands, the structural supports for ERH are more embedded in cultural and national policies. Yet, the emphasis on the essential emotional connections, foundational relationships, and maternal well-being remains universally important to support ERH and future well-being around the globe.

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Reflective Supervision: The State of the Field and Future Directions

25

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This chapter reviews the current state of the Reflective Supervision (RS) field. What is currently known about RS has been identified primarily by White professionals and often represents Euro-centered frames of reference. However, the literature is becoming more diverse, inclusive, and culturally grounded, and thus the field's understanding of RS is likely to shift, enrich, and lead to transformative future directions. In this pivotal moment in the Infant and Early Childhood Mental Health (IECMH) field, attention to both what is known and what is missing may be disconcerting.

A Touchpoint Moment in the Reflective Supervision Field

Readers are encouraged to consider this moment as a "touchpoint" in the field's development. Touchpoints in young children's development are defined as predictable periods of disruption that precede rapid developmental growth (Brazelton, 1992). This concept is used to prepare caregivers for a period of brief regression in development that can be confusing or alarming if not understood. The touchpoint can then be used as an opportunity to better understand both strengths and vulnerabilities and support a developmental leap (Brazelton, 1992). A developmental leap in a shared understanding of RS, including its definition, purpose, research, and how it is practiced in IECMH, is long overdue.

Defining Reflective Supervision

IECMH is a relatively young field, and RS is a relatively new practice. Both have origins in the theory and research on attachment, trauma, grief and loss, pregnancy, parenting, family dynamics, infant and young child development,

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psychodynamic principles, and the mental, behavioral, and developmental disorders of infants, young children, and adults. Reflective supervision (RS) has become a common practice for professionals who work with or on behalf of infants, young children, caregivers, and families. In this chapter, we use "professionals" to indicate anyone in the infant/early childhood workforce, regardless of field or degree.

A consistent description of RS within the IECMH field has been difficult to establish. For the purposes of this chapter, we use RS as inclusive of support through various formats: individual, group, in-person, virtual, provided by one's program supervisor, or provided by an outside consultant. The latter is sometimes referred to as reflective consultation. Some publications combine reflective supervision and reflective consultation with the RSC or RS/C acronym. Some in the IECMH field refer to "reflective facilitation" or "reflective practice." Such terms intentionally replace "supervision" to de-emphasize hierarchy and emphasize the collaborative nature of the practice. In some cases, replacing "supervision" may limit the legal liability of the provider (in some states in the United States, supervision is a legal term and implies oversight of case work; many states require a specific number of hours for licensures).

RS can include various facets and frameworks that align with the type of work and disciplinary perspectives within which it is implemented (Shahmoon-Shanok & Geller, 2009). However, the definition of RS embodies common threads across these disciplines that differentiate this type of support from others: a focus on all important relationships and the professional's emotional response to their work (Parlakian, 2001; Pawl, 1995). RS, as a professional development strategy, maintains a focus on the complexity of relationships within the IECMH system, including the relationships between the infant and caregivers, the caregivers and the professional, and the professional and the supervisor. Through consistent and regular meetings, the supervisor and supervisee develop a working relationship within which the supervisee can express a range of emotional responses to their work, along with their reflection on the experience of the young children and caregivers with whom they work (Pawl & St. John, 1998). Key components of emotional support, clarity of roles, honesty, trust, and safety within the supervisory relationship are essential to attain this level of reflection and knowledge (Barron et al., 2022b; Tomlin et al., 2014; Weatherston et al., 2020). RS offers opportunities to integrate knowledge into practice and support the well-being of the professional.

The Reflective Interaction Observation Scale (RIOS) is one framework that has defined IECMH-informed RS at a conversational level. The goal of its development was to operationalize essential components of RS that indicate quality and distinguish it from other types of supervision. The RIOS was created by collecting and summarizing the ideas of numerous IECMH clinical and research experts. It presents five topics of conversation (Essential Elements) focused on relationships (between family members, the baby/child, the professional, and the supervisor) and five Collaborative Tasks defining various depths of reflection (from describing what happened to synthesizing what was learned; Watson et al., 2022) (Fig. 25.1).

Three foundational elements have been identified as the building blocks of RS: reflection, collaboration, and regularity (Parlakian, 2001). Reflection is an opportunity to slow down to examine the thoughts and feelings that arise when working with a particular infant and family. Through opportunities to reflect on their work with another, RS can become a holding place for exploring the meaning and impact of relationships in the work. Collaboration emphasizes that RS is a relational and two-way process. That is, it is not the role of a reflective supervisor to impart knowledge to a supervisee, but rather an opportunity to work together to better understand and use their emotional responses within their work. Lastly, regularity acknowledges the importance of predictable, consistent meeting time that is protected from disruption and that occurs over a span of time during which a relationship between supervisor and supervisee can grow. These foundational elements build the framework of RS and help to define the ways it is distinct from other

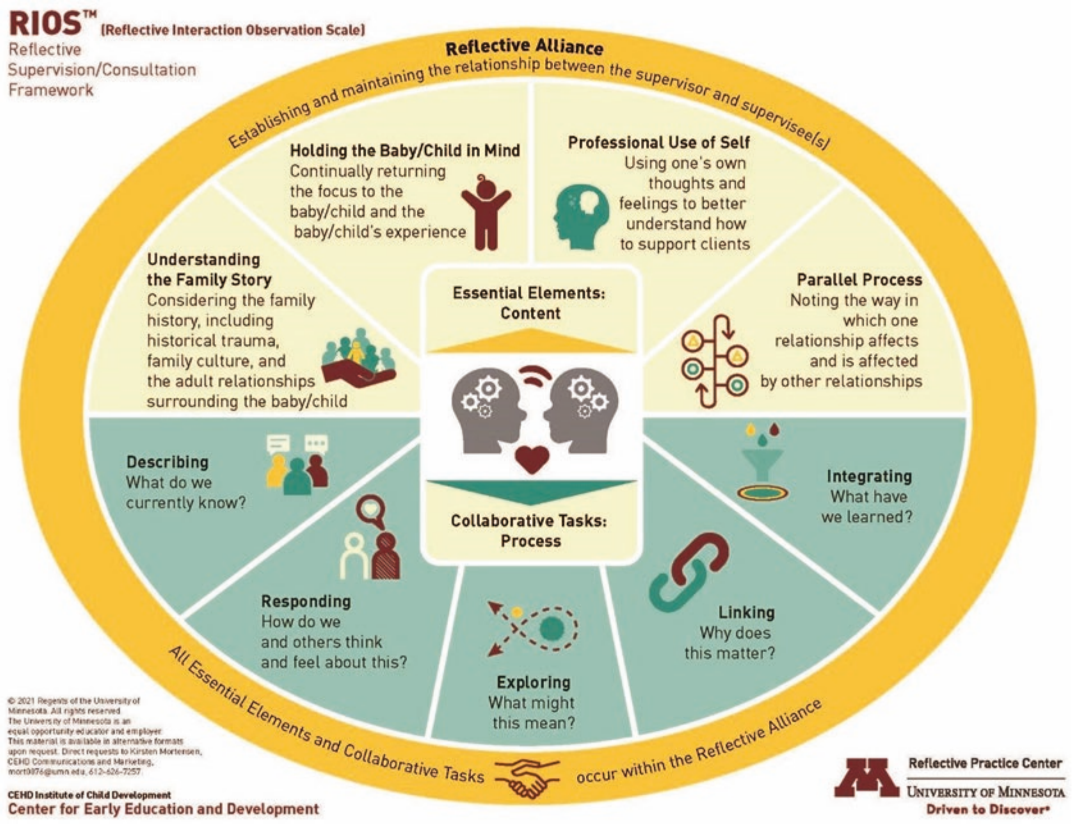

Fig. 25.1 Diagram showing the Essential Elements and Collaborative Tasks of the RIOS

professional development and supervision strategies.

Importance of RS

RS is critical because IECMH-informed professionals are asked to use their relationships with caregivers in ways that can impact the relationship between caregivers and their infants. This relationship-based perspective calls on the professional to consider the unique nature of each relationship, including the relational and developmental needs of the infant (Sparrow, 2016; Weatherston et al., 2020). Often, caregivers who enter IECMH interventions are experiencing stressors or have a history of trauma or adverse experiences, which can make relationship development challenging. IECMH work can sometimes leave the professional wondering if they are making an impact. Further, professionals themselves are bringing their own experiences, values, beliefs, and biases to their work (Wilson & Barron, 2022). Thus, our foundational belief that children, caregivers, and families benefit from sensitive, nurturing relationships should also apply to professionals. O'Rourke (2011) emphasizes, "Supervisees need to experience themselves in an authentic, empathic relationship, which allows them to be vulnerable and feel safely held. As with the mother–infant relationship and their relationship with the client, it is the encounter, the moments of meeting in relationship, which restore the worker's sense of competency and agency" (p. 170).

Considering What We Know About RS

Research on RS is limited but growing. Early research has provided rich qualitative data about some individuals' experiences with RS, and our knowledge about key components and impacts is growing. However, most of the quantitative research thus far has relied on small samples that are often not representative of the workforce. In many of the existing studies, participants are more highly educated and White than the overall workforce and, due to convenience sampling, may be more invested in RS than the general population. Many studies provide little information about implementation details of the RS provided, such as any frameworks used, the format, or dosage. Quality of RS has often been assumed rather than directly measured.

The Invisibility of Race

The literature on RS is growing, yet there are few studies that explicitly address the role of race, culture, racism, or other forms of oppression. Wilson and Barron (2022) invite us to consider that "supporting professionals using reflective supervision requires a trusted, nurturing, and sensitive relationship that includes opportunities to reflect on racial and cultural differences, biases, values, and judgments" (p. 14). There are many reasons why literature is lacking in this area. There is a lack of racially diverse representation among study participants (supervisors, supervisees, or others), and demographics are often not reported. Systemic racism and other systems of oppression have prevented Black, Latine, and Indigenous researchers (among others) from contributing to scholarship (Iruka et al., 2021). Until very recently, the voices of Black, Indigenous, and People of Color (BIPoC) professionals and families have long been missing from the determination of the language, definitions, and best practices used to describe RS. Those who have contributed to this literature have been predominantly White. Their approaches to research and frameworks have limited their awareness of the centrality of exploring the social context including racism and interlocking forms of oppression surrounding RS. Many questions have not been asked. More recent studies have begun to examine the unique experiences of BIPoC supervisees and supervisors. As we review the literature around RS, we will consider how our knowledge is limited and what gaps remain.

Key Components

Several key components of RS are identified in both the theoretical and research literature and provide a picture of the unique relationship-based approach to supervision and consultation. However, as previously noted, due to the failure to include BIPoC voices and perspectives in the development of such frameworks and research, the components are limited in scope. Here, we identify a few key components based on the literature to date, and while each element is described separately, it is important to acknowledge the interconnected nature of all the elements. For example, without self-awareness, the parallel process cannot be identified. This body of research and theoretical and practice knowledge helps us understand some of the components that are hallmarks of quality and potential mechanisms for positive impacts of RS. Thus far, research is lacking on how these characteristics moderate the impacts of RS.

Self-Awareness

To engage in reflection, one must maintain a sense of self-awareness and be willing to explore instances where self-awareness was not at the forefront or was neglected in favor of a defense strategy or a focus on external factors or events (Stroud, 2010). Use of self-awareness was identified as a subscale of the Reflective Supervision Self-Efficacy Scale for Supervisors (RSSESS) (Shea et al., 2020), suggesting that this capacity is a key component of reflective practice. The development of this capacity is strengthened over time and is connected to the supervisee's experience of the supervisor–supervisee relationship as a co-created space where both supervisor and supervisee can be brave enough to explore biases, identities, and emotional responses (Arao & Clemens, 2013).

Supervisor–Supervisee Relationship

Qualitative studies have investigated key components of RS, including characteristics of the participants, aspects of the reflective alliance, and processes that occur during RS. In terms of participant characteristics, there is some consensus that an ideal supervisor has qualities such as being engaged, nonjudgmental, and empathic (Greacen et al., 2017). Supervisee characteristics, such as engagement, desire to reflect, understanding of the process, and confidence, are recognized as also impacting the process (Barron et al., 2022b; McAllister & Thomas, 2007). When considering the bidirectional relationship between the supervisor and supervisee, trust and safety were most frequently discussed (Meuwissen et al., 2022; Tomlin et al., 2014). Other characteristics included vulnerability, predictable availability, and being fully present (Barron et al., 2022a). These studies have not specifically addressed race/ethnicity or cultural characteristics of the reflective dyad. Such cultural differences are necessary to address within supervision, as they can become barriers to reflection and growth (Wilson et al., 2018).

Focus on the Process of Relationships

Studies have also discussed processes that occur during an RS session that are thought to be key to the experience. Considering other people's perspectives and being heard and acknowledged were common themes (Barron et al., 2022b; McAllister & Thomas, 2007). Others focused on topics of discussion, specifying that focusing on the baby/child, and relationships among family members, and the role of the professional are important (Harrison, 2016). Use of the supervisory relationship was identified as a subscale of the Reflective Supervision Self-Efficacy Scale for Supervisees (Shea et al., 2020) and highlights the ways that the supervisor–supervisee relational experience becomes a tool for the supervisee's developing confidence about their reflective practice skills.

One example of such use of the supervisor relationship involves the exercise of rupture and repair. A rupture can be defined as, "a breakdown in the collaborative process" (Safran & Muran, 2006 as cited in Keyes et al., 2009, p. 99). Ruptures can occur when there is mis-attunement resulting in the supervisor and/or supervisee feeling misunderstood. Ruptures pose barriers to relationship-building and create "alliance strains or tears" (Watkins, 2015, p. 284). When unaddressed, ruptures can create cracks in relationships that can lead to greater discord and relational problems. To address ruptures with a supervisor, a supervisee must use self-awareness to identify where the rupture occurred, the multiple contributions to its origins, and its impact on the relationship (Shea et al., 2020). This is a challenging task for a supervisee due to the power differentials inherent in a supervisory relationship. When a supervisor initiates the relational task of repairing a rupture, there is an opportunity to not only strengthen the supervisor–supervisee relationship, but also to provide the supervisee with an experiential model of how to address such ruptures in their work with families (Keyes et al., 2009).

Parallel Process

One of the primary differences between RS and administrative or clinical supervision is the exploration of the impact of relationships on other relationships (Gatti et al., 2011; Pawl & St. John, 1998). Described as a parallel process, it is believed that opportunities to reflect upon each important relationship (infant–parent, parent–professional/supervisee, and supervisee–supervisor) are essential to IECMH work (Dayton et al., 2020; Pawl & St. John, 1998). Importantly, through their "relationship for learning" (Shahmoon-Shanok, 2009), supervisors and supervisees can enhance their understanding of the clinical situation and put into practice interventions that consider the needs of the infant and family. Early references to the parallel process by Searles (1955) included the supervisor and supervisee within the layers of relationships important to consider in clinical work, noting that the "processes at work currently in the relationship between patient and therapist are often reflected in the relationship between therapist and supervisor" (p. 135). When the supervisor and supervisee can become aware of these processes, they can use this awareness in their understanding and clinical conceptualization of the client's experience (Sumerel, 1994). These components often take time and experience to impact the relationship foundation necessary for the parallel process to emerge.

For example, an IECMH professional must consider and support the developing caregiver–infant attachment relationship to address the quality of attachment and social-emotional development of infants and young children, a main goal of IECMH programs. To support caregivers in providing their children with predictable, responsive, and emotionally attuned caregiving, the IECMH professional aims to engage in reflective, consistent, and collaborative therapeutic relationships with parents and caregivers that have the potential to promote the caregiver's own emotional and developmental growth and a sense of trust and security (Gatti et al., 2011). Further, the supervisory relationship can provide a similar place for the professional: the reflective, consistent, and collaborative nature of RS can support the professional's wellness, exploration, and growth (Dayton et al., 2020; Weatherston et al., 2020). Importantly, identifying and using the parallel process within IECMH work require self-awareness and reflection related to the thoughts, feelings, and emotional reactions that are evoked within emerging relationships between the infant, caregiver, professional, and supervisor.

Alexis is a new IECMH practitioner recently hired to work in a home-based program. This is her first home-based position. Alexis identifies as White and talks often about her experiences growing up in a diverse neighborhood and within a working-class family. Madison is the reflective consultant for this program and offers monthly group RS. Madison also identifies as White. Alexis has been part of the group for only a couple of sessions when she began talking about an attempt to engage a parent in initiating services. This parent reached out to the program for help with her 36-month-old whose behavior challenges are placing the child at risk for expulsion from their childcare center. The parent's family came to the United States from Mexico, and they also identify as Black. Alexis stated this was one of her first home visits and expressed frustration with the parent because the parent was not attending to their appointment. The parent did not sit with her at the table to discuss the necessary paperwork. Instead, the parent moved about the house and yelled periodically at the child who was not responding to her. Alexis repeatedly stated, "The parent was the one who called for help, and they aren't even talking to me." The child wanted to play; however, their parent was trying to feed them and was not focused on play. As Madison listened, she noted that she, too, was feeling frustrated with Alexis and found herself feeling angry at Alexis's lack of understanding related to the parent's experience. Madison also felt evoked by the racial differences between Alexis and the family that are framed by differences in power and privilege, as illustrated by Alexis's perspective that put her needs (to get the paperwork done) over the needs of the family.

This example demonstrates the emotional parallel between each relationship identified in this case: Madison feeling frustrated and angry with Alexis; Alexis feeling frustrated with the parent; and the parent's anger and frustration at the child. The child's experience and possible emotional response may be identified as feeling unheard or their needs not being met. Not feeling heard, seen, or responded to may also be an emotional parallel that runs throughout these relationships. In RS, Madison and Alexis can have opportunities to identify and discuss these feelings, along with values and biases related to power, privilege, racial differences, that can help them to better understand the experience of the parent and the child and offer intervention and support that embodies empathy, sensitivity, and attention to emotional needs.

Power and Privilege

Relationships between caregivers and IECMH professionals and between professionals and supervisors are impacted by a myriad of variables that may include race, culture, type of work, and understanding of the RS process (Barron et al., 2022b; Wilson, 2021; Wilson et al., 2021). While RS has the potential to address all aspects of a person's experience, for BIPoC supervisees, cross-ethnic and cross-racial supervisory relationships can be experienced as unsupportive due to supervisors struggling to attend to racial issues effectively (Hill, 2021; Wilson et al., 2018; Wilson & Barron, 2022). Questions have arisen about assumptions of safety in the supervisory relationship when there is a cultural, power, and/or privilege differential between the supervisor and supervisee, for example, when paraprofessionals are being supervised by clinical professionals (St. John et al., 2012). What it means to effectively attend to racial issues, implicit bias, and race-related experiences will vary among professionals and supervisors, thus potentially impacting the use of the parallel process within the RS relationship and, in turn, the supervisee's IECMH work (Lingras, 2022).

Recent studies have begun to share insight into how RS becomes a space where conversations about race, bias, structural racism, and historical trauma can occur (Silverman & Hutchison, 2019) and yield positive results. Eckley and colleagues conducted a study on the effects of integrating professional development on racial equity in the context of providing RS. The model (training plus support around RS) led to changes in participant knowledge, awareness, and comfort (Eckley et al., 2022). Silverman and Hutchison (2019) highlight the power of the parallel process and how having challenging conversations related to racism and historical trauma in RS created a mental model that could be called upon by supervisees in their work with families. They give an example of a White nurse home visitor who reflected on how her experiences with training allowed her to notice, name, and bring up bias and historical trauma in a visit with a Black mother. RS may be a particularly powerful intervention to reduce bias and shame and promote seeing families as individuals rather than stereotypes.

Practice of RS

Competencies and Credentials for Providers of RS

Competencies and skills necessary for the provision of RS have been defined and are undergoing revision to better align with diverse perspectives (e.g., the *Best Practice Guidelines for Reflective Supervision/Consultation* from the Alliance for the Advancement of Infant Mental Health; Alliance, 2018). Changes are being informed by data from providers and recipients of RS, families, and community members from diverse racial/ethnic backgrounds. The intent of the data collection and revision is to expand the Alliance's RS framework to be transformative (e.g., lead to increased diversity in the IECMH workforce and expanded professional development opportunities, etc.), free from systemic and cultural barriers in the IECMH field (that may lead to gatekeeping and hegemonic ways of understanding "the work"), and tools to promote accountability as RS grows as a best practice in IECMH (Shivers & Parker, 2022).

Credentials for providers of RS are available through the California Center for Infant-Family and Early Childhood Mental Health (Reflective Practice Mentor) and from associations for infant mental health (AIMHs) who license the Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health (Infant/Early Childhood Mental Health Mentor-Clinical or Infant/Early Childhood Mental Health Specialist – Reflective Supervisor). This Endorsement is currently available in 35 US states, Ireland, and Western Australia as of this chapter's publication. Applicants must document the accrual of specialized education, work, training, and RS experiences; knowledge and skill in contemplation, self-awareness, curiosity, emotional response, and parallel process; and pass a written exam.

Settings Where RS Is Practiced

RS was identified by Zero to Three as a core component of infant mental health training in 1991 (Eggbeer et al., 2007) and has been integrated in the infant–parent psychotherapy approach pioneered by Selma Fraiberg that focuses on relationship-based, reflective practice (Weatherston et al., 2020). In later years, RS was integrated into nonclinical settings where there is a focus on infant/early childhood relationship-based practice. Currently, RS spans multiple infant/early childhood settings and professional contexts, including early childhood education (ECE) (Paradis et al., 2021), Neonatal Intensive Care Units (NICU; Campbell, 2000), home visiting programs (Eaves et al., 2022), early intervention services (Frosch et al., 2018), IECMH consultation (Davis et al., 2020), and IECMH behavioral health contexts (Noroña & Acker, 2016). Within each of these contexts, RS serves to provide professionals with a space to engage in a process-oriented approach to understanding their work and their relationships with infants, young children, families, and colleagues (Wilson, 2021). RS relies on a collective understanding of the relationship as a target for both prevention and intervention efforts.

At the same time, RS can be tailored to the unique features of each professional context, supporting professionals in both clinical and nonclinical contexts (Shea et al., 2022) and should be culturally relevant and responsive to diversity, equity, and inclusion in all relationships (Wilson & Barron, 2022). The IEMCH field is considering the salience of RS for those professionals who do not practice clinically. There have been some concerns about generalizability to fields outside of clinical infant mental health practice. Do professionals across a broad range of job sectors serving infants, young children, and families claim similar benefits from participating in RS? Does the experience hold the same meaning? Although RS is assumed to be beneficial and routinely recommended in fields like child welfare and home visiting (West et al., 2018), it is less clear whether professionals in these fields regard RS as an integral and beneficial part of their work (Barron et al., 2022a; Eaves et al., 2020). Evaluations of RS implementation have emphasized that tailoring the training and meeting schedule to fit the needs, training and educational background, and time constraints of the participants is key to successful implementation (McAllister & Thomas, 2007; Ordway et al., 2018). We still don't know enough about the extent to which various programs and organizations effectively implement RS in alignment with best practice guidelines and empirically established key components (West et al., 2018). The IECMH field needs more data about RS regarding where it is being provided, to whom, and the benefits and costs.

Promotion of IECMH: Infant and Early Childhood Education

Early childhood education (ECE) settings have struggled with staff turnover, low salaries, and the increased needs of children and families who are exposed to trauma, poverty, systemic racism, and other adversities (Mondi et al., 2022; Paradis et al., 2021). These factors have implications for the ECE professionals' experiences of very young children and their families. There is evidence that illustrates the relationships between factors such as early childhood educators' job satisfaction, stress, hopelessness, depressive symptoms, and preschool expulsion and suspension rates (Gilliam & Shahar, 2006; Mondi et al., 2022). Such expulsion and suspension rates disproportionately impact families who identify as BIPoC, families impacted by ACEs, and young children with disabilities (Davis et al., 2020; Gilliam & Shahar, 2006; Mondi et al., 2022). Attention to the ECE workforce and their training and well-being is critical to ensuring equitable access to ECE for young children and their families (Davis et al., 2020; Mondi et al., 2022). Specifically, supporting early childhood educators' reflective practice can increase the degree to which they can consider their biases, wonder about the ways that culture informs their approach and the experiences of families, and increase their attention to the ways that identities are nurtured and stigmatized, reducing implicit bias in the ECE system and its negative impacts on children and families.

Shamar identifies as a Black woman and has been an infant/toddler teacher in an ECE center for 10 years. The center where she works is in a racially diverse area of her city, culturally vibrant and with families who range in economic stability. Lola identifies as Puerto Rican and has been the reflective consultant for this center for two years. Lola and Shamar have developed a mutually satisfying relationship over the past 2 years and Shamar meets individually with Lola twice per month. Shamar has shared with Lola some challenges she has recently been experiencing with a young mother of a 7-month-old baby in her classroom. The mother identifies as Black and Hispanic and the baby's father is White. Shamar confided in Lola that she feels the mother is neglecting the baby by leaving the baby at the center for too long and often coming late to pick the baby up. The baby is sometimes dirty when they arrive and is not yet sitting independently. Shamar said that she worries constantly about the baby in the evenings and on weekends, stating, "She better be taking care of my baby."

The reflective relationship built between Lola and Shamar over the past two years is a strong foundation for considering Shamar's response to this baby and mother. Their relationship is a base for supporting Shamar in providing a safe space for the baby and developing a partnership with the baby's mother. Lola and Shamar may wonder about values related to motherhood, biases about young mothers, and views related to the relationship between the teacher and the parent. In this example, Shamar may also have values and expectations of Black mothers and her role as a potential mentor of this young mother that are culturally based. These, including Shamar's worry about the baby, are important to reflect upon and consider so Shamar can offer support and sensitivity to the mother, baby, and family.

RS is a recommended professional development support for the ECE sector (Mondi et al., 2022; Paradis et al., 2021), designed to provide educators with opportunities to reflect on their work with challenging classroom dynamics, child behaviors, and caregiver communications (Bernstein & Edwards, 2012; Paradis et al., 2021). RS can increase educators' insightfulness about the infants and toddlers in their classrooms (Virmani & Ontai, 2010). Head Start, a US federally funded education and family services program for low-income preschoolers, identifies RS as an important component of "sustaining effective practice" (Head Start ECLKC, 2019). In such settings, the RS relationship can provide the infant and early childhood educators with support and relational experience that they might be able to then offer in their classrooms (Bernstein & Edwards, 2012). The implementation of RS in infant and early childhood education settings requires consideration of the time restrictions for additional meetings. Also, given that reflective practice may not be an integrated component of the infant/early childhood educational system, it is important to create an RS environment that supports reflection, separate from administrative obligations, and without fear of penalties or evaluation (Emde, 2009).

Prevention: Home Visiting, Early Intervention Services, and IECMH Consultation

The field of IECMH includes significant attention to prevention with services designed to address early signs of developmental delays (Frosch et al., 2018, 2019), vulnerabilities due to systemic inequities that can impact caregiver–child health and well-being (Silverman & Hutchison, 2019), and social-emotional health in infants and young children (Davis et al., 2020). Many of these services are offered by home visitors who can support families during pregnancy and throughout the infant and toddler years. Professionals in these service delivery systems encounter a variety of challenges meeting the multiple needs of very young children in families who are impacted by disproportionate health risks and trauma due to systemic inequities, while negotiating under-resourced communities (Harden et al., 2010). Such professionals may carry caseloads with multiple needs that they must balance with significant administrative demands within the constraints of overwhelmed systems (Sandstrom et al., 2021).

RS is often a recommended component of these home visitor service delivery models (Eaves et al., 2022) and other early intervention programs (Frosch et al., 2018, 2019). RS with IECMH consultants has been described as a means of supporting their reflective practice skills so that they can offer such reflective experiences to the educators with whom they consult (Shea et al., 2022). For early interventionists and home visitors, RS can offer a shared space where professionals can connect with one another or their RS consultant around the stress and pressures of their work, decreasing a sense of isolation (Benatar et al., 2020; Frosch et al., 2018).

The use of RS also assists professionals with maintaining a focus on their relationships with families, staff, and colleagues, rather than only using a solutions-driven approach (Shea et al., 2022). This can be particularly useful for settings such as Nurse Family Partnership (NFP) where nurses have often been trained to address problems in a directive manner (Silverman & Hutchison, 2019). Professionals who participate in RS report that it is associated with increased job satisfaction and decreased burnout (Benatar et al., 2020; Shea et al., 2022).

Teresa is a White woman who has been facilitating RS for over 10 years. She recently started meeting with a new group of early intervention professionals who work with young children who have been diagnosed with chronic and sometimes terminal diseases, as well as children who are struggling developmentally. They serve children across a geographically large area of their state. The group members all identify as women and are racially and ethnically diverse, identifying as White, Latina, Black, and Asian. They have different roles: case manager, occupational therapist, and physical therapist. During one group, Maria, who identifies as Latina and White, described a conversation she had with a mother who is new to their services. Maria received a referral for a developmental assessment from a physician for a 20-month-old boy, whose family identifies as White. When Maria was meeting with the child's mother, she described the process of the assessment. In response to the explanation, the mother said, "He is just lazy, he probably won't do anything for you. He doesn't do anything that I ask him to do." Maria said that she has heard parents say things like this before, but for some reason this mother's comment made her feel frustrated and angry. Her response was to explain to the mother that sometimes young children need extra help to reach developmental milestones. It is not because they are lazy. She began to suggest things that the mother could do to engage her child in play. Teresa, the supervisor, began to feel frustrated with Maria. She talked with Maria about a parent's emotional response to their child who may be struggling and wondered what it felt like to the mother that her child, "doesn't do anything she asks." Maria replied that it is important that parents understand that children aren't being manipulative, but that they need guidance.

This example shows the challenge to focus on developing relationships between professionals and families. In this scenario, even Teresa was challenged to maintain a relationship-based perspective. Within RS, Teresa can return to this exchange and wonder what emotional response was coming up for Maria, herself, and the others within the group. What is it like for them to hear a parent describe their toddler as "lazy" or express the parent's sadness that comes with the belief that their child doesn't respond to them? Reframing the response in this way could support Maria's developing relationship with the mother and promote more positive interactions between the mother and the child.

Treatment/Intervention: Behavioral Health

IECMH behavioral health interventions are relationship-based approaches to addressing concerns about the social-emotional development of an infant or young child, including disruptions to attachment to a primary caregiver that may be influenced by trauma exposure, caregiver substance abuse or mental health challenges, child welfare involvement, and systemic inequities (Fraiberg et al., 1975; Weatherston et al., 2020). The focus on the caregiving relationship requires that the clinician be observant of the caregiver–infant interactions while also maintaining self-awareness regarding the ways in which their own identities, culture, and experiences inform these observations (Lingras, 2022; Wilson & Barron, 2022; Wilson et al., 2021). Additionally, relationship-based practice relies on the clinician–caregiver relationship as a primary transformative vehicle through which caregivers can experience being understood, seen, and valued to offer that relational experience to their children (O'Rourke, 2011).

As such, RS has had a prominent role in many of these intervention approaches to provide the clinician with the parallel experience that they will offer the families whom they serve and to better understand their work (Hill, 2021; O'Rourke, 2011; Wilson, 2021). For example, the Michigan IMH-HV model includes weekly, bi-weekly, or monthly RS (Shea et al., 2020; Weatherston et al., 2020). Child–Parent Psychotherapy (CPP), a trauma-based intervention, is another example of an intervention that includes consistent RS as a component of the ongoing training and fidelity (Noroña & Acker, 2016). Other IECMH clinical settings or approaches use a less regimented RS model; for example, Ordway et al. (2018) describe using RS in a variety of forms in a clinic setting to meet the scheduling and needs of an interdisciplinary clinic.

In IECMH behavioral health, the RS relationship can offer an opportunity to speak about what may be going unaddressed in the caregiver–infant relationship, in the clinician–caregiver relationship, or in the supervisor–supervisee relationship (Hill, 2021). This is particularly true regarding identity, including race, culture, microaggressions, power, and privilege, which are topics about which clinicians and families may have been socialized not to discuss in work settings (Wilson, 2021). The RS relationship, like the clinician–caregiver relationship, is co-created by each member and includes their individual identities, the social expectations for and stereotypes about these identities, and the unique connections in the dyad or group. Reflective supervision self-efficacy, which includes one's confidence about their ability to engage in RS, is in part based on the degree to which supervisee can use the RS relationship to address ruptures and misattunements with a nonjudgmental, open, authentic, and supportive stance (Shea et al., 2020). By explicitly acknowledging the co-created RS relationship and the individual and unique identities and culture of the RS dyad or group, there are opportunities for the clinician to "share vulnerability," "feel heard," and "share perspectives" (Wilson, 2021, pp. 120–21).

This aspect of RS is particularly salient when considering Alexis' experience when meeting the family for the first time (see Sidebar on pp.). As a new infant mental health practitioner, she may be holding the conflicting experience of not knowing what to do and yet being called upon as someone who needs to help this child and family. Her frustration that the parent would not sit with her to focus on the paperwork could reflect her feelings of vulnerability around relationship development with a parent and family who are from a different culture as well as her feelings about being a visitor in their home. Focusing on a task was grounding for her—as it felt like something she could do. As she talked more about this experience, she said that she didn't know what to do when the parent left her in the room by herself, she wasn't sure what to do when the child came up to her and asked to be held, and she felt like she wasn't properly prepared or trained by her agency for this job.

Broader Systems and Indirect Practice

The description above regarding the settings where RS is practiced speaks to the strong roots of RS in IECMH direct practice sectors. There has been much emphasis on the parallel process as a key element of RS whereby the supervisor–supervisee relationship is both a precondition and an outgrowth of the relational experience the supervisee can offer the family (O'Rourke, 2011; Shea et al., 2020; Wilson et al., 2018). However, this focus on parallel process is limited in scope when there is no consideration of the broader systemic parallel process that informs and impacts the relational experiences of supervisor, supervisee, and family. The role of RS in the context of indirect practice is a growing area of interest as the IECMH field acknowledges that limiting RS to direct practice sectors inhibits the use of reflection in policy and decision-making processes (Morelen et al., 2021; Shea et al., 2022). Such processes have significant impacts on the workforce and the communities they serve.

Shea et al. (2022) evaluated a pilot of an RS model in the indirect service context of a statewide infant and early childhood professional development and technical assistance office. Group RS was piloted with leadership and staff, which in addition to IECMH consultants, included grant specialists, program managers, and supervisors. Findings included the participants' self-reported increase in reflective practice self-efficacy and use of a relationship-based approach to their work following participation in 12 months of group RS, illustrating the need to further investigate the use of RS in indirect service sectors and its systemic impacts (Shea et al., 2022). Adequate buy-in to the concept and necessity of RS at every level of the organizational microsystem may be essential to effective implementation and sustainability. According to O'Rourke (2011), relationships are replicated at each level of an organization. If we expect infant/early childhood professionals to offer a relationship based in mutual trust, collaboration, and safety to the families they serve, they must first receive it themselves (i.e., parallel process). RS has been regarded as essential to this process.

Modalities and Delivery Types

RS is offered in both group and individual contexts. According to a recent RS landscape survey of 67 IECMH RS supervisees in the United States, approximately half (49%) receive RS in a combined form of individual and group contexts while another 40% reported receiving only group RS. For supervisees receiving group RS, the largest percentage (57%) participated in monthly sessions. This was also true for participants receiving individual RS (31%) with another quarter (26%) reporting that they receive individual RS on a weekly basis (Meuwissen et al., 2022). While the literature describes experiences with both individual RS (Weatherston & Barron, 2009) and group RS (Harrison, 2016), the differences between the two experiences are not well described nor have they been evaluated.

RS is offered face to face and, in more recent years, through distance technologies. The use of distance technology permits professionals in locations where RS is not well established to grow their RS capacity by contracting with seasoned RS professionals in other geographic regions (Morelen et al., 2021; Shea et al., 2022). Additionally, RS via distance technology met the need of the IECMH workforce during the COVID-19 pandemic when face-to-face RS, home-based work, and other infant-family services came to a halt and were transitioned to virtual platforms (Traube et al., 2022). The use of distance technology in RS requires additional considerations around building and maintaining relationships with more explicit attention to "video meeting fatigue" and group members' preparation of their surroundings to ensure the predictable, quiet, and uninterrupted space required for RS (Alliance, 2020).

As mentioned previously, the terms reflective supervision and reflective supervision/consultation are often used interchangeably. There has been a lack of discussion and research about similarities and differences between engaging in this reflective process with an internal supervisor vs. an external consultant. The dosing, frequency, structure, and nature of the relationship with a supervisor vs. consultant can vary, potentially altering delivery of its critical components. The literature provides little differentiation between the experience of a group that meets monthly with a reflective consultant who is nonaffiliated with the employing organization compared to individuals who meet weekly with a reflective supervisor within the organization. We have no empirical data available to verify whether critical elements of RS are delivered consistently when people are receiving internal supervision or external consultation.

Integration with Other Types of Supervision

In addition to the RS model described in this chapter, there are other IECMH supervision models that integrate a reflective practice approach, while also using more traditional supervision approaches. For example, Greacen et al. describe the implementation of an RS model in the context of a perinatal preventative home visiting program in France where home visitors received weekly individual RS as well as bi-monthly group RS. The results of a Delphi study about the "characteristics of quality supervision in perinatal home visiting programs," (Greacen et al., 2017, p. 271) included elements associated with a traditional RS approach, such as the quality of the supervisor–supervisee relationship and consistency and predictability. The study also found that the supervisors' clinical experience was of importance to supervisees and the authors describe the importance of integrating clinical and practical supervision approaches within this perinatal home visiting supervision model, suggesting that RS alone may not be sufficient to meet the supervision needs of home visitors.

Rowe et al. (2019) describe the models of RS used in international NFP settings. NFP highlights the importance and value of RS for nurses providing home-based preventative services to families with infants and toddlers; however, the organization does not prescribe how countries will implement RS. For example, in England, administrative components of supervision were considered a part of the RS experience, while in Canada and Australia, administrative tasks were often handled separately. In the United States, supervisors who provide RS within the context of their employment to staff in their agency/setting frequently struggle with balancing administrative supervisory expectations with RS (Shea & Goldberg, 2016).

Impact of RS

Measures

Two surveys have been developed to measure RS constructs directly. The Reflective Supervision Self-Efficacy Scale for Supervisees (RSSESS) is a 17-item scale that assesses self-efficacy around aspects of RS based on the Alliance for the Advancement of Infant Mental Health RS Best Practice Guidelines (Shea et al., 2020). There are versions for supervisors and supervisees. The Reflective Supervision Rating Scale (RSRS) is another 17-item self-report scale, which focuses on a supervisee's perception of their supervisor around the constructs of Reflective Process and Skills, Mentoring, Supervision Structure, and Mentalization. These two scales tend to be intercorrelated, and both have shown good reliability, validity, and sensitivity to change (Gallen et al., 2016; Shea et al., 2020). The Reflective Supervision Rating Scale was not correlated with race in a diverse sample, providing initial evidence of cross-cultural validity, but more work needs to be done. The Reflective Supervision Self-Efficacy Scale for Supervisees has limited information about cross-cultural validity. The Reflective Practice Questionnaire is a third survey that has been used in research around RS. It measures the tendency to be reflective in any context (rather than specific to RS) but includes a subscale related to appraisal of supervision. Initial data show good reliability and validity, but did not include data on race or culture (Priddis & Rogers, 2018).

Two observational measures have been developed to measure RS constructs. The Reflective Interaction Observation Scale (RIOS) is a tool which assesses the content and depth of reflection in a recorded RS session. Initial data show that the RIOS is correlated with related self-report measures (RSSESS and RSRS) and is sensitive to change over time (Meuwissen & Watson, 2022). The sample used was almost all White, so we know little about how the tool would function in spaces that are less White-dominated. The Provider Reflective Processes Assessment Scales (PRPAS: Heller & Ash, 2016) is a measure of reflective capacity that codes a 5-minute speech sample about a difficult family a professional has worked with to assess their reflection in multiple domains. The PRPAS has shown sensitivity to change across time and included samples that had some representation across White, Hispanic, and Black populations (Spielberger et al., 2019). Qualitative, self-report, and coder-rated measures all have unique roles to play in understanding the implementation and impact of RS for professionals and families. More work needs to be done to ensure that the measures developed by primarily White researchers are valid and capture their intended constructs in diverse samples.

Outcomes

Two outcomes have been primarily discussed as rationales for RS. First, it has been proposed that RS and core elements comprising the reflective supervisory relationship serve the purpose of more effective, competent service delivery.

However, there is also an argument to be made that promoting growth, support, and well-being in the supervisee should also be prioritized for their own value (Susman-Stillman et al., 2020). RS was built on the assumption that IECMH work is highly emotionally demanding and that professionals need support to sustain the work and face the unknowable and the unsolvable (Shahmoon-Shanok, 2009). We will review the evidence for impacts of RS on supervisee burnout and well-being and on impact on the work.

Burnout and Well-Being

Qualitative investigations have consistently found that RS participants, both supervisees and supervisors, report that RS is highly valued and perceived as useful in promoting well-being and decreasing stress and burnout (Meuwissen et al., 2022; Shea et al., 2022; Susman-Stillman et al., 2020). In these samples, multiple studies found similar themes around RS having a positive impact on emotion regulation, coping skills, and supportive relationships (Barron et al., 2022a; Frosch et al., 2018; Susman-Stillman et al., 2020). Participating in RS enhances positive energy around the work which sustains professionals' ability to continue engaging in emotionally demanding work (Harrison, 2016; Meuwissen et al., 2022). Traube et al. (2022) found that home visitors identified RS and peer support as key supports when transitioning to virtual services during the COVID-19 pandemic. Thus, participants in RS research have strong consensus and can point to specific mechanisms around RS being a useful support for their workplace well-being. Work needs to be done to understand who has not been captured in these research studies and how professionals with different professional backgrounds experience RS.

However, when studies have measured change in burnout after receiving RS with standardized scales, results showed no change (Meuwissen & Reese, 2022; Shea et al., 2022), or an increase in burnout and stress (Frosch et al., 2018; Watson et al., 2016). While several factors may contribute to these results (measures not being specific to IECMH, ceiling effects), recent studies may shed light on some of the nuances in the relationship between RS and burnout. Simpson and Eaves et al. have found (2018, 2020) that IMH clinicians see RS as helpful in managing challenges, but that RS alone cannot eliminate burnout because it is directly impacted by systemic policies such as compensation rates, family leave, flexible schedules, and workplace culture. Interestingly, in the intensely stressful context of the pandemic, Morelen et al. (2022), found no difference in stress or burnout for professionals who did vs. did not receive RS, but those who had received RS for over a year showed lower internalization symptoms, did not show the reduction in self-care practices that characterized the overall sample, and rated their organization more highly on promoting self-care. The studies above either had over 80% White participants or did not report race/ethnicity demographics.

Quality of RS and skill of the provider also seem important when considering impact on well-being. For example, Eaves et al. (2022) found that the presence of a workplace policy to provide RS was not associated with well-being, but experiencing core components of RS (i.e., confidentiality, availability, trust, emotional safety; Tomlin et al., 2014) was associated with lower burnout and secondary traumatic stress, and higher compassion satisfaction. Begic et al. (2019) found that more positive perceptions of one's supervisor was associated with lower burnout, and Shea et al. (2020) found that one's self-efficacy around participating in RS was associated with lower burnout and higher job satisfaction. RS was not seen as valuable when providers strayed from a focus on reflection and instead anchored the meetings in administrative requirements (Benatar et al., 2020). These findings indicate that the quality of the RS is likely to moderate its impact, yet most research has treated RS as a static variable. Additionally, it is also important to consider the systemic factors that are intertwined with burnout and job satisfaction, particularly for BIPoC professionals and professionals facing economic challenges associated with the costs of childcare and the lack of adequate compensation (Simpson et al., 2018).

Thus, it appears that RS can be a useful avenue for promoting skills and relationships that promote workplace well-being, but that the relationship may be complex, and the reliance on short-term correlational research limits our understanding at this point. It is possible that in the short-term, increased self-awareness brought about by RS could make professionals more conscious of their negative emotions and reduce protective numbing. Indeed, Meuwissen and Watson (2022) found that over 6 months, participants in RS groups which increased in self-openness showed increases in burnout/secondary traumatic stress and decreases in compassion satisfaction. Thus, it may be that RS may first increase stress and burnout scores but could reduce them in the long term. The currently available studies do not provide much information on such developmental processes, which may be an important avenue of future research. Also, RS cannot be seen as a replacement for addressing systemic policies that are the root causes of professional's stress, or as a cure for systemic racism and discrimination.

Impact on Work

In addition to supporting professionals, the theoretical foundation of RS also suggests that it should positively impact professionals' work with children and families. Initial research suggests positive impacts, but this should be more thoroughly and rigorously explored. A number of studies have examined changes in self-perceptions of skill and found that experience or training with RS, even in the short term, are associated with an increase on the Reflective Supervision Self-Efficacy Scale, indicating growth in perceived confidence around reflective skills (Frosch et al., 2018; Meuwissen & Reese, 2022; Shea et al., 2022). Child welfare workers showed growth in their reflection around themselves and the parallel process on the RIOS after six sessions of RS (Meuwissen & Watson, 2022).

Qualitative studies have consistently found that participants can describe changes in their work such as increased observation and listening, greater empathy and consideration of clients' perspectives, and placing more emphasis on relationships in the work, rather than directive approaches (Barron et al., 2022a; Meuwissen et al., 2022; Shea et al., 2022). Virmani and Ontai (2010) conducted a observational study comparing groups of new childcare providers who received either 10 weeks of reflective or traditional supervision. More caregivers at the reflective site shifted toward greater coded insightfulness when discussing a video clip of them interacting with a child. However, insightfulness classifications remained stable in both sites. Overall, there is evidence that RS can impact how participants' talk about their work, showing greater alignment with IECMH principles. There is more work to be done around how this translates to measures of relationships in the work or perceptions of services by families. The lack of control groups and randomization limits causal interpretations of this research.

Future Research Needed

To move forward and intentionally embed exploration of race, diversity, and equity in RS, there is a need to examine and practice RS through additional lenses. This could include considering: what we know in the context of the historical political and present-day contexts; who is benefiting and/or burdened by the existing knowledge, translation of knowledge and way of doing RS; and whose voices are missing, down played, or unheard. Operating under the assumption that racism and other forms of oppression are powerful social forces that are present everywhere—every institution, organization, and program—exploration of how racism and other forms of oppression manifest within RS is required (Iruka et al., 2021; Silverman & Hutchison, 2019; Wilson & Barron, 2022). Many of the participants in this body of research are White or their races unknown. Studies with more diverse samples asking questions about discussing issues of race and bias are needed. Future research can and should explore racial/cultural preferences as characteristics in ideal RS relationships, experiences with racial matching and RS relationships, and the experiences of BIPoC people in RS. The relationship is important in RS, and relationships are particularly important when exploring issues of culture, race, and bias

(Davis et al., 2018). There is more to be known about intentional exploration of racial inequities, and racialized experiences in RS, and the barriers and facilitators to such explorations.

Summary and Key Points

Three decades of theoretical framing, practice-based evidence, and empirical investigation have established RS as a cornerstone of effective IECMH practice. However, RS is not a panacea for addressing the factors that complicate IECMH professional development, well-being, and service delivery. We have learned that RS has been framed from a Eurocentric perspective that has not considered the implications of harm done when marginalized IECMH families and professionals are not seen in their full humanity and are excluded from the discourse. It will be important to more clearly specify, measure, and operationalize the parameters of the process (dosing, individual vs. group, online vs. in-person, supervisor/consultant roles) when describing RS in the literature so that the impact of these variables can be examined. The IECMH field has always served marginalized infants, children, and families even if the original framers of RS didn't intentionally hold those particular families in mind. The field has reached a critical point in its developmental trajectory where we must consider the totality of who practices, researches, administers programming, and designs policy in the IECMH field. We must also more deeply explore the role of RS as a mechanism for elevating the work and lived experiences of all sectors serving infants, young children, and families. This is especially important for members of the IECMH workforce who have historically been left out of the conversation.

One of the first steps is establishing shared language across the field about what we mean when we use the terms "reflective supervision," "reflective practice," and"reflective consultation." Research has a prime role in shaping the language that will help the IECMH field define RS in terms aligned with the ethics and values of competent, culturally responsive, and reflective IECMH practice. The first efforts to investigate and define RS were driven by experts who delivered RS. Since then, we have seen the literature expand to include the voices of supervisees as well as professionals from sectors like child welfare and early care and education.

Ways of knowing and building empirical knowledge in the IECMH field has also centered traditional scientific methods because these methods have been the dominant pathway to professional legitimacy. However, ethnographic and qualitative methods of data gathering are gaining prominence as the field elevates lived experience as a valid mechanism of generating rich, in-depth data about the unique perspectives of a workforce engaged in a unique process, RS. This consideration for nondominant bodies of knowledge makes room for voices in the IECMH field who have been silent or excluded from early theoretical frameworks that, although foundational to the field, did not always encompass the totality of contextual influences impacting early relationships, development, and parenting.

Reflective supervision is at a critical touchpoint in its young life where there are opportunities for tremendous growth and evolution. The IECMH field has mostly regarded RS as a dyadic or group approach integral to guiding the work of professionals practicing with infants, young children, and families. However, the IECMH field has a prime opportunity to integrate principles of social justice and anti-racism into practice, policy, and research to promote healthy early relationships for all infants, young children, and families. Reflective supervision, consultation, and practice should be the vehicle to advance these efforts. It is not enough for individual IECMH supervisors to be open, curious, consistently available, and emotionally safe for their supervisees in order to ensure a safe, nurturing, and just society for all babies and families. Organizations and institutions need to integrate these characteristics into operations and relationships from the top-down so that socially just, empathic, equitable principles rooted in reflection, collaboration, and predictable regularity will be embedded throughout IECMH systems governing research, policy, and practice (Sparrow, 2016). This is the new frontier for RS. The babies and families we all serve deserve nothing less.

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Circle of Security: Translating Attachment Science for Diverse Caregiving Contexts

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The fundamental role of early relationships in predicting long term and even intergenerational outcomes is clearly documented in research. The clinician's challenge is to leverage this information to inform potent and useful intervention. Research has established the primary role of attachment security to caregivers in childhood in predicting long-term social-emotional and behavioral outcomes. Insecure and disorganized forms of attachment are associated with a range of negative life outcomes within industrial societies (Thompson, 2016). Thus, the development of interventions targeting the quality of early parent–child relationships has become a core focus in promoting child development and well-being. The Circle of Security (COS) was first a response to the need to meaningfully communicate the complex science emerging from fields of attachment and neuroscience to parents (Powell et al., 2014).

This chapter begins with a review of the centerpiece of the various Circle of Security models, the Circle of Security graphic. First used as the basis for intervention in the late 1990s, the graphic itself has been unchanged even as intervention models based on this graphic have been developed and adapted over the last 25 years. We will first outline the initial COS intervention (now called the COS-Intensive model) and present its evidence base, more recent adaptations of this model, and the core processes of change. Because the COS-Intensive model required a complex assessment system that itself required intensive training and supervision – effectively limiting the model's accessibility – a briefer eight session model that does not include individualized assessment was developed. The Circle of Security Parenting program, its theory of change and the research to date will next be reviewed. In the final section, we will review the most recent intervention, the COS Classroom (COSC) model which targets early childhood caregivers and teachers.

The Circle of Security Graphic

A fundamental goal of the COS group of interventions is for parents to develop an understanding of their child's attachment needs and their

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role as caregivers in meeting these needs. The COS graphic provides a straightforward way to visually communicate the four systems of Bowlby's (1969) attachment theory – the exploration system, the attachment system, the caregiver system, and the fear system – and the dynamic interaction between them. The COS graphic serves as a "roadmap" for parents to begin to track their child's needs in moment-to-moment interactions and, as they become more comfortable recognizing these needs, to respond to them (Cooper et al., 2009). While each of the Circle of Security models uses other graphics – alongside video examples – to help caregivers "see" the circle in action, the Circle of Security graphic is central to each intervention (see Fig. 26.1).

The parents' role as a Secure Base and Safe Haven is represented by the Hands on the Circle. Bowlby (1988) described the core function of the caregiving system as providing both protection of the child and basic support to develop and, over time, become independent in the world. The open hands on the Circle represent the parent as caregiver, both in terms of their physical presence and emotional availability to respond to the child's needs and emotional states. As "the Hands," the caregiver provides a holding environment, characterized by an experience of safety and soothing (Winnicott, 1978) and containment, where the child's emotional states can be received, tolerated, and processed (Bion, 1962). Through the experience of holding, the child learns that others are available and responsive, and the self is worthy of attention and regulation (Winnicott, 1978). It is also in the context of the holding environment that the child can learn that needs and affects are safe and acceptable and can be expressed, understood, soothed, and regulated (Powell et al., 2014). The mantra "*Always be Bigger, Stronger, Wiser and Kind"* is given to parents to capture the role of the Hands.

The top half of the Circle depicts the child's needs when their exploration system is activated (Cooper et al., 2005). At these times, the parent ideally functions as a secure base, an available and present observer, from whom the child can go out confidently, developing a sense of mastery and efficacy in the world (Zanetti et al., 2011). The child needs the parent to be available while

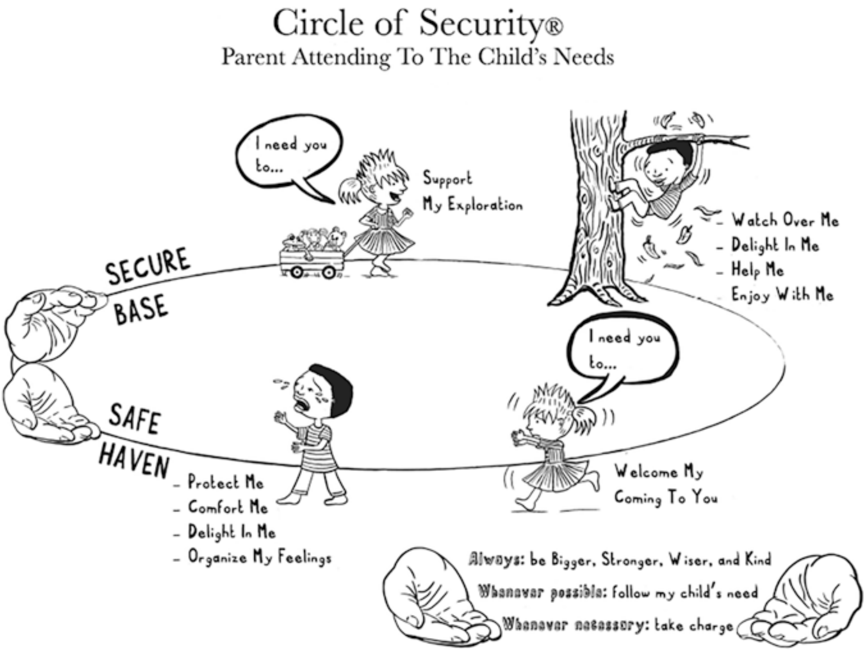

Fig. 26.1 The Circle of Security

he or she explores something of interest, watching over and able to provide protection, or help if it is needed (Cooper et al., 2005; see Fig. 26.1 where the needs appear in bulleted points for the top and bottom of the Circle). With a secure base, the child is able to test his or her independence and skills, while receiving just enough help from caregivers to scaffold their exploration.

The bottom half of the Circle represents the attachment system and the caregiver's role as a safe haven (Bowlby, 1969). As a Safe Haven, parents recognize the child's need for proximity and closeness, providing a welcoming environment for the child to return for protection, comfort, and nurturance (Powell et al., 2014). Establishing proximity can promote a sense of safety for the child, particularly in times of distress (Bowlby, 1969). Proximity to the attachment figure serves an affect regulation function, acting to soothe distress and reestablish a sense of well-being (Sroufe, 2005). Children not only need comfort and closeness in moments of distress but also sometimes simply need connection and attunement from the caregiver to "fill their cup," renewing their energy or enthusiasm to continue to explore (Zanetti et al., 2011; see Fig. 26.1).

In each Circle of Security intervention model, the specific needs on the top and bottom of the Circle are illustrated using video examples, stories that caregivers share, and discussion prompts. The specific needs on the top and bottom of the Circle are summarized in Table 26.1.

Transitions around the Circle occur continually, as different internal experiences (hunger, fatigue, hurt, frustration, and fear) and external or relational events (social interaction, stranger's arrival, play, and injury) occur. The parent's role is to observe their child and guess the child's needs as they move between exploration and proximity-seeking. As the Hands, caregivers aim to follow the child's need whenever possible and to take charge when necessary, setting boundaries or limits or acting to keep the child safe. By providing a confident and reassuring (Bigger, Stronger, Wiser, and Kind) presence, caregivers give the child confidence to move around the Circle and to directly signal their needs.

Table 26.1 Needs on the Circle

Top of the Circle	Bottom of the Circle
Support my exploration: A child's need to have his or her parent encourage and support the child's developing autonomy in mastering his or her world.	Welcome my coming to you: A child's need to reconnect with an approachable parent when exploration has been curtailed for any reason.
Watch over me: A child's need to know that his or her parent is present and available for the child as he or she explores the world.	Protect me: A child's need to be protected physically and emotionally, allowing him or her to feel safe.
Delight in me: A child's need to feel that he or she is pleasing to the parent just for who the child is as he or she explores.	Comfort me: A child's need for soothing and comfort from the parent when experiencing distress.
Help me: A child's need for a parent to scaffold learning, pitching the parent's help at the level required to build the child's competence, navigating the extremes of taking over, or leaving the child on his or her own.	Delight in me: A child's need to feel that he or she is pleasing to the parent just for who the child is as he or she seeks nurturance.
Enjoy with me: A child's need to feel that exploration is a shared and enjoyable experience for the parent also.	Organize my feelings: A child's need for help in regulating intense emotions in which a parent supports by being present with the child's intense feelings.

Around the Circle, the caregiver has the opportunity to organize emotions, whether they are the joy, pleasure, and satisfaction from exploration, or sadness, fear, loneliness, and anger (Powell et al., 2014). It is through this process of co-regulation that the infant's capacity to recognize and regulate his own emotions develops, and his internal working models of relationships are formed (Bretherton & Munholland, 2008). A parent who is able to "Be With" the needs on the Circle, attuning and responding with sensitivity and empathy is one of the most important aspects of secure attachment (Hoffman et al., 2017). The child's later capacity to self-regulate is fostered by the infants' experience of clear, consistent, and responsive mutual regulation in the early years (Mikulincer & Shaver, 2008).

Among the more important research findings on attachment is that caregivers (and correspondingly, children) tend to be more comfortable with interaction on one half of the Circle, preferring to support exploration and autonomy (Top half) or to maintain proximity, provide nurturance, comfort, and protection (Bottom half; Powell et al., 2014). Parents can also struggle with maintaining the balance of providing Hands, becoming overly harsh (mean), ineffective (weak), or psychologically absent (gone). As Sroufe and Waters (1977a) note, by the latter half of the first year of life, the child adapts his or her behavior to the particular patterns of the caregiver, learning to manage the expression of needs in a way that is experienced as safe and acceptable to the caregiver.

In securely attached dyads, children are able to engage in exploration (Top of the Circle) and directly express needs for comfort, protection, and safety when needed (on the Bottom of the Circle). The child's capacity to flexibly and directly make bids for closeness and confidently explore the world are markers of secure attachment (Ainsworth et al., 1978). The caregiver in the securely attached dyad is responsive to the child's needs for exploration and protection, as well as serving as a consistent, strong, and kind caregiver (Solomon & George, 1996). The caregiver's emotional availability, willingness to follow and respond to the child's cues provides the child with both a secure base and safe haven (Bowlby, 1969), functions which are portrayed as equally important in all the Circle of Security models of intervention (Powell et al., 2014). Attachment security does not require complete and unwavering attunement on the part of the parent, but consistent attempts to respond to the child's need and make repair when misattunements occur (Siegel, 2012).

Patterns of attachment insecurity correspond to the dyad's relative difficulty with either distance (resistant/ambivalent attachment) or closeness (avoidant/dismissing of attachment) in the attachment relationship (Ainsworth et al., 1978). Resistant attachment is characterized by hyperactivation of the attachment system where the child tends to amplify distress and may appear preoccupied with the parent's whereabouts and availability (Ainsworth et al., 1978). Exploration tends to be inhibited, and the focus of the child is on the parent. The caregiver in an ambivalent dyad is observed to be inconsistent in the provision of care and unpredictably available to the child (Solomon & George, 1996). The parent may also place an emphasis on the child's closeness, subtly or overtly communicating that exploration or distance is not acceptable or safe. Using the Circle of Security diagram, this is represented by a struggle on the Top of the Circle (Powell et al., 2014).

Avoidant attachment is characterized by minimal displays of affect, particularly distress, although physiological measures suggest the distress is equal to that of ambivalent dyads (Sroufe & Waters, 1977b). The child tends to focus on exploration and may appear to be oblivious to the caregiver's presence (Ainsworth et al., 1978; Cassidy, 1994). Hill (2015) notes that caregivers of infants with avoidant attachment classifications tended to withdraw or dismiss expressions of affect or rebuff bids for closeness. Using the Circle of Security diagram, this pattern is represented by a struggle on the Bottom of the Circle (Powell et al., 2014).

Disorganized attachment is characterized by the lack of a clear strategy for seeking care and proximity in times of need (Main & Solomon, 1990). The child appears to be disoriented and may display bizarre or contradictory behaviors to their caregiver. The caregiving in disorganized dyads tends to be typified by absence, helplessness, hostility, or contradiction and ultimately undermines the child's sense of safety and stability in the world. The caregiver's behaviors, rather than soothing and regulating the child's state of distress, further activate the threat response of the child. Main and Hesse (1990) argue that the infant simultaneously feels threatened by the caregiver, but also motivated to seek comfort from that caregiver. This paradox is irresolvable and is characteristic of disorganized attachment relationships, where the caregiver's struggle to regulate the child leaves the child without a consistent Safe Haven. The COS framework represents this pattern as a difficulty with the Hands, the capacity to serve as a stable and consistent caregiver, able to balance warmth and strength, and to take charge when necessary. By representing these complex attachment patterns as difficulties with an aspect of the Circle of Security, attachment strengths and struggles can be meaningfully represented and discussed with caregivers.

COS Intensive Intervention

The Circle of Security Intensive intervention (COS-I) draws on attachment theory and object relations theory to promote attachment security. Initially designed as a weekly group-based intervention spanning ~20 weeks, the COS-Intensive intervention has more recently been adapted for use with individuals and couples. The sessions are structured to involve a mix of psychoeducation and psychotherapy, with three phases of individualized video review. A comprehensive dyadic assessment underlies this video-based therapy and is derived directly from studies on attachment patterns.

Dyadic Assessment

A fundamental attribute of the protocol is the individualized assessment and treatment (Powell et al., 2014). Each dyad participates in a modified Strange Situation Procedure (SSP; Ainsworth et al., 1978) where their patterns of interactions are observed across a number of episodes designed to activate exploration, attachment, and caregiving systems. The caregiver then participates in the Circle of Security Interview (COSI), a semi-structured interview where they are invited to reflect on the Strange Situation Procedure, on their relationship with the child, their historical relationship with their parent, and their child's thoughts and feelings. The interview contains questions from both the Parent Development Interview (Aber et al., 1985) and the Adult Attachment Interview (George et al., 1984) and takes approximately 1 hour to administer (Cooper et al., 2005).

Both the interview and the Strange Situation Procedure (SSP) are video-recorded for two main reasons. First, the interactions are reviewed to understand the dyad's attachment relationship and the caregiver's state of mind. The assessment guides the target of the intervention, helping to identify the dyad's specific strengths and struggles in relationship and linchpin issue that, if addressed, would have the strongest impact in moving the dyad towards security – supporting exploration and autonomy (Top of the Circle), providing a safe haven (Bottom of the Circle) or maintaining the balance of Bigger, Stronger, Wiser, and Kind Hands. Throughout the intervention, the therapist maintains a focus on the dyad's linchpin struggle supporting them to recognize the child's needs and reflecting on their capacity to respond to these. Second, video review is a key component of the intervention process. The video recording allows specific interactions between caregiver and child to be reviewed on a moment-to-moment basis with the caregiver and procedural information to be brought into awareness and reflection. Video review between therapist and caregiver also sets an emotional tone that allows for the weaving in of moments of connection while also exploring moments of struggle.

Targets of Change

The COS Intensive intervention works from the premise that almost all parents have positive intentions for their children. Parents do not intentionally ignore or deny their child's attachment needs. However, all parents struggle to some extent with responding to needs on the Circle. Their capacity to respond to the child's needs is impacted by their own state of mind with respect to attachment (Powell et al., 2014). State of mind, encompassing the parent's own attachment history, their reflective functioning, and mental representations shape their perceptions and interpretations of behavior in relationships, including that in relationship with the child. State of mind also determines the caregivers' characteristic (defensive) responses to particular emotions, needs, and behaviors. These sensorimotor, nonlinguistic models of relationship operate procedurally, and are thus typically outside of awareness. State of mind can be impacted by the context of caregiver but also can buffer adverse environments from affecting the parent–child relationship negatively (see Fonagy et al., 1994). Fraiberg, Adelson, and Shapiro (1975) refer to these procedural memories and responses as "ghosts in the nursery," internalized and unarticulated rules and representations about relationships that were primarily learnt through the caregiver's own experience in childhood. These internal working models and representations shape the parent's responses to the child and are among the most powerful predictors of the quality of the attachment relationship with the child (Fonagy et al., 1991).

A core assumption of the intervention is that these internal working models are open to change (Bretherton & Munholland, 2008). The capacity to bring procedural assumptions and representations into awareness and reflect on their impacts on caregiving behavior is a key mechanism of change. Through reflective dialogue, the implicit memories and feelings associated with historic caregiving experiences become explicit and the ways these intrude on the parent's responses to the child in the present can be recognized and explored. In the COS model, the unconscious processes that underlie a caregiver's specific struggle on the Circle are captured by the concept of Shark Music. This metaphor helps to represent those relational experiences the caregiver is uncomfortable with or fearful of from their own procedural histories. Shark Music encompasses those needs in the child that activate a caregiver's fear/discomfort even though the child's needs are not actually dangerous. Children learn to adapt their expression of needs in response to the parent's Shark Music. Where a need is consistently recognized and responded to, the child can comfortably communicate it, cueing the parent directly. Where a need or feeling consistently makes the parent uncomfortable, activating Shark Music, the child learns to miscue the parent, by hiding or concealing that need (Powell et al., 2014).

The COS-Intensive intervention supports parents to recognize their own Shark Music and the ways their child has learned to miscue the needs the parent is uncomfortable with. Parents are introduced to these ideas through psychoeducation before they are explored directly in their own relationship via video review. In the first phase of treatment, caregivers gain confidence in using the COS graphic as a map for observing their relationship. The goal is to develop the caregiver's observational skills recognizing how the attachment needs of the child are "hidden in plain sight." By seeing how genuine needs are represented by behavior, the caregiver can make more accurate inferences from the child's communications and in turn experience greater empathy (Powell et al., 2014). The use of video of personal interactions with their child allows the parent to see their own relationship and practice applying this map in real time. The video can be paused and replayed multiple times, allowing specific questions about the child's needs to be asked and answered by reference to the video clip.

Three phases of video review take place with each parent. In each video review session, a series of clips from the SSP are selected to present to the parent. Phase 1 video review focuses on introducing the core themes of the linchpin struggle on the Circle, highlighting how the child miscues specific attachment needs. Using a process of reflective dialogue learned in the earlier sessions, parents are supported to observe and describe the interaction and make guesses about the child's needs on the Circle. Phase 2 video reviews aim to help parents reflect on their internal experience of Shark Music as they observe moments that capture the linchpin struggle in their relationship with the child. A key skill each therapist must develop is selecting a series of about four clips for each Tape Review that together show the caregiver how much they are needed (engendering hope) while also showing the caregiver where they struggle (engendering vulnerability; Powell et al., 2014). All tape reviews end with highlighting the caregiver's underutilized capacity to meet their child's need on the area of the Circle they seem to struggle with most; this emphasis on "lifting up" the caregiver's capacity, while also directly identifying their struggle, is important (McDonough, 1995).

The therapist's formulation of each parent's state of mind allows the therapist to sensitively work to maintain reflective dialogue throughout the distress, co-regulate and ultimately contain that distress. "The capacity to remember and comment on an event that was frightening evokes a very different response than simply feeling frightened" (Cooper et al., 2005, pp. 138). This process can assist the parent to reflect on their own attachment histories and the ways internal working models of relationships influence the synchrony with their child. Training in the COS-Intensive model specifically highlights the parallel process of the therapist calmly addressing a caregiver's fear or discomfort, which in turn models for that caregiver the way they might manage their own fear or discomfort in meeting their child's needs. Therapist training also focuses on how best to select clips from the Strange Situation Procedure to highlight the key area the caregiver can focus on to promote security within the relationship and to encourage reflective dialogue about that struggle. Promoting caregiver reflective function is particularly important given the body of research that has documented the role of state of mind on child development (e.g. Arnott & Meins, 2007; Fonagy et al., 1991; Fonagy & Target, 2005) and its relevance to the therapeutic process more broadly (e.g. Fonagy, 2001). For further discussion of the therapeutic process underpinning the model, see Powell et al. (2014) and Coyne et al. (2019).

Evidence

The effectiveness of the COS-I model was initially assessed using a longitudinal pre-intervention post-intervention design using the SSP to classify the attachment security of the dyads (Hoffman et al., 2006). Participants were 75 at-risk dyads from Head Start and Early Head Start programs. Two hypotheses were explored: (1) that there would be a significant reduction in disorganized attachment and (2) a significant increase in secure attachment. There was a significant reduction in disorganized classifications (from 60% pretreatment to 25% posttreatment) and a significant increase in secure classifications (20% pretreatment to 54% posttreatment). These early promising research results led to manualization of the COS-Intensive model and to a training and supervision pathway that has allowed providers around the world to implement the model.

Huber et al. (2015a) examined the COS-I model among 83 Australian parent–child dyads with children aged between 1 and 8 years old. These dyads were referred to a community clinic for concerns relating to child behavior or emotion. The study assessed changes in caregiver reflective function, caregiver representations, and child attachment classifications using the SSP. Following intervention, improvements were observed in caregiver representations and reflective functioning. The most positive shifts from pre- to post-treatment were observed in caregivers and dyads who had shown the most risk in terms of attachment disorganization and representations of relationship, with the 47 parents lowest in reflective functioning demonstrating positive change at a significant level and large effect size. There were significant shifts also in the degree to which parents held frightening or frightened representations of their child. While change in attachment classification was nonsignificant, significant change in attachment dimensions of the 23 insecure dyads in terms of security and a significant decrease in the disorganization dimension for the 13 children disorganized at baseline.

Further analyses (Huber et al., 2015b) assessed the impact of the COS Intensive intervention on measures of child behavior and emotion. The intervention resulted in significant reductions in child internalizing (among 38 children in clinical range at pretest) and externalizing behaviors (38 children in clinical range at pretest) as well as promoting protective factors.

Ramsauer et al. (2020) used COS-I with 72 mothers with a diagnosis of depression and infants aged 4–9 months. This sample was recruited in Germany, though most participants were refugee parents from various parts of the world. The RCT compared treatment-as-usual (TAU) which was a dyadic mother–infant treatment incorporating individual psychotherapy, pharmacotherapy, and social support with TAU plus COS-Intensive group intervention on attachment security and maternal sensitivity. No significant differences were identified in attachment security and disorganization at follow-up. The majority of infants were securely attached in both the TAU and COS-I group. Both groups also improved significantly in terms of maternal sensitivity between time points and COS-I did not appear to provide any additional benefit over the intensive treatment that made up TAU in this study. However, mothers who had an unresolved attachment status on the Adult Attachment Interview (AAI) demonstrated improvement in sensitive caregiving after completing COS-I, compared to nonunresolved mothers (secure autonomous, insecure preoccupied, and insecure dismissing); an effect not observed in the TAU group. This finding suggests that unresolved mothers received a positive benefit from undertaking the COS-I intervention. The authors suggest that perhaps the COS-I model is best suited for supporting those with negative attachment histories rather than postpartum depression alone.

These promising results, together with the model's intuitive appeal, saw clinicians around the world undertake training in the Circle of Security Intensive intervention. However, the COS-I model is resource and labor-intensive requiring hours of work in administering and reviewing video of the SSP and state of mind interview for each dyad. In the research and university context, these procedures allow for scientific rigor. However, there are few service delivery contexts that allow clinicians to bill for dyadic assessment or allow them the time to review that assessment, select video material, and edit clips to show to caregivers.

At Queensland University of Technology (QUT), the COS-I model has been integrated into graduate training, utilizing a student-led clinic to deliver the intervention to families within the local community. Training students within an existing graduate psychology program and the availability of appropriate facilities within a university clinic service have allowed this program to prosper. Further, the availability of onsite training and supervision has fostered innovation; for example, a version of the COS-I Individual protocol specifically designed to be accessible to those in private practice was developed at the QUT clinic (Andrews & Coyne, 2018). This COS-I Individual model uses preexisting clips of parent–young child interactions for psychoeducation on attachment. It also condenses the intervention so it can be delivered in 12–14 sessions. For further detail on the adjustments for individual delivery see Andrews and Coyne (2018) and Andrews (2019). However, in community settings, clinicians are often faced with large and complex caseloads and limited nonclinical time. Time-limited and resource-efficient interventions are favored, and the longer term and more complex clinical models are challenging to deliver (Cassidy et al., 2017).

Despite the enthusiasm for the COS-Intensive model, there are a limited number of clinical settings worldwide that have been able to embed COS-Intensive in their service context. Further, there has been some research that suggests that shorter, more focused attachment-based interventions might actually be more efficacious than longer protocols (van IJzendoorn et al., 2005). Given that many clinical settings are pushed by payors to implement lower cost, more efficient interventions, the demand for brief intervention protocols has grown.

Broadening Application: Circle of Security Parenting

In response to the continued demand for more scalable versions of the model, Cooper et al. (2009) developed a brief manualized program designed to be used in primary care and community settings, Circle of Security Parenting (COSP). The program consists of eight chapters, designed to be delivered flexibly in eight to ten sessions (Coyne et al., 2019). Distinct from the COS-I Intervention which uses video of the parents' own relationship, COSP uses third-party video to introduce the attachment concepts and practice recognizing children's needs. COSP was designed as a preventive intervention that could be used universally, given that its cost to implement is low (Asmussen et al., 2016).

While parents learn key ideas from attachment science, the COSP program is not intended to solely be a parent education class; rather the program uses video-based learning paired with reflective questions to promote parent reflection. As with the original program, COSP aims to begin to develop specific relational capacities in the caregiver. For lower risk caregivers, simply identifying areas of struggle on the Circle and reflecting how better to meet the child's needs may be enough to produce significant change. At the same time, COSP may function more as an engagement tool for more at-risk caregivers, a platform from which more individualized parenting support or trauma focused therapy can be conducted.

A key target of change in COSP is caregiver reflective functioning. Parents are supported to develop observational and inferential skills to recognize their child's needs, using the COS graphic and prerecorded video clips of third-party parent–child dyads. Through reflective dialogue, caregivers learn to observe behavioral signals and make inferences about the needs and feelings these represent. As parents begin to look beyond behavior to see the genuine needs underlying behavior, they begin to have more empathy and can respond to the authentic relationship needs. The development of observational and inferential skills also supports parents to discover the ways their interpretations and responses to their child may be unduly influenced by their own procedural attachment histories and associated anxiety from these experiences (Shark Music). The concept of Shark Music gives parents a nonblaming language to identify and discover implicit memories and feelings that drive their responses to their child. As in COS-I Intervention, reflective dialogue is used throughout COSP to support caregivers to re-evaluate the conclusions they have internalized about specific relationship needs and "turn down the volume" of the frightening feelings associated with Shark Music (Powell et al., 2014).

The relationship between caregiver and facilitator is central to the delivery of the program. Facilitators strive to create a holding environment where caregivers experience a sense of Secure Base and Safe Haven as they explore relationship patterns. The facilitator acts as Hands, welcoming the caregiver in, co-regulating emotion and distress, and supporting the caregiver to explore and experiment with new ways of being in relationship (Cooper et al., 2005).

In producing this shorter variant, the key question has been, can a nonindividualized approach be impactful in promoting attachment security, and if so, for which groups of caregivers? The worldwide uptake of this variant of the Circle of Security has been significant with more than 40,000 providers trained worldwide and translations into 14 languages. As such, the dissemination of COSP has far outpaced the research (McMahon et al., 2016; Mercer, 2015). However, studies investigating its impact have been conducted in recent years. The first RCT of COSP (Cassidy et al., 2017) was undertaken with a US Head Start population of 141 dyads with children aged 3–5 years. Dyads were randomly allocated into the COSP treatment group or waitlist control. Groups did not differ in terms of attachment security at post-test – dyads did not shift from categories of insecure and disorganized attachment to secure attachment following the program. However, caregivers' unsupportive responses to children's distress were significantly lower in the COSP group compared to those in the waitlist control group. Inhibitory control, a component of executive functioning, was also greater for children in the COSP intervention group, after researchers controlled for marital status and maternal age.

A second RCT was undertaken with a clinical sample of 52 Swedish parents attending infant mental health clinics (Risholm Mothander et al., 2018). The study compared parent–infant interaction quality and parent representations between two groups – treatment as usual and treatment as usual supplemented with COSP delivered in a small group format. Outcomes were assessed at baseline, 6 months after participation, and 12 months after participation. Those caregivers who completed COSP showed significant improvements in representations of the child and themselves as caregivers. Parents in the COSP group were less likely to be classified as disengaged or distorted on the Working Model of the Child Interview (Zeanah & Benoit, 1995) and had a higher proportion of balanced representations than those in the TAU group. Significant improvements were also observed in the proportion of emotionally available interactions. Parents in the COSP group were assessed as being more emotionally available over time; a change not observed in the TAU group.

A third RCT examined the COSP program delivered individually (rather than the typical group format) to 85 Australian caregivers considered at-risk of child protection involvement (Zimmer-Gembeck et al., 2022). This study found reductions in caregiver anxiety in intent-to-treat analyses following completion of the program; however, no other significant differences were found when comparing COSP to the waitlist control condition – both groups showed significant improvements in child externalizing and internalizing symptoms, a decrease in caregiver stress and increase in interest in the child. When examining the data from those who completed the program (but not intent-to-treat analyses), COSP led to reductions in negative parenting practices. Together, these findings suggest that while COSP does not result in shifts in attachment security, positive changes in parental representations and responses to the child are observed.

Several nonrandomized studies have investigated the effects of COSP on a range of caregiver variables, particularly self-efficacy, parental stress, parental mood, and well-being. Kolhoff et al. (2016) studied 15 mothers attending a community early intervention parenting service. After completing COSP, parents reported significantly less stress, less fear, anger, and rejection toward the child and lower levels of helplessness. Similar findings came from a study with a small sample of women (n = 34) admitted to a private mental health facility for treatment of maternal mood disorder (Foster, 2014). Those who completed COSP reported reduced parental stress and decreased helplessness in their capacity to parent their children. An observational study of COSP with foster carers (Krishnamoorthy et al., 2020) also reported positive impacts on caregiver stress, parent–child interactions, and parent perceptions of the child's difficulty. Following completion of the eight chapters of the program, foster carers reported reductions in their perceptions of their foster child as being difficult to take care of. Caregivers also reported that there were also fewer dysfunctional interactions with their foster child following completion of the program.

Horton and Murray (2015) investigated the impact of COSP for 15 mothers participating in a residential substance abuse treatment program. Among those participants who completed the program, improvements were noted in emotion regulation, parental attribution, and parent discipline practices. Parents reported a decline in laxness and overreactivity in their discipline following completion of the program. Of note, those caregivers with more education, no personal history of child maltreatment, and shorter time in the residential program showed the greatest improvement on the variables measured. Given several of these studies (e.g., Foster, 2014; Horton & Murray, 2015) were undertaken in residential facilities where simultaneous treatments were also delivered, it is difficult to confidently isolate the effects of COSP on these parenting outcomes.

The largest nonrandomized controlled effectiveness study examined an Australian community sample of 256 parents of children aged 0–6 years (Maxwell et al., 2021). Parents in the COSP treatment group, as compared to a waitlist control group, reported significant improvements in self-efficacy in terms of empathy and affection toward the child. They also reported significant reductions in hostility and helplessness in caregiving toward the child as well as reduced depressive symptoms. The greatest reductions in caregiving helplessness were reported by caregivers of older children. Further, mothers with "probable clinical depression" reported the greatest reduction in hostility and depressive symptoms post-intervention. A similar reduction in maternal depressive symptoms was reported in a small implementation study (Maupin et al., 2017).

There is also evidence that COSP changes practitioner's views in response to viewing a difficult parent–child interaction pre- and post-training (McMahon et al., 2017). This study examined 202 practitioners from a range of professional backgrounds undertaking COS training workshops in Australia and New Zealand. The training workshops utilize significant portions of the COSP video material, aiming to build professionals' capacity to use these resources with caregivers. Three training workshops (a 2-day introduction and a 4-day and a 10-day facilitator training) were examined. Both prior to and at the conclusion of the training, participants were shown a video clip of a parent–child dyad where the parent, trying to complete some paperwork, responds to increasingly dysregulated behavior from her preschool aged child. In the clip, the parent struggles to contain the child's emotional distress and gives in to the child's demands, appearing overwhelmed and frustrated herself. After viewing this clip, participants were asked to "(a) list five short words or phrases to describe the relationship they had seen in the video segment and indicate (b) what they saw, if anything, that might be a challenge, and (c) what they thought most needed to change" (McMahon et al., 2017, p 662). The descriptions were coded by two independent coders blind to time condition for empathy, judgment, and attachment understanding. Following the training, participants used significantly more attachment descriptions and demonstrated greater attachment understanding. Those who attended the longer trainings (4- and 10-day trainings) showed very few judgmental and critical comments. While it is unclear how these changes might inform and influence practitioner's work with families, the COSP model appears to provide a usable and accessible way to understand complex-relational concepts.

How these changes in parent perception, efficacy, and parental well-being affect parent–child interactions are not clear. Most of these studies have been conducted in "real-world" settings and thus rely on convenience sampling resulting in limited controls over confounding variables. The use of self-report measures also limits the examination of the impact of the program on parent–child interaction. The nature of the research reflects the contexts in which COSP has been particularly sought after – community child and family health clinics, perinatal, child and youth mental health services, and private practice. It is in these settings, the centrality of the parent–child relationship for long-term child well-being is recognized, yet the resources available to intervene are often most limited. Thus, finding effective strategies to promote attachment security with limited resources remains a worthwhile goal.

Together, these studies suggest that COSP does seem to influence caregiver's (and professionals') perceptions of their child, their attachment, and exploration needs and their behavior. COSP particularly appears to provide both caregivers and practitioners alike with a sense of confidence, agency, and self-efficacy with concepts of attachment theory and state of mind processes (Kohlhoff et al., 2016; Maxwell et al., 2021; McMahon et al., 2017). There is a simplicity in the graphics and the language that allows caregivers to readily absorb and meaningfully apply the information to their own relationships. It is interesting to note that in some studies, the changes were most pronounced for those with more severe presenting symptomatology (e.g., Maxwell et al., 2021), whereas in other studies with higher risk samples, change was greater for those with lower risk presentations (e.g., Horton & Murray, 2015). This variation in findings makes it difficult to argue if COSP is more suitable for particular populations.

However, these changes in understanding resulting from COSP do not seem to translate into changes to attachment status, at least not in the interval of 8–10 weeks of intervention. Engaging caregivers in reflecting on their relationship with their child is a first step, but it seems more is needed to promote shifts from insecurity and disorganization to security. Particularly for high risk and complex dyads, it is likely that more targeted, therapeutic and individualized treatment is needed to shift patterns of attachment from insecure and disorganized states of mind (Horton & Murray, 2015; Zimmer-Gembeck et al., 2022). The attachment-focused interventions with the strongest evidence are those that are more focused, video-based, and individualized to the dyad's presentation (e.g., Attachment and Biobehavioral Catchup; Dozier & Bernard, 2019; Video intervention to promote Positive Parenting; Juffer et al., 2018). It may be that COSP provides a means for translating complex attachment concepts and building empathy and understanding of children's needs but that caregivers need more direct feedback by means of focused and clinically targeted video to recognize the procedural patterns contributing to insecurity in their relationships. Thus, the challenge remains of balancing clinical potency with accessibility and scalability.

Beyond the Group

In order to provide therapeutic intervention and individualized video review using the COS Intensive framework, several teams in different global settings have adapted the COS-Intensive model to respond to the particular needs of the community and the resources available in their service delivery context.

Kitagawa et al. (2021) have studied a modified COS-Intervention with Japanese parent–child dyads. In their hybrid model, participants undertook the standard eight-chapter COSP protocol in a group of six to eight mothers. Following this, two phases of individualized video reviews were undertaken with each parent adding a further ten to eleven sessions, depending on group size. Attachment security, parenting stress and caregiver representations were assessed prior to the intervention, following completion of COSP, after the video review process and 6 months after program completion. At the 6 month follow up, a significant increase was observed in the number of dyads classified as securely attached and none were classified as disorganized. These changes were not observed at the earlier points of measurement (i.e., after COSP and immediately after video review). The authors suggest this may indicate a sleeper effect, whereby categorical changes in attachment classification are not observable immediately. A reduction in parent stress and concern regarding their child was also observed immediately after the completion of COSP, and further at the 6-month follow-up.

Huber et al. (2021) have also integrated COSP material into the delivery of the Circle of Security Intensive program with both individuals and groups of parents. Participants in the study were 71 parent–child dyads with relationship concerns referred to a community program in New Zealand. As with the original COS Intensive intervention, the group protocol was undertaken with groups of five to six parents over 20 weeks. The individual protocol retained the same content and video review processes but took place over 16 sessions as parents did not see the video reviews of other parents. The study found significant changes in caregiver behavior and representations of self as a parent following the intervention delivered both individually and as a group. Parents were more likely to respond with greater empathy and emotional support to their children, and there was less harsh and hostile behavior reported. Parents also reported greater satisfaction in the parenting role and improvements in their sense of competence and efficacy as parents. These changes were sustained at 3-month and 12-month follow-up.

In a series of case studies, Coyne and colleagues found brief individualized versions of the COS-Intensive intervention, which included COSP components, effective in intervention with children on the autism spectrum (Fardoulys & Coyne, 2016) and older children outside the typical preschool age (Andrews & Coyne, 2018; Andrews, 2019).

The evidence that the intensive program can be effectively delivered individually provides greater flexibility than the original COS-Intensive intervention. While Powell et al. (2014) indicated that individualized delivery of the program was always an option for parents not suitable or able to attend group, only recently have data or case studies of COS-Intensive used individually been available. The individualized protocols may be particularly important for parents who may be uncomfortable with engaging in a group-delivered intervention. Those with young infants can attend individually without being concerned of the impact of an infant in the group and some highly defensive or vulnerable parents, who may find group processes challenging, may better be served by individual intervention.

Of course, recent studies also extend the length of the intervention, so parents receive a longer dose of intervention than those completing COSP. A higher intervention dose may indeed be necessary for higher risk dyads. The findings of these collective studies of the intensive protocols suggest that the addition of individualized video review to a program like COSP may be necessary to result in change to attachment security and caregiving behavior.

COS Classroom Approach

The positive outcomes resulting from secure attachment relationships are not confined to the parent–child relationship. There is now clear evidence that a secure attachment to early child care providers and teachers contributes to long-term social-emotional, academic, and behavioral outcomes. Several longitudinal studies (Hamre & Pianta, 2001; Hughes et al., 2008; O'Connor & McCartney, 2007; Rudasill, 2011) suggest that children's relationships with their early care providers serve as a model for future relationships with teachers. There is also evidence that positive relationships with teachers are protective even where there is an insecure attachment relationship with the primary caregiver (O'Connor & McCartney, 2007). However, many early childhood professionals lack guidance on how to promote secure attachment with the children in their care. Furthermore, many children struggle to manage the social and emotional demands of childcare or preschool. Schools tend to have an implicit planning process that assumes all educators have a secure state of mind in regard to attachment and relationships and all children come to school feeling safe and secure and ready to learn. Neither are true.

Children with insecure attachment histories are more likely to have insecure interactions with educators (deMulder et al., 2000) because they tend to behave in ways that elicit negative responses from their educators, reinforcing insecure internal working models of relationship. Interactions between children with insecure attachment histories and their teachers are marked by higher levels of control, lower expectations of cooperation, and more frequent directives (Pianta, 1999). Children with an avoidant attachment to their primary caregiver tend to experience more rejection and isolation from their early care providers. Educators respond with greater tolerance and nurturance of children with ambivalent attachment to parents but perceive these children as more immature and have lower expectations of competence (Kennedy & Kennedy, 2004). Children with a secure parent–child attachment relationship are more likely to elicit warm responses from educators than are insecure children.

While it is possible for children with insecure attachment histories to form secure relationships with their preschool educators, this outcome occurs less than one-third of the time (Howes & Ritchie, 1999). High-quality connection with an educator can offer some protection against the negative outcomes (e.g., on academic achievement and school engagement) associated with insecure attachment with the primary caregiver (O'Connor & McCartney, 2007). Attunement and sensitivity are underpinned by a capacity to understand and interpret children's attachment behaviors. Sensitive responding involves the accurate identification and appropriate responding to children's experiences and their cues (and miscues) regarding their needs (Pianta et al., 2008).

Naturally, accurate identification and appropriate responding to attachment needs can be more difficult in students with insecure attachment histories because of the ways insecure internal working models shape the expression of attachment needs. Further, just as the child's attachment histories shape future relationships, educators' relational experiences and internal working models influence the process of forming relationships with students (Pianta, 1999). Educators interpret children's behavior and the needs it reflects through the lens of their own representations, including representations of attachment.

Adults with a dismissing attachment state of mind are likely to find it more challenging to perceive and respond to children's needs for emotional closeness, co-regulation of emotion, physical proximity, comfort, and soothing. Educators with a dismissing state of mind may also demonstrate expectations of self-sufficiency and distance in the relationship and may be less warm and sensitive in their interactions with students. Adults with a preoccupied attachment state of mind are likely to find it more challenging to perceive and respond to children's needs for autonomy and exploration. They may find themselves overly attentive to children's emotions and behaviors and struggle to take charge and make decisions for fear of rejection.

Because of these complexities, educators are more likely to be able to attune to attachment needs if they have a map to track attachment needs and can understand the ways that children's behavior may represent or misrepresent their relationship needs (Pianta, 1999). COS Classroom Approach (COSC) uses the very same Circle of Security graphic (see Fig. 26.1) as one of several visual aids to help educators see what children need to feel safe and secure. In early education settings, children need to develop a wide range of cognitive skills and social/emotional competencies to support their success throughout their school career and into adulthood. Children learn within the context of relationship, so it is not surprising that secure attachment to childcare providers has a significant positive effect on children's school readiness and learning (see Bergin & Bergin, 2009 for a review). In other words, children learn to go to school so that, later, they can go to school to learn. Thus, there is substantial evidence to suggest that interventions targeting the quality of teacher–student interactions are important. "Attachment theory and COS in particular provides critical organizing principles for the development of teacher-child relationships" (p. 27, Cooper et al., 2017).

The COS Classroom Approach has been designed to enhance educators' abilities to form secure relationships. It incorporates a vast body of research in attachment and developmental psychology. COSC is an adaptation of the COSP model, customized to the early childcare environment and designed to be conducted with child care professionals and teachers. The program employs a two-tiered approach. Tier 1, COSP Classroom Professional Learning Series, can be delivered as a stand-alone professional development program, or combined with classroom implementation at Tier 2 for programs seeking to deepen their learning in the application of attachment theory into the classroom.

The first tier involves making the theory of attachment accessible. With a COSP Classroom facilitator, early care professionals complete the eight-chapter, video-based curriculum (COSP) which provides a clear model of children's attachment needs. An initial focus in the model is supporting teachers to recognize themselves as attachment figures and in doing so acknowledging the significant role their relationship with the children in their care plays in long-term development. The program also supports teachers to look beyond behavioral approaches to seeing the ways attachment needs are communicated by behavior. The COSP program has been significantly adapted for use with teachers and providers take additional (online) training to be certified to present the additional reflection prompts, handouts, and other materials created to allow a focus on the teacher–child relationship.

The second tier (COSC Coaching) uses reflective consultation to help educators apply the Circle of Security in early care settings, addressing the relational needs of both individual children and classroom structures and procedures. Through regular coaching sessions, early care providers are supported to identify children who are struggling to develop secure connections with their teachers, clarify the specific relational pattern that is interfering with the connection, and develop a plan to respond to each child's attachment needs. This tier utilizes processes adapted from the COS Intensive framework, including assessment and intervention plans and individualized video review. Educators share videos from their classrooms of interactions with a child they are struggling with. The COS Classroom Coach supports the teacher to explore the child's needs and feelings and make inferences about where the child might be struggling on the circle. This reflective consultation also allows exploration of the educator's discomfort with specific child needs, and they are supported to reflect on their own internal representations and how these shape their responses to the child. By clarifying the relational pattern operating, an action plan can be developed to find new ways to respond to the child's needs and support their secure attachment with the caregiver.

Classroom Coaches also reflect and explore with teachers on ways to offer structures and procedures to develop relationship friendly classrooms. Early care providers are supported to find ways to bring to their classroom organization and routines to create an environment that supports secure connections. For example, pairing children with a specific caregiver in the classroom and creating primary groups of a small number of children that meet together each day with a particular educator strengthens connection. This group might meet for lunch, circle time, or during other specific transitions in the day. Primary groups also support the connection between the child's parent and educator – there tends to be more consistent communication and closer contact between the child's important caregivers. Another example is a fresh way to think about transitions. Dropping children off at school can be stressful for both the parent and the child. Educators often offer reassurance to the child that their parent will return. But the pressing question on the mind of the child while their parent is away is who then will keep them safe and watch over them. Rather than reassurance, the COS Classroom Approach focuses on creating for the child a sense of confidence that the educator is in charge and is there to meet their needs, which supports a sense of belonging and connection.

The adaptations to the parenting program arose out of several working groups over an extended period of time. For example, the Teacher's Circle was developed with teachers in mind to capture the complexity of relationships in the classroom – as caregivers to multiple children, they are typically responding to the differing needs on the Circle of several children at once (Fig. 26.2).

A pilot evaluation investigating the impact of the COSP Classroom Professional Learning Series (Tier 1) was undertaken with family child care providers to assess the impact of the program on caregivers' psychological functioning and self-efficacy in responding to challenging behaviors (Gray, 2015). A group of caregivers (n = 34) who self-selected into COSP Classroom were compared with a comparison group of child care providers (n = 17). Caregivers who completed COSP Classroom reported significant improvements in self-efficacy in managing challenging behaviors compared with the comparison group who reported significant decreases in self-efficacy in the same time period.

Topple (2018) examined the eight-chapter COSP Classroom Professional Learning Series with early childhood educators (N = 16) in a Head Start Center. Using a group randomized trial design, educators completed either COSP Classroom or training as usual. They reported on depression, stress, self-efficacy, and student social-emotional functioning prior to and following the program, as well as relationship closeness between students and teachers. Educators who completed COSP Classroom reported decreases in stress and increased self-efficacy in responding to children's challenging behaviors compared to their baseline levels, while the training as usual group reported slight increases in stress. However, the differences between the groups did not reach statistical significance. Of interest, educators who completed COSP Classroom showed significant increases in closeness with students with the highest levels of adversity, while educators in the training as usual group reported decreased closeness with these students during the same time period. The small sample size limited the conclusions that can be drawn about the effectiveness of the program. At the same time, these results suggest further investigation of the impact of the program on teacher well-being and teacher–student relationships is worthwhile.

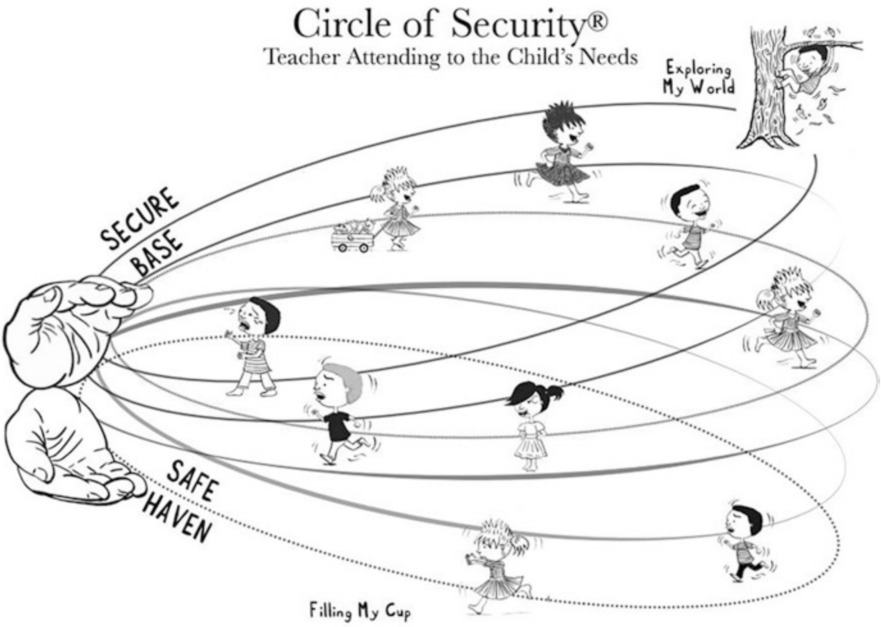

Fig. 26.2 The Teacher's Circle of Security

The SECURE Project is a prospective randomized wait-list controlled trial aiming to compare the COS Classroom Approach with care as usual in 31 childcare centers in Denmark (Smith-Nielsen et al., 2022). The study will evaluate the quality of interactions between caregivers and children, measuring the sensitivity of caregiver responses and caregiver mind-mindedness following completion of COSP Classroom Professional Learning Series (Tier 1). This study is adequately powered to provide more conclusive data on the impact of Tier 1 of the COSC Approach.

Summary and Key Points

- The importance of early relational health in predicting long-term well-being is clearly documented in research. One of the gifts of Circle of Security has been its accessibility and flexibility in bringing a coherent lens for understanding relationships across the lifespan.
- The suite of programs includes a therapeutic model, the COS-Intensive Intervention which has been shown to be effective in changing attachment classifications among high-risk dyads.
- The shorter variant, COSP, is widely used worldwide across contexts. Research to date suggests that while this model does not result in shifts in attachment security, parents who complete the program show improvements in caregiving representations, improved self-efficacy in understanding children's needs, greater empathy, and affection and reduced parental stress.
- Particularly for high risk and complex dyads, it is likely that more targeted, therapeutic, and individualized treatment is needed to shift patterns of attachment from insecure and disorganized states of mind. It may be that while COSP provides a powerful means for translating complex attachment concepts and building empathy and understanding of children's needs, that caregivers need more direct feedback by means of focused and clinically targeted video to recognize the procedural patterns contributing to insecurity in their

relationships, such as that offered via the COS Interventions.
- Expanding the model into early care settings through the COS Classroom Approach aims to share the wisdom arising from attachment science with caregivers outside the home and ultimately support children's earliest relationships in early care settings.

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27

Infant and Early Childhood Home Visiting

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The primary goal of most infant and early childhood home visiting programs is to support caregiving and relational health behaviors that optimize children's early development. One distinction of home visiting from other parenting and child development services is that home visiting takes place in the intimacy of families' homes. The home environment is essential to understanding the context in which families live, their cultural norms, family strengths, and priorities as well as the context in which the child is developing. Supporting families in the home is also important in the effort to provide services in a "natural environment" as identified under the Individuals with Disabilities Education Improvement Act (IDEIA; Reynolds et al., 2014).

Around the world, home visiting programs operate from a two-generation framework, in which services simultaneously support the development of children and their caregivers. Child outcomes are improved through direct supports from the program (e.g., developmental screening) and indirectly through improving the quality of caregiving (e.g., information about child development, direct support for caregiver–child interactions) and broader family environments (e.g., screening and referral for mental health, economic needs). It is through enhanced knowledge, competencies, and resources that caregivers can optimally promote their children's development (Raikes et al., 2014). Home visiting has been termed two generation, but supporting the child's broader caregiving environment is within the purview of home visiting. Programs often aim to include every caregiver of the child's in home visiting activities, including fathers, grandparents, other family members, and extended kin (e.g., tribal or community elders).

Home visiting can be viewed as an effort at systems change. When the home visitor first meets a family, it introduces a disturbance into an existing system of interacting relationships, which may include family members and extended kin, who may also impact family dynamics. Therefore, one key to success for the home visitor is to become familiar with the structure of the family system and the extent to which the family has boundaries that may challenge change processes, currently and over time.

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Home visiting provides a unique opportunity for engaging in relationship-based change practices. Serving families in their own physical space is not only conducive to understanding the unique culture, resources, and values of families but it also helps equalize the power dynamic between the family and practitioner. Home visitors bring expertise to the daily interactions of families and support caregiver self-reflection about relationships and the impacts of past relationships on current ones (i.e., paternal and maternal ghosts and angels in the nursery: Barrows, 2004; Fraiberg et al., 1975). As home visitors develop warm, responsive relationships with families, caregivers' willingness to try new strategies and engage in meaningful reflection increases. These reflective behaviors break down barriers impeding interpersonal transactions and improve the relationship quality between caregivers and their children; promoting positive mental health and well-being in children (Menashe-Grinberg et al., 2022).

Approaches to Home Visiting

Clinical and Preventive Interventions

Home visiting provides a unique opportunity for both clinical and preventive intervention and many models exist for individual families across contexts. Clinical interventions can include early intervention for children in need of additional development supports. Existing clinical adult behavioral interventions, including Cognitive Behavioral Therapy (Ammerman et al., 2013) and Interpersonal Therapy (Beeber et al., 2010) have been adapted for use in home-based settings. Additionally, there are multiple in-home adaptations of relationship-based clinical interventions, such as Parent–Child Interaction Therapy called the Infant Behavior Program (Bagner et al., 2016), Circle of Security-Home Visiting (Cassidy et al., 2011), and Child First, which incorporates Child–Parent Psychotherapy into services. These programs often have workforce requirements for intensive education and training around trauma, behavioral and therapeutic knowledge, and skills that are more stringent than for the broader home visiting workforce.

Preventive approaches are used to strengthen protective factors and decrease the impact of stress and trauma on young children and families. Prevention programs serve families with a variety of challenges. Eligibility for preventive services often include caregiver behavioral health risks associated with child abuse and neglect (e.g., including family alcohol/drug problems, family mental illness, domestic violence, crime, and incarceration), as well as broader characteristics of caregiving environments (e.g., economic insecurity, low educational attainment, single parenthood, homelessness, and exposure to neighborhood violence) associated with structural inequities and less optimal child outcomes.

Cumulative risk models assert that the probability of poor outcomes increases as the number of risks experienced by a child increases. Developmental studies of childhood adversities have identified numerous life-course experiences (e.g., maltreatment, poverty, and deprivation) that can negatively impact child development, health-related behaviors, and psychosocial and physical health outcomes that persist into adulthood (Anda et al., 2006). Studies have explored early exposure to adversities in infancy and early childhood and have documented robust detrimental effects for social-emotional and physical development (Kerker et al., 2015).

These findings give rise to serious concerns about the long-term health and development of children who experience trauma. They also highlight the need for interventions that aim to decrease the exposures directly and support the safe, stable, and nurturing caregiving experiences of children. However, just knowing that there are a specific number of adversities does little to structure individualized treatment programs (Kelly-Irving & Delpierre, 2019). Home visitors must examine which specific adversities are impacting the family and how those adversities are intertwined systemically, so trauma-informed prevention approaches can target the specific risks unique to a family. A trauma-informed approach also requires understanding and building on family strengths and resources that promote resilience.

Caregiver-Driven Approach

A primary goal of home visiting is to empower caregivers to support their children's development by providing services in individualized ways while building parents' capacity through collaborative relationships. Parent involvement (i.e., intention to enroll, enrollment, retention, and engagement) is crucial to the provision of services and includes (Korfmacher et al., 2008). Research indicates that increased parent involvement leads to more positive child and family outcomes, but family retention in programs is a significant challenge; many programs lose more than half of families during the first year of services (Michalopoulos et al., 2019).

While family, home visitor, and program characteristics show mixed results when predicting program involvement, there is consistent evidence that using a caregiver-driven approach to services is key (Popp & You, 2016). Caregiver-driven approaches actively engage caregivers in goal setting, planning, and home visit activities. The Early Intervention Program for Infants and Toddlers with Disabilities (Part C) of the IDEIA offers home-based services designed to support the development of infants and toddlers with special needs and to strengthen the capacity of families to foster their development. Part C emphasizes the role of the home visitor as a "coach" who actively engages families in goal setting, planning, and providing learning opportunities within their everyday routines and activities, optimizing both quantity and quality of those opportunities (Rush & Shelden, 2011).

Strength-Based Approach to Services

Supporting the caregiver–child relationship is a focal task of the home visitor, which requires a variety of skills for facilitating interactions that are sensitive, nurturing, and developmentally stimulating (Roggman et al., 2008a). Effective home visitors use their observations of interactions to point out positive caregiving behaviors that promote healthy development in children (Shanley & Niec, 2010). Some individual characteristics that support effective practice include interpersonal empathy, self-awareness, curiosity, and cultural humility (Schaefer, 2016).

A strengths-based approach is collaborative, and the family's interests and goals are actively incorporated into home visit content and processes. This approach allows families to work toward goals they value for their children in ways they value for their families. In addition, home visitors are better able to use family goals and preferences to individualize their intervention content and demonstrate respect for caregiving strengths within families' cultural contexts (Xiong et al., 2021). For families with higher levels of risk use of both "…strengths-based and empowerment-oriented approaches (which include shared decision-making) should occur" where home visitors address the impacts of stressors on children's development while also acknowledging family strengths and engaging in collaborative planning with caregivers (Azzi-Lessing, 2013, p. 379).

Developmental Parenting Approach

A Developmental Parenting approach (Roggman et al., 2008a) acknowledges that while young children are in a rapid period of development, so are their caregivers. Building on strengths-based strategies, a developmental parenting approach targets caregiver behaviors empirically related to children's developmental outcomes including affection, responsiveness, encouragement, and cognitive stimulation. Home visitor practices that promote these behaviors include strong relationships and non-intrusive collaborations with families, responding to family strengths, and facilitating caregiver–child interactions. Studies show that when these practices are used, there is a decrease in harsh parenting and childhood aggression and an increase in secure attachment (Roggman & Cook, 2010), thereby disrupting the cycle of abuse and aggression.

Programs with a developmental, culturally responsive approach to home visiting strive to improve child development and family well-being by supporting caregiver–child relationships, respecting family values and cultures, and recognizing and building on family strengths and connections to community and cultural supports. Developmental home visiting engages caregivers in supporting children's early development in ways that are appropriate for both the parent and the child, mutually enjoyable, and adapted to the family's strengths and interests.

Individualized and Complex Service

Home visitors are responsible for multiple components of intervention. Infant Mental Health home visiting includes "…concrete assistance, emotional support, developmental guidance, early relationship assessment and support, infant-parent psychotherapy, and advocacy" (Weatherston, 2000, p. 3). In addition to teaching caregivers about development stages, facilitating interactions, and providing support for the development of the child, home visitors often to conduct developmental screening and monitoring and support families with appropriate referrals for developmental intervention when needs are identified. Home visitors also complete family assessments to guide caregiver skill building and resource referrals, which can include basic tangible support, but also screening and referral for mental and behavioral health needs. At each home visit, home visitors balance the goals of the program and curricula with meeting the concrete needs of the family – all while nurturing their relationships with the family (Roggman et al., 2008a). Home visitors report feeling the need to focus on meeting families' basic needs before other activities (Jones Harden et al., 2010), but there is evidence that greater focus on case management is associated with shorter program duration (McKelvey et al., 2018) and decreased caregiver engagement during activities (Hughes-Belding et al., 2019).

A recent study documented that home visitors often engage in multiple processes to connect families to needed services but also that those efforts are often have limited success. Across all referrals made, only 21% resulted in the receipt of services by families. Some referrals were less successful than others; only 10% of referrals for early childhood care and education were successful, for example (Goldberg et al., 2018). Another study reported that only one-quarter of families in need of support for domestic violence, substance abuse, and/or mental health received services related to those risks (Tandon et al., 2005). The social service context is complex; home visitors often support families as they navigate the system and provide tangible supports in the process. Home visitors also provide emotional support when barriers are experienced, which supports families' problem solving and self-advocacy within systems (Goldberg et al., 2018), which may be as beneficial as providing resources.

Within this context it is important for home visitors to build competencies that will enable them to work collaboratively with families who have experiences that may be different from their own. Home visitors working with Tribal families (Novins et al., 2018), immigrant families (Xiong et al., 2021), and families experiencing poverty need to meet their cultural needs while also understanding the impacts of structural inequities that may impact them. For families who experience domestic violence, substance use, and/or psychopathology, home visitors need specific skills for engaging with family members in effective ways, providing resources, helping family members regulate their emotions, attending to their personal safety, and establishing healthy boundaries (Dauber et al., 2017). Importantly, all home visitors need to have a foundational understanding about the intersectionality of all these dynamic factors.

Supporting Relationships and Attachment

Most home visitors support caregivers to be positive and responsive in interactions with children (Roggman et al., 2008a). A central goal of home visiting involves support for babies' safe, stable, and nurturing relationships with their caregivers.

Addressing Caregiver Behavioral Health

There are multiple adult behavioral health challenges known to impact behaviors that can negatively affect the caregiver–child relationship. Home visiting provides opportunities to support optimal parent–child interactions and promote children's resilience in the face of such challenges. Indeed, home visiting interventions around the world are tasked with supporting families with behavioral health resources and referrals. For example, there are requirements from federal funders in the U.S. to provide screening for depression and intimate partner violence along with suggested screening for substance use (Maternal, Infant, and Early Childhood Home Visiting: MIECHV). Similarly, programs like Triple P-Positive Parenting Program® (implemented in multiple countries), Early Start New Zealand, the Compétences Parentales et Attachement dans la Petite Enfance (CAPEDP) program in France, and many others include specific supports for caregivers with a variety of behavioral health concerns.

We focus this section on the discussion of parental depression, as it is commonly addressed in home visiting programs and is often associated with other behavioral health concerns. Depression interferes with caregivers' capacity to provide engaged and positive care, which in turn has negative impacts on children's development. Caregivers with depression engage in behaviors with children that are more negative in affect and less reciprocal. These effects on behavior and interaction have even been demonstrated when depressive symptoms do not meet clinical criteria for a major depressive disorder (Conners-Burrow et al., 2014).

While most home visiting programs do not purposefully recruit parents with depression, results the Mother and Infant Home Visiting Program Evaluation (MIHOPE) study in the U.S. suggest that serving parents with depression is common; four in ten parents reported depression at enrollment (Michalopoulos et al., 2019). Past studies have documented limited impacts on depressive symptoms, except for an enhancement of the SafeCare model (Carta et al., 2013) and Family Check-Up (Shaw et al., 2009). However, the national MIHOPE study reported marginal reductions in depression symptoms for parents enrolled in four home visiting models: Early Head Start (EHS)– Home-based option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers (Michalopoulos et al., 2019). There is also evidence that home visiting has longitudinal impacts on depression, measured beyond the duration of the intervention. A study examining families enrolled in EHS documented a positive program impact on parental depression when children were near age 5 (Chazan-Cohen et al., 2007).

To directly address caregiver depression, additional interventions have been provided in conjunction with home visiting. Moving Beyond Depression™ provides in-home Cognitive Behavioral Therapy (Ammerman et al., 2013), the Mothers and Babies intervention supports mothers with postpartum depression (Tandon et al., 2014), and an in-home adaptation of Interpersonal Therapy (IH-IPT; Beeber et al., 2010) have all been implemented with existing home visiting programs. These interventions have had positive impacts on maternal depression (Ammerman et al., 2013).

Paternal–Child Relationships

A body of evidence has demonstrated that positive engagement of fathers with their young children is beneficial. There is significant cultural diversity in the extent to which fathers play a direct, indirect or any role in child rearing, although fathers' caregiving role is gaining increased international attention. Fathers in Western cultures are active caregivers as co-parents or stay-at-home parents, and/or as single parents (Pruett et al., 2017). Nevertheless, there are few studies of home visiting that focus on fathers across all family configurations, including gay families.

The national MIHOPE evaluation documented that, although 40% of fathers lived in the home, only 13% of visits included fathers (Michalopoulos et al., 2019). A recent scoping review of fathers in home visiting (Burcher et al.,

2021) documented mostly inconsistent associations between involvement in home visits and demographic characteristics of individual fathers, family structure, and program content. Findings that were consistent across studies included that father involvement in services was associated with longer periods of family enrollment and more positive mother-father relationships. Studies suggest that fathers want to be involved in services, especially when the content is father-focused (Guterman et al., 2018). The extant literature on fathers as caregivers has generated innovations in approaches to research and one suspects similar innovations will be needed to access fathers in other than nuclear family configurations, particularly those families most likely to qualify for home visiting interventions.

Culturally Responsive/International Perspective

Currently, the field of home visiting makes fundamental assumptions about supportive qualities of the home visitor–parent relationship as well as about parenting and parent–child relationships that have not been adapted to all cultural contexts. The field of home visiting has the potential to significantly advance the IMH agenda for diversity, equity, and inclusion, and belonging (DEIB). Illustrated by the Diversity-Informed Tenets (Irving Harris Foundation Professional Development Network Tenets Working Group, 2018), and the position statement by WAIMH (World Association for Infant Mental Health, 2016), there is a critical need to better understand and mitigate the systemic and individual practices that continue to marginalize families of young children from a variety of cultural, racial, and structural backgrounds. Countries have taken different approaches to addressing structural inequities by either providing universal approaches to reach as many families as possible (for example, some implementations of the Jamaican early childhood home visiting program) and/or targeting specific populations that have experienced marginalization (i.e., Early Start New Zealand).

By its nature, home visiting services and the associated competencies, models, and curricula are designed to individualize experiences to meet the vast diversity of needs of families. Home visitors need specialized preparation and critical skills to provide the services this unique role requires. Even with these skills in place, the implementation of effective practices is limited by systemic/structural constraints, policies that hinder the implementation process, and a lack of support for the workforce to understand and engage with families on sensitive topics (Roggman et al., 2016b). Concerns about workforce preparation, development, and turnover are ubiquitous. Programs are working around the world to determine the appropriate balance between manualized (sometimes scripted) curriculum and highly flexible curriculum to meet the needs of their workforce while maintaining effective, culturally responsive practices.

Evidence-Based Home Visiting Models for Families with Infants and Toddlers

Multiple clearinghouses have reviewed the evidence for interventions that may include home-based delivery (e.g., the California Evidence-Based Clearinghouse for Child Welfare, the Title IV-E Prevention Services Clearinghouse), but the US Department of Health and Human Services commissioned an ongoing evaluation of intervention effectiveness that is specific to the home visiting delivery method, the Home Visiting Evidence of Effectiveness (HomVEE) clearinghouse. To develop the HomVEE, evaluators identified programs and applied a rigorous set of criteria to determine the strength of the evidence that documented the program achieved its desired outcomes (Sama-Miller et al., 2017). It should be noted that empirical evidence is based primarily on measures from Western perspectives. Outcomes measures used in home visiting research are often not developed within culturally anchored perspectives, which can limit the validity of the measurement across cultural contexts (Whitesell et al., 2022). Table 27.1 provides a summary of evidence-based programs with outcomes theoretically associated with IMH practice.

Table 27.1 Favorable infant/early childhood mental health related impacts by home visiting models

Program	Description	Impacts
Attachment and BioBehavior Catch-Up Intervention (ABC)	ABC was designed to help caregivers provide nurturance by using mutually responsive interactions in which caregivers follow children's lead and use positive parenting practices.	Child Health, Child Development and School Readiness, Positive Parenting Practices
Child First	Child First was designed to decrease the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect among high-risk children and families.	Maternal Health, Child Development and School Readiness, Reductions in Child Maltreatment
Early Head Start-Home Visiting	Goals were set in the areas of maternal health, child development and school readiness, and reductions in child maltreatment through positive parenting, healthy family functioning, and family economic self-sufficiency	Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment
Early Intervention Program (for adolescent mothers)	The EIP is designed to help young mothers gain social competence and achieve program objectives by teaching self-management skills, techniques for coping with stress and depression, and skills to communicate effectively with partners, family, peers, and social agencies.	Child Health
Early Start (New Zealand)	A voluntary home visiting program designed to improve child health, reduce child abuse, improve parenting skills, support parental physical and mental health, encourage family economic well-being, and encourage stable, positive partner relationships.	Child Health, Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment
Family Check-Up® for Children	This prevention program is designed to help parents address typical challenges that arise with young children before challenges become more serious or problematic.	Maternal Health, Child Development and School Readiness, Positive Parenting Practices
Family Connects	The program aims to support families' efforts to enhance maternal and child health and well-being and to reduce rates of child abuse and neglect.	Child Health, Maternal Health, Positive Parenting Practices
Family Spirit®	This program focuses on enhancing mothers' parenting skills while assisting them in developing coping and problem-solving strategies to overcome individual and environmental stressors.	Maternal Health, Child Development and School Readiness, Positive Parenting Practices
Health Access Nurturing Development Services (HANDS)	HANDS is a voluntary home visiting program designed to prevent child maltreatment, improve family functioning, facilitate positive pregnancy and child health outcomes, and maximize child growth and development.	Child Health, Maternal Health, Reductions in Child Maltreatment
Healthy Beginnings	This model aims to prevent childhood obesity by improving children's and families' eating patterns, reducing sedentary activities such as television viewing, and increasing physical activity.	Child Health, Maternal Health, Child Development and School Readiness, Positive Parenting Practices
Healthy Families America (HFA)®	HFA strives to reduce child maltreatment, improve parent–child interactions and children's social-emotional well-being, and enhance children's school readiness.	Child Health, Maternal Health, Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment

(continued)

Table 27.1 (continued)

Program	Description	Impacts
Home Instruction for Parents of Preschool Youngsters®	HIPPY aims to promote preschoolers' school readiness and support parents as their children's first teacher by providing instruction in the home.	Child Development and School Readiness, Positive Parenting Practices
Maternal Early Childhood Sustained Home Visiting Program (MESCH)	Registered nurses conduct a minimum of 25, 60- to 90-min home visits, from pregnancy and until the child's second birthday. During the visits, nurses focus on parent education, maternal health and well-being, family relationships, goal setting, and other issues such as housing and finances.	Child Health, Maternal Health, Positive Parenting Practices
Maternal Infant Health Program (MIHP)	Uses a home visiting team comprised of a licensed social worker, a registered nurse, an infant mental health specialist, a lactation consultant, and a registered dietitian, MIHP aims to promote healthy pregnancies, positive birth outcomes, and healthy growth and development for infants.	Child Health, Maternal Health, Reductions in Child Maltreatment
Minding the Baby® Home Visiting (MTB-HV)	This program was designed for first-time mothers living in low-income settings. The program is based on a model of care that aims to bridge primary care and infant mental health services by paring a pediatric nurse practitioner with a licensed clinical social worker to conduct home visits.	Child Health, Maternal Health
Nurse Family Partnership (NFP)®	NFP is designed to improve: (1) prenatal health and outcomes; (2) child health and development; and (3) families' economic self-sufficiency and/or maternal life-course development.	Child Health, Maternal Health, Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment
Parents as Teachers (PAT)®	The goal of PAT is to provide parents with child development knowledge and parenting support, early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness	Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment
Play and Learning Strategies (PALS) Infant	PALS is designed to strengthen parent–child bonding and stimulate children's early language, cognitive, and social development.	Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment
Promoting First Relationships® – Home Visiting Intervention Model	A master's-prepared home visitor and parent view and reflect on recordings of parent–child interactions. Parents are also provided information on supporting the social and emotional development of young children.	Maternal Health, Child Development and School Readiness, Positive Parenting Practices, Reductions in Child Maltreatment
Safe Care® Augmented	SafeCare aims to prevent and address factors associated with child abuse and neglect with a curriculum that focuses on parent–infant/child interactions, infant health, and home safety.	Reductions in Child Maltreatment

Note: Table includes models eligible for MIECHV funding with support available for implementation. https://homvee.acf.hhs.gov/

Model Fidelity, Effective Practice, and Competency Frameworks

Home visiting model fidelity is defined as the degree to which implementation of evidence-based programs matches the services as they were designed. Fidelity is typically assessed by tools directly tied to the model, including the delivery of a curriculum, dosage, and key staffing features associated with intervention effectiveness (Allen et al., 2017). Model fidelity is always a crucial aspect of implementation; however, evidence-based models that were not specifically developed in partnership with Tribal and Immigrant communities may need significant adaptation when implemented to reflect the local cultures and contexts.

While model fidelity promotes the use of specific curriculum and strategies that are empirically related to outcomes, other home visitor competencies are overarching and not tied to specific program models. Key to the effectiveness of home visiting programs are the knowledge, skills, and dispositions of home visitors. These characteristics of home visitors influence the likelihood of high-quality implementation of evidence-based models and the individualization of services in response to the unique needs of families.

Professional organizations like the Alliance for the Advancement of Infant Mental Health (Weatherston et al., 2009), the Institute for the Advancement of Family Support Professionals (Institute for the Advancement of Family Support Professionals, 2022), the Division of Early Childhood (Division for Early Childhood, 2014), ZERO TO THREE (Critical Competencies for Infant-Toddler Educators™), the National Association for the Education of Young Children (National Association for the Education of Young Children, 2020), and the Collaborative for Understanding the Pedagogy of Infant/Toddler Development (CUPID: Roggman et al., 2016b) are releasing competency frameworks for home visiting. These frameworks have developed from a variety of disciplinary perspectives because the work of home visitors is complex, addressing early learning, adult learning, human nutrition, safety, trauma, family dynamics, relational health (i.e., attachment, trauma, and interactions), and other needs. As mentioned, particularly relevant to IMH are the relational aspects of home visiting and the impacts of adversity and resilience on the relationships between very young children and their caregivers. Related competencies include domains of family dynamics, caregiver–child interactions, infant and early childhood development, relationship-based partnerships, and cultural and linguistic responsiveness.

Embedded within these relationship-based competencies is a strong focus on understanding and supporting families impacted by trauma. A trauma-informed perspective is where "all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers" (National Child Traumatic Stress Network & Schools Committee, 2017). While many home visiting models implement trauma-informed practice, all early childhood home visitors need to understand and address the impacts of trauma on development, relationships, and systems as well as incorporating appropriate assessment practices.

Home Visitor Training and Professional Development

There is a vast variability in pre-service education and training of the workforce. Home visitor minimum education requirements differ by model and range from paraprofessionals, who may work alone or in concert with professionals, to college-prepared professionally trained interventionists (e.g., nurses, social workers, counselors, early childhood educators, or child development specialists). Key qualifications for paraprofessionals often include lived experience and/or some degree of higher education combined with professional development.

Even when home visitors have college training, there is a variation in pre-service content and experiences within and across the multitude of disciplines in which home visitors may be educated. For example, some home visitors are trained in accredited or licensure programs that have required national- or state-specific curricula and/or practicum experiences (e.g., Occupational and/or Speech-Language therapies, Early Childhood Education/Special Education, clinical Infant Mental Health/Social Work), while others are trained in fields that may not have licensure requirements (i.e., psychology, sociology, human development, communication, and family science). Even in programs with licensure requirements, training in home-based skills is often not a component of undergraduate programs (Chang et al., 2005). Indeed, research has documented that many home visitors were unaware of home visiting as a field during their undergraduate schooling (Plagge, 2021). Unfortunately, even graduate education that includes home-based skills is often limited to didactic, rather than practice-based content. Variations in state-level licensure requirements, disciplinary norms, and lack of coordination across home visiting funding streams and service providers perpetuate a significant problem with establishing a highly qualified home visiting workforce (Hebbeler et al., 2011).

Because of the gaps in pre-service preparation, more attention has been given to professional development efforts that support home visitors. For instance, recommended practices for models often include reflection on service provision with others, including peer learning groups known as communities of practice. Other models use face-to-face experiences to train home visitors to fidelity on parent coaching strategies (Kaiser & Roberts, 2013) and video recording and self- and observer-implemented assessments as tools to support intensive coaching (Walsh et al., 2021).

Coaching

Much like families, home visitors' behaviors are positively affected by observation and feedback (Walsh et al., 2021). Home visiting competency frameworks and infant and toddler frameworks suggest that coaching is an important skill in home visitor preparation in the primary competency of adult learning principles (e.g., coaching parenting behaviors that support child development) and self-reflection (e.g., experiencing coaching by a professional to gain insight into working with families). Coaching is a professional development tool for improving home visitor effectiveness in meeting the complex needs of families and supporting child development.

Coaching supports the maintenance or improvement of home visitors' skills and evidence-based practices (Peterson et al., 2018). Recognizing that receiving and giving coaching should be a parallel process is important, therefore supervisors, site leaders, and other support staff need training on coaching. Coaches of home visitors should apply strategies associated with effective home visiting because the way they interact with the home visitor coachee can function as a model for how the home visitor engages with their clients (Roggman et al., 2008a). There should be a positive relationship between the coach and home visitor coachee that includes strength-based reflection. The coach needs to be responsive to and use strengths of the home visitor coachee in jointly planned goals to improve the process. The coach and home visitor coachee need to be collaborative and realize that each brings unique skills to the coaching transaction. This is the mutual competence perspective and is part of the parallel process. This applies to the supervisor–home visitor relationship as well as the home visitor–client relationship (Roggman et al., 2008a). Mutually competent relationships allow home visitors to connect with families as they show warmth and understanding and encourage family strengths. These relationships can foster a sense of trust, making it easier for the family to share their goals and priorities, which enables the home visitor to respond to a family's unique strengths and qualities to individualize services.

Communities of Practice

Research-based approaches to improve home visiting practices are needed. A Community of Practice (CoP) approach can be an effective resource for professional development of home visitors. CoP have two theoretical bases: Situated learning (applying learning in everyday settings) and reflective practice (guided observation and self-observation). Although each CoP varies in implementation, the primary feature is home visitors reflecting on their actual practices. Qualitative and quantitative data demonstrate effectiveness of the CoP approach including increased use of best practices and more knowledge and skills related to home visiting competencies (Cook et al., 2018).

Home Visitor Well-Being and Reflective Supervision

While attention to and advances in training and professional development is growing, home visitors report high levels of burnout and secondary trauma, which are both associated with workforce attrition. The incorporation of essential IMH practices shows promise for improving home visitor well-being and effectiveness. Reflective supervision (RS) with an IMH reflective supervisor is a key element of these practices (Weatherston et al., 2009) and is characterized as a consistent and nurturing environment where home visitors can process the interactions they have experienced with families, their own emotional responses, and the impact of those emotions on their work (Tomlin et al., 2014). In parallel to the ways home visitors work most effectively with families, the processes of RS are intended to build capacities in the home visitor for reflection and reflective practices that support the parent–child relationship (Shea et al., 2020).

Empirical support for RS in improving home visitor well-being, reducing burnout and subsequent turnover is growing. Modest impacts on job satisfaction and burnout have been found as well as impacts on reflective practices (Shea et al., 2020). Implementing RS into non-clinical programs is increasing as well as the need to address complex sociocultural elements into this dynamic relationship. A recent conceptual piece identified four guiding principles for incorporating diversity-informed tenets into RS, including: honest self-examination, embracing and honoring who we are, finding your relationship rhythm, and sitting with tension (Wilson et al., 2018). Just as the home visitor is providing a nurturing context in which the parent may reflect and grow, so, too, is the reflective supervisor working with the home visitor in building an environment of reflection and growth in professional practice.

Future Directions and Recommendations for Practice, Research, and Policy

Engagement and Retention in Services

A meta-analysis of parenting interventions, which included home visiting as one implementation strategy, determined programs spanning 3–6 months had stronger impacts than interventions that were shorter (fewer than 3 months) and longer (greater than 6 months; Pinquart & Teubert, 2010). However, a meta-analysis of home visiting studies reported stronger effects with greater quantity (Nievar et al., 2010). Despite not knowing whether there is a threshold of program quantity required to achieve desired outcomes, programs often struggle to retain families through the evidenced length of services (Azzi-Lessing, 2011). In the MIHOPE study, the average length of enrollment was 8 months, with fewer than half (46%) of families remaining in services for 1 year (Duggan et al., 2018). The same study reported that the largest loss of families occurred between the first and second months of services.

Understanding family and program characteristics associated with family involvement in services is needed. Involvement has been defined as "the process of the parent connecting with and using the services of a program to the best of the parent's and program's ability" (Korfmacher et al., 2008, p. 171) and includes two specific components. The first is participation, defined by measures of the quantity of services such as the total time enrolled, and/or the total number, length, and frequency of visits. The second is family engagement, which measures the quality of services, which may include the positive and negative feelings parents may have toward services and the quality of their relationship with their providers.

Studies have examined predictors of program involvement across many dimensions. Several studies have examined parent and family demographic characteristics as predictors of program participation. Together, these studies tend to suggest that families at higher levels of sociodemographic risk have shorter program durations. These associations have been demonstrated for parent education (Hicks et al., 2008), economic need (Boller et al., 2014), and single parenthood (Roggman et al., 2008b). Studies examining cumulative risks (e.g., single parent, teen parent, and minority ethnicity) show similar results (Peterson et al., 2016).

Research has also examined associations between parent and family well-being and the quantity of home visits received; the findings are mostly inconsistent. For example, several studies of home visiting programs reported no association between caregiver depression and retention in services (e.g., Booth et al., 2014), while other studies reported positive associations between depressive symptoms and program duration (Girvin et al., 2007), sometimes within the same home visiting model. Similar inconsistencies have been found for family conflict; one study reported that intimate partner violence is associated with leaving services (Herzog et al., 1986), another reported a small, positive association between violence and the number of home visits families received (Eckenrode et al., 2000).

Research has also examined whether the duration of services is associated with the content of the home visits themselves. There is some evidence to suggest that families remain in services if they see the services as meeting their needs (Holland et al., 2014). Studies suggest that case management is associated with shorter service duration, while time spent on child development and supporting parent–child interactions is associated with longer service duration (McKelvey et al., 2018). Spending time focused on child development and supporting parent–child interactions supports engagement in the visits themselves (Roggman et al., 2016a).

There are also programmatic predictors of family involvement. A meta-analysis of home visiting documented stronger impacts for a number of implementation characteristics, including model training, staff supervision, and fidelity monitoring (Casillas et al., 2016). An additional reason for participant attrition is staff turnover. Because strong home visitor–caregiver relationships are central to the implementation of home visiting, when a home visitor leaves the program, families often elect not to continue services.

Precision Home Visiting and the Promise of Implementation Science

The essential elements of how home visiting works are still largely unknown. A focus on "precision" home visiting has pushed for more clarity regarding what makes for effective home visiting. The specific behaviors by which home visitors effectively engage with families to increase developmental support in home environments are not as well documented as effective classroom teaching practices, for example. To support families' involvement in and the success of home visiting programs, we need a clearer understanding of the variations in home visiting services across families enrolled in the same program, the family characteristics associated with those variations, and the implications of those variations for program quantity and quality.

The existing evidence suggests that there are specific program implementation characteristics associated with stronger outcomes. A meta-analysis documented that pre-service training opportunities such as practicing and role-play, reflective supervision, recorded observations of home visitor practice, and ongoing fidelity monitoring from independent sources that included measurement of implementation quality were associated with program outcomes (Casillas et al., 2016). Studies examining quality practices such as building relationships with families, collaboration, and facilitation of parent–child interactions have also been associated with better parenting and child outcomes (Hughes-Belding et al., 2019). Studies have also examined characteristics of participants as moderators of program impacts. Most studies have examined demographic moderators of service impact, but a handful of studies have documented interactions between caregiver attachment styles and outcomes (McFarlane et al., 2013).

Additional comprehensive examinations of families' characteristics and experiences in home visiting are needed to elucidate the program variations that enhance intervention effectiveness for all participants (Azzi-Lessing, 2011). This research in the home visiting field has the potential to identify specific strategies that promote effective home visiting and may improve how we deliver and assess home visiting; help refine definitions and indicators of quality and enhance the outcomes of home visiting programs. Applying precision research principles within the home visiting context offers the promise of better understanding the active ingredients of interventions using innovative research methods.

Virtual Home Visiting

Home visiting programs began to offer the option of virtual home visiting services in response to the COVID-19 public health emergency. This transition highlighted the untapped potential of virtual delivery methods to increase service access to underserved, geographically isolated populations and increase caseload capacities that are limited by the cost and time of travel. Most home visiting models plan to provide services using a hybrid in-person and virtual approach moving forward. However, like with in-person services, the practical implementation of virtual services is complex, and there are unanswered questions about family involvement in programs, the characteristics and quality of home visits, and their overall effectiveness.

As previously discussed, prior to the rapid implementation of virtual home visiting that resulted from the pandemic, family involvement in in-person services was already greatly variable. A brief report in April 2020 by the Home Visiting Applied Research Collaborative provided an early snapshot of program challenges during the pandemic, which included difficulties with family engagement (O'Neill et al., 2020). A recent study documented a reduction in attrition in the first 6 months of the pandemic compared to the same annual quarters before the pandemic (Mersky et al., 2022). However, there was also a reduction in the number of completed home visits after the start of the pandemic, which may suggest that programs were less likely to discharge families, but instead provided fewer visits.

Data obtained from the Home Visit Rating Scales – Adapted and Expanded (HOVRS-A+; Roggman et al., 2019) demonstrated that the families who received services virtually were more engaged in the intervention than those receiving in-person visits, and home visitors were more responsive to the families when providing services virtually compared to those they served in the in-person group. Families who received virtual services felt equally supported, knowledgeable, and confident in fostering their child's development as families who receive in-person services (Behl et al., 2017). However, virtual home visits differ from in-person visits, with a larger portion of time focused on listening, asking for information, and providing information (72%). Virtual visits included a large portion of time devoted to child development information, but home visitors reported difficulty engaging children in visits (Cole et al., 2019). This is not unlike in-person visits, unfortunately, as many home visitors model child-directed intervention to families, rather than facilitate the intervention for the family and child. This presents a potential benefit of virtual home visiting. Although coaching is widely accepted as best practice, past research has documented challenges to its use during traditional home visits.

Despite the promises of virtual service implementation, the transition to virtual home visiting is too recent to understand program effectiveness, and whether there are families for whom telehealth provides superior experiences and/or evidence.

Summary and Key Points

Home visiting is a complex practice requiring practitioners to work with multiple families, each of whom has unique needs, experiences, and values. Because home visiting improves child outcomes indirectly through services to caregivers and families, home visitors must equally understand adult learning and child development. Additionally, as caregivers are the conduit through which intervention impacts occur, it is imperative that home visitors can develop warm and trusting relationships with caregivers that may have very different backgrounds, goals, and expectations from their own. Home visitors need to be prepared to work with families facing serious challenges (e.g., mental illness, domestic violence, and child maltreatment) all within a disjointed system of care. Further, participation in home visiting programs is primarily voluntary, adding an additional level of complexity to the decisions that home visitors make in their work with families – balancing service delivery with retention in programs.

The field has endeavored to create core professional competencies, but there is yet to be one set of agreed upon standards for the field. As such, there is a diverse set of opportunities for training and professional development, which may be chosen to support home visitors' skill development. While the application of coaching has the promise of supporting home visitors' skill development and increase overall program effectiveness, there is still much to be understood about best practices in the home visiting context. We should also not ignore the evidence that much of the home visiting workforce is new to the field and do not make a living wage (Franko et al., 2019). Our workforce will find it challenging to support others when they need supports for their own financial, emotional, and physical well-being.

Recent work in the field has also documented challenges with larger-scale implementations of existing evidence-based services. For example, the MIHOPE study of home-visiting programs documented impacts in fewer domains than expected and a recent study of a well-established model documented no impacts on birth outcomes with statewide implementation (McConnell et al., 2022). Model fidelity measures whether interventions include elements that support their efficacy, but the complexity of services required to meet each family's individual needs and the unique communities in which services are provided requires that evidence-based practices be adapted to local cultures. Precision home visiting methods can support this work, but there remain challenges – including the adaptation of a primarily in-person to virtual delivery which adds an additional layer of complexity to home visiting services.

The future of home visiting rests in the development of more precise measures to identify and address family strengths and needs, methods to use technology effectively to reach families that might otherwise be difficult to reach, and the use of precision strategies to understand the active ingredients of our services. Most importantly, home visiting requires an appropriately supported workforce, not only in the professionalism and skills required to do their work but also as valued individuals.

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28

Community-Based Mental Health Interventions for Families with Young Children

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Background

Having a good start in life is fundamental to good mental health, well-being, and resilience to adversity throughout life. The period from conception to 3 years is critical in shaping a child's life trajectory (Shonkoff & Phillips, 2000). Adverse exposures early in the life course can have impacts on offspring development, including emotional, neurodevelopmental, and physical development (Gluckman et al., 2008). Children's early experiences, both positive and negative, and their environments impact how the brain adapts and develops for learning, laying down the foundations for their long-term mental health and well-being. Having a parent or caregiver who can recognize a child's cues and respond in a loving nurturing way is a foundational component of attachment and promotes positive mental health and well-being outcomes (Ainsworth, 1979; Gottesman, 1999). Conversely, experiencing abuse, neglect, and household dysfunction (e.g., caregivers' mental illness, substance use, and interpersonal conflicts) in early childhood has been found to exert a powerful negative effect on a child's development, behaviors, and later mental health outcomes, such as increased risk for alcoholism, drug abuse, depression, and suicide attempt, as well as comorbid chronic diseases (Felitti et al., 1998).

The lasting effects of early childhood experiences on later mental and physical health outcomes and the wide-ranging health and social consequences and long-term costs, both human and economic, of adverse childhood experiences underscore the necessity of primary, secondary, and tertiary prevention efforts for both the caregiver and the child. Primary prevention involves intervening before health effects occur. Secondary prevention includes screening to identify disorders or diseases in the earliest stages, before the onset of signs and symptoms. Tertiary prevention includes managing disorders or disease post-diagnosis to slow or stop the condition's progression. Considering all community settings that a caregiver–child dyad might interact with in the first 3 years of life is important when planning primary, secondary, or tertiary prevention interventions (Centers for Disease Control and Prevention, 2019a, b).

The Centers for Disease Control and Prevention (CDC)'s socioecological framework

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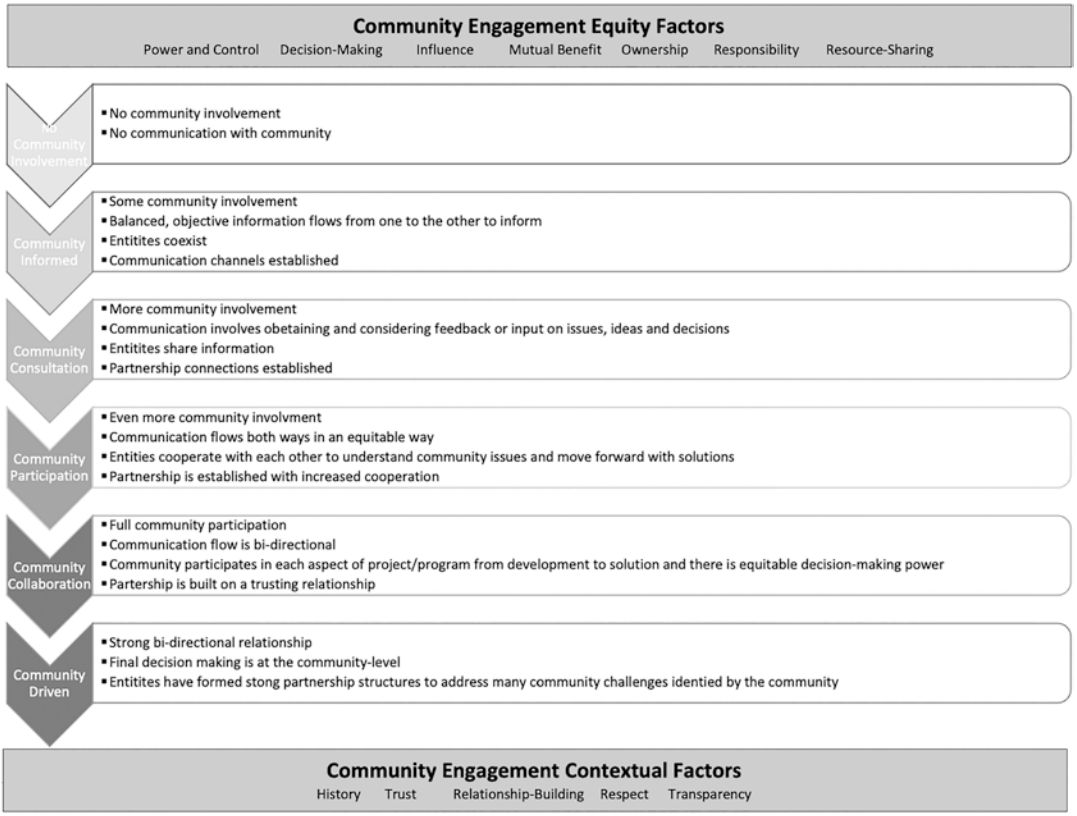
suggests that there are four levels of prevention strategies: individual, relationship, community and societal (CDC, 2021). Prevention strategies may be applied in multiple settings to reach diverse populations and are most effective and sustainable when they target multiple levels, especially the community. Community-level prevention strategies focus on community engagement, involving community members (e.g., community health workers) as part of the intervention, often utilizing multisector partnerships, and/or the delivery of services in community settings (e.g., preschools, churches) (Castillo et al., 2019). The social-ecological framework is helpful to consider when planning community interventions (Bronfenbrenner, 1979) because it recognizes the reciprocity and bidirectionality of influence across levels.

An example of a multilevel community intervention aimed to enhance infant mental health may include prevention strategies that target caregiver knowledge and skills to enhance healthy caregiver/infant interactions (relationship-level), while simultaneously strengthening caregivers' connections to community resources to promote mental health and well-being (community-level). Key components and examples of effective community interventions that aim to enhance caregiver and child mental health are discussed later.

Component #1. Engage the Community to Promote Caregiver and Child Mental Health

Community engagement is a key component to implementing effective and sustainable multi-level interventions in communities (McCloskey et al., 2011). The rationale for community-engaged prevention research and policy making is largely rooted in the social-ecological model and the recognition that lifestyles, behaviors, and the incidence of illness are all shaped by social and physical environments. As such, health issues are best addressed by engaging community partners who can bring their own perspectives and understandings of community life and health issues to a program. The CDC has defined community engagement as "the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being" (McCloskey et al., 2011, p. 9). Community engagement can take many forms, and partners can include organized groups, agencies, institutions, or individuals. Collaborators may be engaged in health promotion, research, or policy making, but the overarching aim is to improve population health by building trust, enlisting new resources and allies, creating better communication, and creating long-standing collaborations (Fawcett et al., 2001). Community engagement can be considered on a continuum of community involvement from no community involvement to being community driven (see Fig. 28.1). Over time a specific collaboration is likely to move along this continuum toward greater community involvement and ultimately to empowerment (i.e., fully community-driven engagement). Often, community-engaged partnerships begin during time-limited projects but can evolve to longer-term partnerships that move from the traditional focus on a single health issue to address a range of social, economic, political, and environmental factors that affect health. Figure 28.1 also highlights equity and contextual factors that were identified by Key et al. (2019) as being influential points of community engagement listed in the continuum.

The benefits of engaging the community in prevention work have been broadly recognized (Mason et al., 2008; Staley, 2009). These benefits include improvements in program design, tools, participation, communication, dissemination; improved ethics of health promotion programming; enhanced knowledge and skills of the community members or organizations involved in the project or program; and the general public being more receptive to the health promotion programming; all of which result in more effective and sustainable population health changes (Staley, 2009). In general, there are costs associated with community engagement, such as increased time to develop partnerships and increased skills



Community Engagement Equity Factors

Power and Control Decision-Making Influence Mutual Benefit Ownership Responsibility Resource-Sharing

No Community Involvement	▪ No community involvement ▪ No communication with community
Community Informed	▪ Some community involvement ▪ Balanced, objective information flows from one to the other to inform ▪ Entitites coexist ▪ Communication channels established
Community Consultation	▪ More community involvement ▪ Communication involves obetaining and considering feedback or input on issues, ideas and decisions ▪ Entitites share information ▪ Partnership connections established
Community Participation	▪ Even more community involvment ▪ Communication flows both ways in an equitable way ▪ Entities cooperate with each other to understand community issues and move forward with solutions ▪ Partnership is established with increased cooperation
Community Collaboration	▪ Full community participation ▪ Communication flow is bi-directional ▪ Community participates in each aspect of project/program from development to solution and there is equitable decision-making power ▪ Partership is built on a trusting relationship
Community Driven	▪ Strong bi-directional relationship ▪ Final decision making is at the community-level ▪ Entitites have formed stong partnership structures to address many community challenges identied by the community

Community Engagement Contextual Factors

History Trust Relationship-Building Respect Transparency

Fig. 28.1 Community engagement continuum and equity factors. (Note: Figure integrates concepts from models presented previously (including McCloskey et al. (2011) and Key et al. (2019)))

needed of the community members/organizations, but these costs often are outweighed by the positive aspects of engaging the community in health promotion planning (Mason et al., 2008).

Component #2. Identify and Target Key Protective Factors to Promote Caregiver and Child Mental Health

In addition to the importance of engaging the community, an understanding of the mechanistic pathways to positively influence or protect a child's mental health and well-being is also important to consider when designing community prevention interventions. The effects of parenting start early and there are several mechanisms by which a caregiver can impact a child's development. Focusing on protective factors, or conditions or attributes in individuals, families, and communities that promote the health and well-being of children and families, is important to promoting caregiver and child mental health. Many of the protective factors are modifiable and can be a focus of community-based child mental health interventions. The Children's Bureau has a framework that community-based service providers can use to identify strengths within families, and these include prevention efforts that focus on the following six protective factors: caregiver knowledge; caregiver resilience; caregiver–child attachment; child's social-emotional competency; caregiver social connections; and referral of family to and engagement of family with community supports (Children's Bureau, 2020) (see Fig. 28.2).

Caregiver Knowledge There is extensive research linking healthy child development to effective caregiving and this, to some extent, is

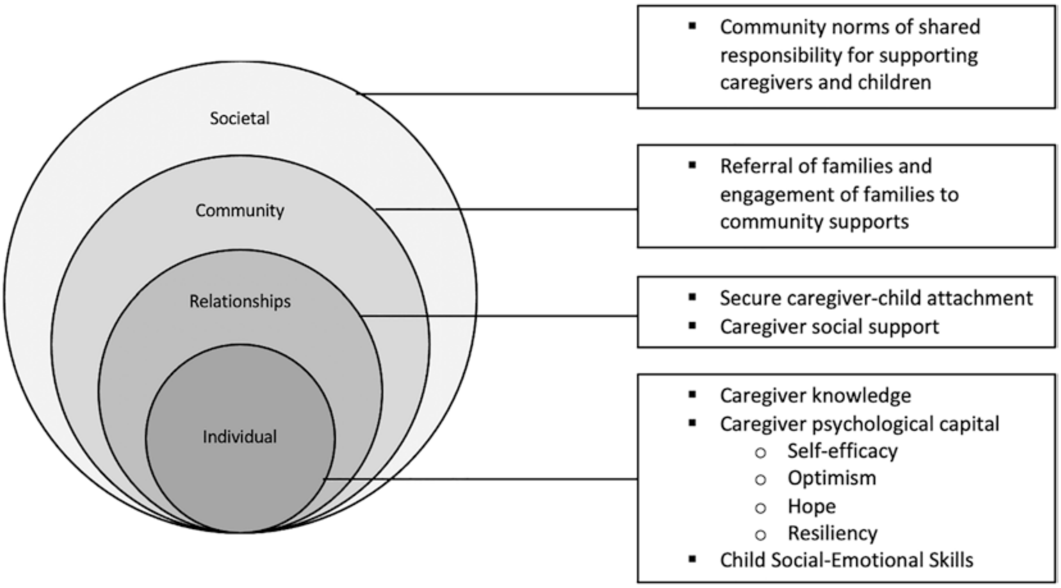


Fig. 28.2 Protective factors by social-ecological model level. (Adapted from the CDC's Social-Ecological Model: A Framework for Prevention (https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html))

related to caregiver knowledge (September et al., 2016). Children thrive when caregivers provide not only affection but also respectful communication and listening, consistent rules, and expectations and safe opportunities that promote independence (Children's Bureau, 2020; Pinquart, 2016). They also thrive when caregivers have family resources to devote to child rearing and provide a rich and responsive language environment (September et al., 2016). Effective parent education programs often address some "changeable" parental risk factors associated with ACEs, such as inadequate parenting skills, attitudes about child rearing, and dysfunctional parenting habits (AcademyHealth, 2016). Parenting education programs have also been shown to have an impact on other risk factors such as depression and stress (AcademyHealth, 2016).

Caregiver Resilience Positive caregiver and child mental health, particularly in the face of chronic strain, is likely to result from a combination of resources that foster the ability to cope well despite severe and long-lasting demands (Lazarus & Folkman, 1987). Resilience refers to good outcomes despite serious threats to adaptation or development (Masten et al., 2004). Caregivers who can cope with the stresses of everyday life, as well as the occasional crisis, have resilience; they have the flexibility and inner strength necessary to bounce back when things are not going well. Psychological capital (PsyCap) is an individual's positive psychological state characterized by having the confidence (self-efficacy) to take on challenging tasks, making positive attributions (optimism) about the likelihood of success, being determined to achieve goals in order to succeed (hope) and persevering in the face of difficulties (resilience) (Youssef-Morgan & Luthans, 2015). Harnessing PsyCap can strengthen positive interactions with the environment and is especially critical in shaping stress appraisals to support an adaptive coping process, which may translate to better maternal and child health outcomes. For example, caregivers with higher levels of PsyCap are more likely to use problem-focused coping strategies (Rabenu et al., 2017; Scheier & Carver, 1992; Song et al., 2019), which can have improved outcomes for children.

Caregiver–Child Attachment A child's early experiences of being nurtured and developing a bond with a caring adult affect all aspects of behavior and development (Bowlby, 1988). It is during this period that children develop their interpersonal attachments, learn about their external world, internalize parental standards, and gain the ability to control their emotions, impulses, and behaviors (Cummins & McMaster, 2006). When caregivers and children have strong, warm feelings for one another, children develop trust that their caregivers will provide what they need to thrive, including love, acceptance, positive guidance, and protection (Children's Bureau, 2020), and this translates to other relationships in the child's life, such as peer relationships. Research shows that infants who receive affection and nurturing from their caregivers have the best chance of healthy development (Maselko et al., 2011). A child's relationship with a consistent, caring adult in the early years is associated later in life with better academic grades (Pinquart, 2016), healthier behaviors, more positive peer interactions, and an increased ability to cope with stress (Bellis et al., 2017; CDC, 2019a; Dewar, 2017).

Child's Social-Emotional Competency Caregiver–child relationships should provide children with comfort, protection, and security during the early years because basic social skills emerge within the context of these relationships (Hartup, 1989; Sroufe, 1989). Caregivers support healthy social and emotional development in children when they model how to express and communicate emotions effectively, self-regulate, and make friends (Ashiabi, 2000). Research has suggested that children who have developed their emotional skills tend to have an increased level of social competence, good mental health, and good academic performance compared to those children who have not adequately developed their emotional skills (Alzahrani et al., 2019). These latter children are reported to have poorer mental health than the former children, including experiencing depression and anxiety (Thomson et al., 2019). They also engage in more destructive relationships as well as being associated with drugs and alcohol (Brackett et al., 2015).

Caregiver Social Connections Caregivers with a social network of emotionally supportive friends, family, and neighbors often find that it is easier to care for their children and themselves compared with those who do not have such a network (Children's Bureau, 2020). All caregivers need people they can call on when they need a sympathetic listener, advice, or concrete support. Among caregivers, social support may be particularly protective for both caregiver and child (Armstrong et al., 2005). Caregivers experiencing poor mental health may experience hindered ability to parent effectively and consistently and handle daily parenting-related stresses, ultimately resulting in poor maternal–child attachment—all of which are associated with poorer child social-emotional and behavioral outcomes (Brook et al., 2011; Meadows, 2011; Seymour et al., 2015; Turney, 2012; Xie et al., 2009). Social support may offset some of these stresses. For example, maternal perceptions of having strong social support are associated with decreased perceived stress, increased parenting warmth, and increased parenting self-efficacy (Leahy-Warren et al., 2012; Reid & Taylor, 2015; Thoits, 2011). Research has shown that caregivers who are isolated and have few social connections are at higher risk for maltreating their children (Chen & Chan, 2016; Lee et al., 2022).

Referral and Engagement of Family in Community Supports Working with caregivers to identify and access resources in the community may prevent the stress that sometimes precipitates child maltreatment (Children's Bureau, 2020). Recent intervention efforts have successfully assessed caregivers' needs related to social determinants of health (e.g., housing, education, food security, income, and transportation) (Morone, 2017) during health care clinic visits and then connected caregivers to appropriate community resources

(Andermann, 2016). Assessment of mental health in addition to identifying social needs is also critical. Approximately one in five U.S. adults experience a mental illness each year (Center for Behavioral Health Statistics and Quality, 2016) and more than 50% will be diagnosed with a mental illness or disorder at some point in their lifetime (Kessler et al., 2005). Unfortunately, over half do not receive the needed treatment (Kessler et al., 2005) due to associated stigma, limited insurance coverage, financial barriers (Ali et al., 2017), and lack of available resources and mental health specialists, especially in rural and underserved communities (Jameson & Blank, 2007). Identifying unique family needs and strengthening connections to appropriate mental health services in the community is critical (Andermann, 2016; Daniel et al., 2018). Providing referrals to services may also help prevent the unintended neglect that sometimes occurs when caregivers are unable to provide for their children (Reinert et al., 2021; US Preventive Services Task Force et al., 2018).

Component #3. Identify Evidence-Based Strategies and Programs to Promote Caregiver and Child Mental Health

Evidence-based strategies and interventions can promote child and maternal health and broader associated outcomes at all social-ecological levels: individual, relationship, community, and societal and can do so by incorporating primary, secondary, and tertiary intervention strategies (see Table 28.1).

Community involvement is represented in various ways, including in the form of individuals engaged (e.g., community health workers, and community leaders), the settings in which programming takes place (e.g., health clinics, early childhood education centers, churches), and the multisectoral partnerships involved in the health promotion work, especially at the community and societal levels. Community interventions recognize the need for whole family care because the context surrounding children in the first 3 years of life, including the caregiving environment, homes, childcare settings, neighborhoods, communities, and society impact early childhood developmental outcomes. Ecological systems theory highlights the ways in which the contextual environment impacts a child' health and development outcomes (Bronfenbrenner, 1994). Young children are strongly influenced by the relationships surrounding them and if these relationships are supportive and healthy, it is likely that the child will feel safe, secure and stable. Therefore, effective community-based strategies to promote infant and early childhood mental health must be tailored to the needs of the whole family and recognize the embedding of the child in a web of interrelated influences.

The primary prevention strategies listed in Table 28.1 are evidence-based and can be implemented by the community to collectively increase access to community-based mental health supports, raise awareness, and reduce mental health-related stigma. The secondary prevention strategies listed in Table 28.1 are directed toward families and children who may be at higher risk for experiencing poor mental health outcomes due to structural inequities, prior history of mental illness, current mental health challenges, and/or parental or child disabilities. These types of prevention strategies often target low-resourced communities to bolster community resources and support higher risk families. Tertiary prevention strategies listed in Table 28.1 focus on families who are experiencing challenges related to mental health. The goal of tertiary prevention efforts is to mitigate the negative consequences associated with poor family and child mental health and provide treatment (Children's Bureau, 2018). All of these prevention strategies can be implemented at multiple levels of influence to yield maximum community health impact.

Table 28.1 Overview of community intervention primary, secondary and tertiary strategies by social-ecological model level and targeted protective factor

	Intervention Strategies by Levels of Prevention		
Socio-ecological Model Level and Targeted Protective Factor(s)	Primary	Secondary	Tertiary
Individual (Protective Factors: caregiver knowledge, caregiver resilience, child social-emotional skills)	Increase access to mental health services and evidence-based programming to enhance caregiver knowledge skills, caregiver resiliency, and children's social-emotional development Increase acceptability of mental health services (e.g., peers, community health workers)	Screen caregivers for mental health disorders during pregnancy and post-partum Screen infants at birth and at regular well-child check-ups for developmental delays	Provide treatment for caregivers who have clinical depression and anxiety during pregnancy and post-partum Provide early intervention services and programming for infants and young children with developmental delays
Relationship (Protective Factors: caregiver-child attachment, caregiver social support)	Increase access to programming that promotes positive social connections (e.g., caregiver–child attachments) for families Increase access to education and skills training to reduce risky behaviors (e.g., child abuse, intimate partner violence) with mental health consequences Increase access to programming that promotes positive peer social support for all caregivers	Screening of higher risk families in clinical and community settings (e.g., health clinics and early childhood education centers) Home visitation programs to address access-related concerns in under-served and low-resourced communities Peer support groups for caregivers across the perinatal period who screen as high-risk	Case management and system navigation and referral for higher risk families High fidelity wraparound services for higher risk families Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes
Community (Protective Factor: referral of families and engagement of families to community support services)	Change community organizations' policies and practices to refer families to support services Integrate mental health services within community locations (e.g., jails, workplaces, and schools) Enlist trusted community leaders to promote mental health and reduce public stigma Activate multisector coalitions in the planning and implementation of mental health services	Change community organizations' processes to increase mental health screenings and referrals Integrate mental health supports within primary care and pediatric clinical care settings Caregiver education programs located in high schools, focusing on teen parents, or those within substance abuse treatment programs for mothers and families with young children Family resource centers that offer information and referral services to families living in low-income neighborhoods	Change community organizations' processes and policies to better serve those with mental illness (e.g., mental health courts) Community organizations' commitment to trauma-informed approaches and policies Caregiver mentor programs with stable, non-abusive families acting as "role models" and providing support to families in crisis

(continued)

Table 28.1 (continued)

	Intervention Strategies by Levels of Prevention		
Socio-ecological Model Level and Targeted Protective Factor(s)	Primary	Secondary	Tertiary
Societal (Protective Factor: Community norms of shared responsibility for supporting caregivers and children)	Create financial incentives to encourage formation of multisector partnerships Expand coverage for behavioral health services and coordinate across sectors	Create financial incentives to encourage expanded screening in the first 3 years of life Incentivize evidence-based practice and support training and infrastructure development	Increase funding for intensive family preservation services with trained mental health counselors that are available to families 24 hours per day for a short period of time (e.g., 6–8 weeks)

Modified from a figure in: Castillo et al. (2019)

Component #4. Identify Settings in the Community and People in Those Settings to Implement Mental Health Promotion Programs

Community interventions to support child mental health are widespread and often implemented by various community members (e.g., doctors, early childcare providers, and community health workers) in diverse community settings including health care clinics, early childhood education centers, faith-based locations, and in the home and other community-based environments – wherever caregiver–child dyads can be found in the first few years of life. Though not intended to reflect a comprehensive list, the following section showcases examples of promising and evidence-based strategies and interventions that can be implemented by community members with different professional roles in the various community settings (strategies highlighted in the community-level row in Table 28.1). All the programs selected are evidence-based and illustrate the types of programs that have been successfully integrated into various community settings to bolster the well-being of caregiver and child mental health.

Clinical Settings

Clinical settings are prime locations for targeted interventions to support infant mental health because of the existing relationships between families and primary care providers (PCPs). For example, the American Academy of Pediatrics recommends that PCP’s conduct 14 routine screenings between the prenatal period and 3 years of age, which provides extensive opportunities for early intervention (American Academy of Pediatrics, 2014). Supporting families to access mental health care during standard of care pediatric visits can address barriers related to access, stigma, transportation, and coordination of care. The following three strategies are recommended to improve child mental health care in clinical settings: (1) integration of services, (2) increases in screening, and (3) improvement in referral systems.

Integrated care allows for physical and mental health practitioners to work collaboratively and systematically to coordinate care for families (Simpson et al., 2016). The child mental health endorsement is an example of an integrated strategy, which can be leveraged for reimbursement by mental health and PCPs. This type of credential, as well as professional opportunities for PCPs that focus on how best to integrate mental health screening and referral services into primary care settings, may increase PCP knowledge and self-efficacy to help them better support very young children and their families. The patient-centered medical home (PCMH) model is implemented in clinical care settings and includes a patient-centered orientation, coordinated and holistic team-based care, strategies to minimize access-related barriers, and a systems-based approach to promoting parent and child mental health (Belzley et al., 2015; Croghan & Brown, 2010). The PCMH model includes a variety of integrated care strategies that may help to reduce stigma specifically among low-resourced communities and facilitate better collaboration between medical and behavioral health providers (Croghan & Brown, 2010).

The Triple P Positive Parenting program is a multilevel family prevention intervention that employs multisector partnerships including the integration of primary care supports and behavioral health services into health promotion programming (Sanders et al., 2014). The goal of the program is to prevent and treat social, emotional, and behavioral problems in children by enhancing the knowledge, skills, and confidence of parents and linking parents to supportive healthcare services. Triple P incorporates both universal and targeted strategies to meet the needs of both individual families as well as broader communities. A key component of the intervention is regular, ongoing interactions with healthcare providers using a variety of formats including in-person, telephone, and online sessions. Depending on the level of care needed, providers support families via brief primary care visits (Level 2), a series of individual consultations (Level 3), individual- and group-based counseling sessions (Level 4), and intensive supports for families with complex needs and referred by PCP (Level 5). Rigorous and extensive evaluations demonstrate both the cost-effectiveness and impact of the Triple P program with respect to parenting practices, reports of child behavior, and numerous child mental health outcomes (Sanders et al., 2014).

Increasing screenings for both parents and young children is a best practice that can be implemented into clinical settings and included as a key component of a child's developmental assessment. Best practice recommendations include screening for social-emotional well-being of the child, pregnancy-related depression and anxiety in the mother, and alcohol and drug use in the pregnant women (Mental Health Colorado, 2018). One example of a community-based intervention that targets increased screening to support infant mental health is Assuring Better Child Health and Development (ABCD). ABCD is a nonprofit that focuses on improving the lives of families through early identification of development needs. The organization leads the Healthy Steps program (Valado et al., 2019), which seeks to integrate a child development specialist within a pediatric primary care team. The program works collaboratively with primary care, early childhood education settings, and community agencies to increase developmental screenings of young children to identify potential social, emotional, or behavioral challenges or developmental delays. The impact of the ABCD program is significant; findings suggest that for every dollar invested in early identification and intervention, long-term societal costs are reduced by $4 to $9 (Center on the Developing Child, 2015). Over the course of a lifetime, children who receive early identification and support for developmental needs experience lower rates of teen pregnancy and teen arrests and higher high-school graduation rates (Center on the Developing Child, 2015).

Finally, improving comprehensive systems of referral for families and caregivers of young children is needed. The referral navigation system must include supports for crisis situations and is particularly important for low-resourced communities where infrastructure for mental health resources is severely lacking. Navigating care is difficult for families, even in high-resourced communities resulting in costly and less effective care. Community-based approaches that foster multisectoral collaborations to improve networks between primary care clinics and existing mental health resources reflect cost-effective strategies that bolster access to quality mental health care for young children and their families (Belzley et al., 2015).

Early Childhood Education (ECE) Settings

Second only to the immediate family, the child-care environment most often dictates early human development. High-quality ECE programs are an important and often unrecognized resource for addressing the stress-related roots of health disparities. Early childhood intervention that focuses on strengthening the capacity of the centers and childcare providers to refer and treat children and families, particularly for low-income children, has the potential to influence the developmental trajectories of children, resulting in lifelong benefits for individuals and society. (Campbell & Ramey, 1994; Engle et al., 2011; Shonkoff et al., 2009). ECE centers can also protect children from family-based risks, including exposure to ACEs (Heckman et al., 2013). Therefore, ECEs are ideal locations for a proactive approach to health promotion and one that can reach many children in the first 5 years of life.

One-time professional development training opportunities can increase the capacity of the ECE workforce, thus fostering positive child development outcomes. Professional development training that addresses how ECE providers can recognize and manage children's social-emotional health needs, as well as their own psychological needs, improve emotional and behavioral regulation and social skills of children in care (Substance Abuse and Mental Health Services Administration, 2022). An ECE caregiver is best equipped to promote healthy childhood development through supportive, positive interactions if their own self-regulation and coping strategies are supported (American Academy of Pediatrics, 2014). The Cultivating Awareness and Resilience in Education (CARE) program (Jennings et al., 2013, 2020) is one example of an evidence-based professional development intervention focused on reducing stress of ECE providers (Garrison Institute, 2022). The program is implemented by trained community facilitators and utilizes a blend of didactic instruction and experiential activities, including mindfulness strategies, to promote emotional responsiveness and sensitivity of ECE providers enabling them to better and more effectively respond to the needs of the children in their care. CARE has been tested with diverse samples using rigorous randomized controlled trials and findings are consistent. ECE providers who participated in CARE showed significant decreases in psychological distress, reductions in ache-related physical distress, significant increases in emotion regulation, and some dimensions of mindfulness, improved productivity, and enhanced classroom quality (Jennings et al., 2017). Improvements in classroom quality are strongly associated with child social-emotional development outcomes (Kwon et al., 2019).

Increasing mental health consultation and coaching in ECE settings can also improve infant mental health (Belzley et al., 2015). Mental health consultants support the needs of all children by giving information to the adults who care for them on topics such as typical development, social and emotional skills, problem-solving, and preventing or managing challenging behaviors (National Center on Health, Behavioral Health, and Safety, 2021). Mental health consultants can work across all levels of childcare programs, including child- and family-focused consultation; consultation with teachers and families to better support children in the classrooms; consultation with administrators and staff to address program-level needs; and consultation to assess the professional development needs of staff (National Center on Health, Behavioral Health, and Safety, 2021). In general, mental health consultation supports caregivers' self-efficacy, mental health and well-being, and improves overall quality of care provided in early childhood education settings (Mental Health Colorado, 2018). Coaching is ongoing professional development that emphasizes the application of knowledge to practice and is emerging as a critical factor in overall quality improvement in early childhood settings, although coaching must be sustained, systematic, and directly linked to the intervention practice(s) (Sheridan et al., 2009). Practice-based coaching (PBC) is an evidence-based approach designed to support teachers to use effective teaching practices that will translate to enhanced social-emotional development of children in their care (Snyder et al., 2015). PBC integrates varied components including goal-setting and action planning, focused observations, and reflection and feedback sessions with a trained coach (The Circle of Security International, 2022). Integration of mental health consultants and coaching supports can improve the care children receive and in turn improve children's social and emotional development in the first few years of life. The Play and Language for Autistic Youngsters (PLAY) project is an example of an evidence-based intervention that utilizes the mental health consultant approach to support infant mental health (The PLAY Project, 2023). A certified PLAY project consultant partners with families to build trust, promote family confidence and competence, and strengthen family–child relationships. The evaluation of the PLAY project suggests that young children of parents who received consultation made gains in social interaction and various child development outcomes (Solomon et al., 2014).

Faith-Based Settings

Religion and participation in religious groups may promote the mental health of families with young children (Hays & Aranda, 2016). Faith-based settings can be instrumental in supporting the behavioral health needs of families because these types of organizations often engage in public education and advocacy in efforts to support community well-being. Faith-based organizations are engrained in the community and have access to a multitude of coalition building resources including their ability to bring people together around a common cause, build trust among community members, develop visions and strategic plans, and maximize community resources to implement policy changes (Christens et al., 2008). These organizations are also proficient in mobilizing individuals and groups to collaborate to achieve common goals (Speer et al., 2010). Additionally, faith-based leaders often support individual community members and families by providing support and counseling for behavioral health challenges (Drayton-Brooks & White, 2004). Churches can link families to formal and informal supports and provide behavioral health services such as substance use support, health screening, and public health education. Importantly, these types of groups often have strong and trusted ties in low-resourced communities, and as such, are positioned to address access-related barriers and stigma related to seeking behavioral health supports (Dekraai et al., 2011).

CAPAS: Criando con Amor, Promoviendo Armonía y Superación (Raising Children with Love, Promoting Harmony and Self-Improvement) is a promising intervention implemented in faith-based settings (Domenech Rodríguez et al., 2011). CAPAS was adapted specifically for Latino families from the evidence-based Parent Management Training Oregon (PMTO) program (Forgatch et al., 2009), which is traditionally delivered with individual families in agencies or families' homes, parent groups, and through virtual platforms. Formative work underscored the importance of integrating faith-based settings into program implementation to reach more diverse audiences (Domenech Rodríguez et al., 2011). The CAPAS intervention teaches parenting strategies to support caregiver well-being as well as mental health needs of their children. The meetings teach five core parenting practices: appropriate, noncoercive discipline (e.g., setting limits, following through, reinforcing prosocial behavior); skill encouragement (e.g., breaking tasks such as homework into achievable steps); monitoring; problem solving; and positive involvement. Additional skills-building activities are tailored to parents experiencing divorce or separation and include: (1) emotional regulation (e.g., recognizing negative emotions and practicing techniques to help regulate them); (2) managing inter-parental conflict (e.g., through problem solving and negotiation); and (3) addressing children's divorce-related concerns (e.g., through active listening, problem solving, and recognizing and managing emotions) (Social Programs That Work, 2018). Adaptations from the original program include a focus on culturally specific stressors including immigration-related challenges, discrimination, and biculturalism. The CAPAS-enhanced intervention was found to be associated with significant improvements in child mental health outcomes such as reduced anxiety and behavioral problems. Qualitative data suggested that participants expressed a significant interest in participating in faith-based parenting programs because the church represents a safe and trusted space in which to learn how to better support mental health needs (Parra-Cardona et al., 2017, 2021). The CAPAS intervention has been translated and adapted by researchers conducting PMTO implantation in Mexico (Baumann et al., 2014).

Other Community-Based Settings

Implementation of promising and evidence-based interventions into home environments and other community-based settings can also be effective approaches to promoting the mental health of families with young children. Home-visitation supports that provide well child support and information to parents with young children can significantly buffer exposures to adversities early in life. For example, the Home Instruction for Parents of Preschool Youngsters (HIPPY) program (Children's Bureau, 2022) provides school readiness support and services at home to parents of children under the age of five. The focus of the HIPPY program is on building the natural bond between parent and child (Children's Bureau, 2022). The program seeks to improve early childhood mental health by taking a three-pronged approach: (1) supporting families to advocate for high-quality comprehensive services and supports that lead to future success; (2) increasing parents knowledge and self-efficacy to better support children's learning and development, including social and emotional development outcomes; and (3) ensuring all children are ready for school and achieving by 3rd grade regardless of ability, race, place, income, language, and culture (Early Childhood Colorado Framework, 2022).

Another evidence-based intervention that can be implemented in a variety of community settings is the Circle of Security – Parenting (COS-P) program (Circle of Security International, 2022). COS-P is rooted in decades of research and provides caregiver wellness supports recognizing that healthy child development is based on fostering supportive interactions with all caregivers and a safe environment very early in the life course. The program supports caregivers to reflect and prioritize their own needs, resources, and support systems, as well as the needs of the children in their care. COS-P facilitators are trained community members and support families to (1) understand their child's emotional world by learning to read emotional needs, (2) support their child's ability to successfully manage emotions, (3) enhance the development of their child's self-esteem, and (4) honor the innate wisdom and desire for their child to be secure. COS-P has been identified as one of the lowest cost, evidence-based programs that effectively supports health child development outcomes (Washington State Institute for Public Policy, 2019). The COS-P program can be implemented in numerous community settings including the home, healthcare clinics, ECE settings, and virtually (Hoffman et al., 2006).

Finally, Child First (Invest in Kids, 2022) is a two-generational model that supports young children and their families through providing intensive, home-based services. This program works to connect families to necessary community-based services. The goals of Child First are to promote coping and decrease stress and build strong, loving, caregiver–child relationships that support healthy brain development among children exposed to trauma and stress in the first 5 years of life. Families that participate in the program work with a two-person team within their home environment that consists of a mental health clinician with specific expertise in early childhood development as well as family support partner who supports the entire family on coping with stress and connecting them to existing community resources. The program is unique because it targets both risk and protective factors of the family unit to support positive mental health and well-being outcomes. Rigorous studies have found that Child First results in lower prevalence of externalizing symptoms, less language delays, improved maternal mental health, lower involvement in child protective services, improved access to support services, and high parent satisfaction (Crusto et al., 2008, 2013).

Multilevel Community Interventions

Many interventions exist that work across the multiple levels of the social-ecological model. One example is the Linking Actions for Unmet Needs in Children's Health (LAUNCH) program (The National Center for Healthy Safe Children, 2022a) designed to promote the mental health and overall well-being of young children under 8 years of age. Project LAUNCH activities target the physical, social, emotional, cognitive, and behavioral components that comprise healthy early childhood development with the long-term goal of supporting school readiness and positive learning outcomes for all children (The National Center for Healthy Safe Children, 2022a). The project is funded, and the work is guided, by federal partnerships including the Substance Abuse and Mental Health Services Administration, the Administration for Children and Families, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention. Project LAUNCH takes a public health approach to promoting infant and early childhood mental health, and views health holistically and comprehensively by targeting multilevel risk factors that cross the individual, interpersonal, and community levels of influence. This intervention is also novel because it embeds a strength-based approach to supporting resilient families and healthy development, thus protecting children from negative health trajectories later in the life course (The National Center for Healthy Safe Children, 2022b).

Project LAUNCH utilizes five evidence-based strategies to achieve the programs' goal: (1) integration of behavioral health in primary care, (2) embedding mental health consultation in early childhood education settings, (3) enhanced home visiting, (4) strengthening family connections, and (5) increased screening and assessment. Pediatric caregivers are recognized as instrumental supports to foster healthy child development and as part of Project LAUNCH, they receive cross-sector training on behavioral health topics, developmental screeners, referral and care coordination with community-based services, and best practices related to providing parenting support. Mental health consultation is implemented, and services are expanded to reach children receiving care in ECE settings. Home visitors receive enhanced training related to social emotional development and behavioral health of families with young children, reflective supervision, care coordination, and brief behavioral health interventions. Families are strengthened by providing evidence-based parenting and skills training, increased education related to healthy child development, peer-to-peer supports, linkages to community services and resources, and efforts to build parents leadership and advocacy skills. Finally, clinical-level resources including enhanced screening and referral systems are improved by increasing training and tracking of valid screening tools and protocol utilization. Findings suggest that Project Launch leads to improvements in parent and child outcomes, systemic changes at the state level, and promotion of positive trajectories among families with young children (Goodson et al., 2014).

Component #5. Consider Ethical Guidelines When Implementing Community-Based Mental Health Promotion Interventions

Individuals and agencies who seek to implement community-based interventions for caregiver and child mental health must consider a number of ethical issues in doing so. Several ethical guidelines have been developed to conduct this work and all encourage individuals who represent the community agencies, educational institutions, healthcare systems, and other common organizing bases for interventions to be mindful of the power differential between their institutions and the individuals their interventions serve (MacKnight, 1995). Following from this, McKnight advises interventionists to work to manage the following issues that can arise from this discrepancy in power: (1) Respect intervention participants as end beneficiaries of the intervention rather than means to enact an effective intervention; (2) respect program participants' right to actively determine what they need and to provide ongoing consent for intervention that serves those needs; (3) respect program participants' human, civil, and legal rights; and (4) seek to find the best solution for the most people given the needs and limitations that arise in the circumstances of the intervention.

The guidance provided by McKnight for work in communities integrates well with existing principles that guide healthcare practice and intervention research, such as the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) or the American Psychological Association's Ethical Principles (American Psychological Association, 2002), which exist in part as an effort to expand and modernize the principles found in Belmont. These suggest a number of best practices for interventionists who work within communities, and which are particularly important for those seeking to research the effectiveness of their interventions (Anderson et al., 2012). First, interventionists and staff representing agencies in which interventions are based need comprehensive education in ethics related to community-based practice. Ethics education should include elements related to laws, regulations, and local policies that may affect stakeholders as well as broader ethical principles that govern community-based intervention. Moreover, specific applied training may be necessary for individuals in certain roles, such as those who are responsible for informed consent with program participants, or interventionists who manage risks that are specific to the intervention, such as assessment and management of suicidal ideation. To this point, ethics education should be broad in its coverage of universal principles while also being specific to the needs of the target population and the intervention being provided. Second, interventions with the strongest empirical support should be selected and intervention staff must be appropriately qualified and trained to implement the intervention. Over the life of an intervention, supervision and in-service training of intervention staff may be important to maintaining competent intervention that maximizes benefit to participants. Third, intervention staff should identify and appropriately manage conflicts of interest. In community-based interventions, these conflicts can include existing relationships with participants that might require identification and management of the dual role that is created when an interventionist takes on that role within their community. Fourth, informed consent is an essential and collaborative process in which intervention staff help program participants understand what is involved in the intervention to the extent that participant can freely decide both to participate in the intervention at the outset and to continue their participation, absent any coercion from intervention staff. Informed consent is ongoing and should evolve over the course of an individual's participation in the intervention. It may cover a range of activities that participants engage in both passively and actively. Fifth, intervention staff must respect participants' privacy and confidentiality, and this practice is of particular importance in the domain of mental health, as the potential for harm to arise from violations of privacy is greater. Moreover, in interventions with families, measures should be taken to protect one individual's privacy in the context of other families. When interventions are limited in assurance of privacy within families who participate, these limits should be made clear as part of the informed consent process.

Summary and Key Points

There is substantial evidence supporting the effectiveness of community-based interventions for improving child mental health and promoting healthy trajectories throughout the life course. Community involvement in these types of interventions may be represented in various ways, target numerous settings, and involve multisectoral partnerships. Promising and evidence-based interventions can encompass primary, secondary, and tertiary prevention efforts and promote numerous protective factors that operate at multiple levels of influence. Most community-based interventions focus on targeting protective factors at the individual-, relational-, community-, *or* societal-level with some intervening at multiple levels of influence. Specific recommendations related to the implementation of community-based interventions to promote caregiver and child mental health include (1) Implementing multifaceted approaches that target whole communities rather than individuals and involves implementation in varied community settings; (2) collaboration and coordination of diverse stakeholders that are responsible for supporting and promoting child mental health including health care providers, families, caregivers, and community groups; (3) continued investment in ongoing resources and trainings targeted to families and providers throughout the first 5 years of life in order to maintain long-term outcomes; (4) attention to ethics and processes that foster equitable partnerships and policy reform to support sustainable community collaborations; and (5) further research adopting a life course perspective that rigorously investigates community prevention interventions in racially/ethnically and socioeconomically diverse populations, both antenatally and through the first 5 years of life, to support better mental health outcomes and the well-being of low-resourced families.

Infancy and early childhood are key developmental periods during which a constellation of risk and protective factors interact to shape physical and mental health trajectories throughout the life course. As detailed throughout this chapter, the evidence supporting the need for community-based early intervention using a public health framework to promote infant mental health is indisputable. Moreover, recent evidence highlights spillover effects, suggesting that when interventions are implemented early in the life course and effectively brought to scale, all children experience positive outcomes, even those who did not directly receive the intervention (McLuckie et al., 2019; Nagle, 2018). Community-based interventions to support child mental health are also cost-effective and sustainable (McLuckie et al., 2019)**.** The rate of return from high-quality education programs that target all children aged 0 to 5 years was found to be 13% per year compared to an estimate of 7–10% per year for comparable programs that begin at age 3 years (Garcia et al., 2016). Finally, community-based interventions focused on child mental health represent effective solutions to promoting health equity. Interventions that adopt upstream, universal approaches to support young children, caregivers, and families within whole communities may be best suited to promoting child mental health because of their ability to reduce access-related barriers and stigma associated with mental health diagnoses (Bayer et al., 2007). These types of prevention interventions represent inclusive strategies and can more effectively reach low-resourced communities and populations compared to more traditional, psychological approaches to treating mental health disorders.

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Broadening the International Lens on Infant and Early Childhood Mental Health Interventions: Looking Beyond the High Income World

Anna Huber, Jane Barlow, and Maree Foley

This chapter examines parenting and caregiving interventions in families with infants and very young children in low- and- middle-income countries (LMICs) that are aimed at improving parenting interactions, behaviours, knowledge, attitudes, practices, and beliefs, so as to improve child development outcomes. The World Bank (2022) estimates that in LMICs there are 250 million children under the age of five, who are at risk of not reaching their developmental potential because of extreme poverty and stunting (or low height for age) associated with inadequacies in their nutrition, health services, psycho-social care, and opportunities to learn (WHO & UNICEF, 2012). Early poverty and stunting have been closely associated with subsequent deficits in cognitive, social emotional development, educational performance, adult income, and risks of chronic diseases. Using a moderate poverty index, Lu and colleagues estimated that children under five from 141 LMICs faced a disproportionate exposure to risk of poor development, with those in some regions more exposed, e.g., East Asia & Pacific 58.7 million (40%), South Asia 119.7 million (71%), Sub Saharan Africa 115.5 million (81%) compared with Europe and Central Asia 6.3 million (23%), Latin America & Caribbean 11.9 million (22%), and Middle East & North Africa 12.1 million (33%) (Lu et al., 2016).

Irrespective of compromised and limited resources, parents and caregivers of infants and young children living in LMICs want to protect their children and see them grow well, with optimal health and education outcomes (Bornstein & Putnick, 2012). However, the challenges of caring for and parenting their infants and young children within the context of daily threats to their health, safety, and survival are immense and have been well documented (e.g., WHO, 2020). Parent-level interventions (e.g., family nutrition programs and state-level social security) have long been in place to support parents and carers raising infants in adverse conditions for early childhood development (ECD) (Emmers et al., 2022). In many communities experiencing extreme poverty and child stunting, a major target of such parenting interventions has been to improve child health and nutrition. But optimal ECD requires parental investment in more than just child survival (Francesconi & Heckman,

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2016), and surveys of many LMICs have also identified high rates of inadequate caregiving of infants and young children in a broader sense (e.g., lack of adequate stimulation) (McCoy et al., 2022). Therefore, parenting interventions in LMICs are increasingly including a focus on responsive and stimulating interactions between caregivers and their young children, as these are positively associated with broader developmental gains in infants (Eshel et al., 2006).

This chapter examines what is known about the nature and effectiveness of such intervention programs. Specifically, the chapter starts by describing the global context of ECD in addition to the range of ECD-focused interventions in LMICs. It goes on to examine the effectiveness of parenting interventions aimed at improving ECD in LMICs drawing on the findings of recent systematic reviews. The chapter concludes with some of the key cultural and contextual considerations, identifies further research needed, in addition to providing some guidelines for the delivery of effective intervention in these contexts.

The Global Context for Early Childhood Development

In 2015, 193 nations committed to fulfil the United Nations (UN) 2030 Sustainable Development Goals (SDGs), underpinned by the shared maxim: “leave no one behind”. The 2030 Agenda and SDGs represent global commitments to international collaboration aimed at improving the quality of life for all, in all countries and all communities. These SDGs, aimed at reducing the human impacts of ongoing global inequities in development of countries, include an emphasis on the role of early child development (ECD) for all infants and young children across the globe (Black et al., 2017). ECD includes physical, cognitive, language, social, emotional, and motor development in the first 8 years of life (WHO, 2016). Global scientific evidence related to infants and children up to 3 years of age has highlighted how exposure to adverse conditions including extreme poverty, violence, and environmental hazards during this sensitive developmental period exerts the greatest long-term harm, while effective interventions to mitigate such adverse early experiences have the greatest potential for benefit over the life course (Black et al., 2017).

Promotion of Nurturing Care and Infant and Early Childhood Mental Health (IECMH)

Central to the global operationalization of ECD goals has been the publication of *The Lancet* ECD series (Black et al., 2017), which presented the concept of “nurturing care” as an organising framework for policy and practice interventions aimed at meeting the developmental needs of children aged zero to five, specifically living in LMICs. Simply stated to grow and develop optimally, “children need to receive the five inter-related and indivisible components of nurturing care: good health, adequate nutrition, safety and security, responsive caregiving and opportunities for learning” (nurturingcare.org, 2019). The concept of Nurturing Care goes beyond the definition of Infant and Early Childhood Mental Health (IECMH), which involves supporting “healthy social and emotional wellbeing in young children from the prenatal period to 5 years of age through culturally responsive and relationship-based care (and) can include caregiver–child intervention or treatment to nurture the child’s healthy development” (Zero to Three, n.d.). Both frameworks highlight the importance of responsive caregiving and addressing the needs of both caregivers and young children.

> Responsive caregiving includes observing and responding to children’s movements, sounds and gestures and verbal requests. It is the basis for: protecting children against injury and the negative effects of adversity; recognizing and responding to illness; enriched learning; and building trust and social relationships … Responsive caregiving also includes responsive feeding, which is especially important for low-weight or ill infants… These

> social interactions also stimulate connections in the brain (WHO et al., 2018, p. 14)

Parent-Level Interventions to Support ECD in LMICs

The Lancet ECD series (Richter et al., 2017) advocated for the delivery of multisector nurturing care-based interventions that collectively target nutrition and child development as well as maternal and family health and well-being, child protection against violence, family support, financial support, and social protection for all families as well as optimising their capacity to access health and education services and quality early learning opportunities. Against this background, the focus of parenting interventions to support ECD in LMICs has evolved over time. Earlier efforts were narrowly focused, e.g., targeting nutrition, whereas later efforts have addressed several nurturing care components. These interventions, grouped according to their main focus, include the following:

(a) Nutrition programs, in contexts where there are high rates of stunting or malnutrition (Frongillo et al., 2017; Prado et al., 2019),
(b) Psychosocial stimulation interventions aimed at increasing infant stimulation and involving caregivers being given information on ECD and the role of interactive and responsive parenting, coaching and opportunities to practice talking, playing and reading with their infants (e.g., Abimpaye et al., 2019),
(c) Interventions that combine social protection (e.g., conditional cash transfers), health or nutrition activities with responsive care and stimulation (Yousafzai et al., 2014, 2015; Tofail et al., 2013; Chang et al., 2015; Fernald et al., 2017; Knauer et al., 2016; Zhou et al., 2019),
(d) Targeted maternal psychological well-being interventions to support ECD (e.g., Singla et al., 2015; Baumgartner et al., 2021; Cooper et al., 2009; Alvarenga et al., 2019).
(e) Child protection/violence prevention programs (Jensen et al., 2021),
(f) Interventions aimed at improving caregiving for institutionalized children (Zeanah et al., 2017; Lopez et al., 2013).
(g) Interventions aimed at supporting families with infants in war and conflict zones (Richter et al., 2018).

Delivery approaches used by the above programs range from one-to-one training sessions between parenting instructors and caregiver–child dyads on interactive caregiver child activities (Attanasio et al., 2014; Walker et al., 2004; Yousafzai et al., 2014; Heckman et al., 2020; Hartinger et al., 2017) to combined individual and group sessions (Hamadani et al., 2006) usually delivered by community health workers (Yousafzai et al., 2014); lay health workers (Attanasio et al., 2014); community-based lay workers (Barnhart et al., 2020); or community volunteers (e.g., Abimpaye et al., 2019).

Intervention Practice Examples

Examples of specific interventions that have been found to be effective in LMICs include the following: a community-based parenting program that explicitly addressed both maternal psychological well-being (e.g., via increasing father involvement) and child development and growth (play, talk, diet, hygiene, love, and respect) in rural Uganda (Singla et al., 2015); a responsive stimulation and/or enhanced nutrition community-based health intervention: The Pakistan Lady Health Worker (LHW) Intervention (Yousafzai et al., 2014; Obradović et al., 2016); and the Sugira Muryango (Strengthen the Family) violence-prevention home-visiting-based parenting intervention in Rwanda (Betancourt et al., 2020; Jensen et al., 2021).

For example, the Sugira Muryango (Strengthen the Family) family coaching program in Rwanda included psychoeducation and coaching of caregivers to promote responsive caregiving, nutrition, hygiene, and nonviolent interactions among household members. Families in the program were living in extreme poverty, were eligible for Rwanda's social protection program and included 1084 children aged between 6 and 36 months of age, their caregivers and intimate partners aged 18–84 years (*n* = 1498). The intervention was delivered to 541 families, with 508 families in the control group who received the government social protection program only (Jensen et al., 2021).

Efficacy evaluation of the Sugira Muryango program found the program to have a large and ongoing effect on engaging fathers in childcare, and there were small significant effects on reducing intimate partner violence and harsh discipline, and small significant positive effects on child development outcomes and caregiving practices (Betancourt et al., 2020; Jensen et al., 2021).

Effectiveness of These Kinds of Parenting Interventions to Improve ECD in LMICs

A number of recent systematic reviews, some including meta-analyses, have examined the effectiveness of parenting interventions aimed at improving ECD in LMICs across a range of developmental domains by improving parent and or caregiver knowledge, practices, and interactions with the children (Emmers et al., 2022; Jeong et al., 2021a; Zhang et al., 2021).

Key Findings from These Reviews

Emmers et al. (2022) conducted the first economic review of evidence for parent training programs aimed at improving "human capital" outcomes of young children under 5 in developing countries. The authors examined intervention effectiveness and "demand" (i.e., parental inputs) and "supply side" (e.g., training of intervenors, intervention implementation) mechanisms underlying this. They reviewed studies of randomized controlled trials (RCTs) of 17 psychosocial stimulation, 20 child nutrition and 16 integrated parenting training programs targeting both cognitive/psychosocial stimulation and child nutrition/health outcomes in 22 LMICs in Africa, Asia, and Latin America, during pregnancy or the first 5 years of life to improve the developmental potential of children. They excluded programs only targeting children who were severely malnourished, prematurely born or suffering from a severe disease, mental trauma, or disability. They found significant positive effects of psychosocial stimulation programs on child cognitive, language, motor, and social-emotional domains as well as parent investments in a cognitively stimulating environment, parent-related knowledge and beliefs among caregivers. The authors also found mixed evidence with regard to the treatment impact of nutrition programs on ECD, with some studies reporting positive impacts (e.g., Frongillo et al., 2017) and other studies reporting no impacts (Vazir et al., 2013).

Similar findings on child outcomes were reported by Zhang et al. (2021) in their review of studies of 21 RCTs of parenting interventions that included responsive caregiving and stimulation components with 10,400 children under 2 years delivered across 12 LMICs in Asia, Africa, and Latin America. They reported small to medium effects on cognitive, language, and motor skills, but nonsignificant effects on social emotional skills, the latter being due to the small number of underpowered studies that measured this outcome.

A comprehensive global systematic review and meta-analysis of child and parent outcomes of 102 RCTs of ECD parenting interventions delivered in the first 3 years of life (in 14 high income countries-HICs- 61 trials and 19 LMICs-41 trials) found overall improvements in early childhood cognitive, language, motor and social emotional development, improved attachment and reduced behaviour problems (Jeong et al., 2021a, b). Pooled effect sizes were greater for cognitive, language and motor development, and attachment, and lower for socio-emotional development and behavioural problems. This may have been because the majority of interventions reviewed engaged caregivers in providing stimulating activities or greater verbal responsiveness to foster early play and learning. Fewer interventions directly aimed to develop child emotional competence or reduce behaviour problems, and few addressed parental mental health or supported caregivers with behaviour management including encouraging non-violent discipline. Jeong et al. (2021a, b) also found that overall, parenting interventions improved parenting knowledge, parenting practices, and parent–child interactions with their children but had no overall significant effect on parent depressive symptoms.

Emmers et al. (2021) reviewed ten studies evaluating the effectiveness of developmental outcomes of parenting interventions ($n = 13{,}766$) in rural China with children under 5 years. They found that parent training programs designed to increase stimulating parenting practices (e.g., talking, singing, and storytelling with young children) had positive effects on child cognition, language and social emotional development, and parenting practices.

Prado et al. (2019) reviewed 75 intervention studies (72,275 children) from across the globe, the large majority in LMICs (61in LMICs vs 14 in HICs), with caregivers during pregnancy and with children aged 0–5 years targeting both linear growth and ECD neurobehavioural development. They found that while intervention with nutritional supplementation was associated with linear growth there were only small improvements in cognitive, language or motor development scores; and that while nurturing and stimulation interventions had significant effects on child development, there was no impact on linear growth. The authors concluded that the factors that influence linear growth and neurodevelopment are only partly shared, and that interventions with caregivers designed to nurture and support early childhood development should target both. So, while nutritional supplementation during early childhood appeared to be important for socioemotional development, caregiving had a 4–5 times greater effect on developmental outcomes than nutritional supplements alone, pointing to the importance of also targeting caregiving behaviour and learning opportunities, which appear to be critical to support cognitive, language, motor, and social emotional skills in young children.

A review of ECD + violence prevention (VP) interventions to foster ECD and reduce violence identified 6 programmes that were delivered in Chile, Jamaica, Lebanon, Mexico, Mozambique, and Turkey, 5 of which were directed at parents. Improvements in both child development and maltreatment outcomes were reported by all but one study (Efevbera et al., 2018). The authors concluded that there remains a lack of evidence on ECD + VP interventions. These findings were confirmed by Jensen et al. (2021) who reported that evidence for ECD + VP interventions is of low quality and that results have been mixed, all of which suggests additional quality research is needed.

Moderators of Intervention Effects

Jeong et al. (2021a, b) found significant heterogeneity in terms of the effects of parenting interventions for all child and parent outcomes. Given the diversity of intervention contexts, study participants, intervention components, and delivery approaches the identification of moderators and mediators of intervention effects is important.

Zhang et al. (2021) found significant heterogeneity in effect sizes across intervention studies and also that effects on child development were greater in parenting programs encouraging nurturing care that targeted vulnerable groups including rural communities and caregivers with lower education levels. They also found that group sessions (rather than individual visits) and higher program doses (> 12 sessions) were associated with stronger intervention effects on child development. In contrast with this finding, Emmers et al. (2021) in their review of ECD interventions in rural China found that individual delivery of the parenting intervention in the home was more effective than centre-based delivery in engaging the most vulnerable families.

Jeong et al. (2021a, b) found that while effects on children's social-emotional development, parenting knowledge, parent–child interactions, and parent depression did not differ significantly according to whether the country was high or low income, the size of effects were consistently greater for all of these outcomes in LMICs. This review also found that interventions that included a responsive caregiving component were more effective than those that did not in improving child cognitive development, parenting knowledge, parenting practices, and parent–child interactions (Jeong et al., 2021a, b). They also found that timing of the intervention in terms of the child age at baseline (≤12 months or ≥12 months) made no difference to effects on any child or parent outcome, but that interventions lasting less than 12 months had larger effects on parenting practices than those lasting more than 12 months (in contrast to Zhang et al., 2021). Given that some of Jeong et al.' (2021a, b) findings relate to interventions in both HICs and LMICs, separate analyses for LMICs would be important before generalising conclusions about moderation of effects on both child and parent outcomes.

Emmers et al. (2022) suggested that heterogeneity in the outcomes measured may also be related to baseline skills (i.e., more disadvantaged children with lower baseline skills may benefit most), which developmental domain is targeted, and at what age, as well as baseline household characteristics.

Other potential moderators of intervention effects include intervention compliance. Emmers et al. (2022) identified that the effects of interventions can be diminished if there is limited uptake in the targeted populations (e.g., due to parental resource, time, and knowledge constraints). They also proposed that intervention effects would be moderated by poor quality of intervention delivery (e.g., monitoring, delivery setting) and program fidelity, both of which can be affected by the skills and commitment of intervention providers and the delivery location. The provision of supervision of intervenors and financial incentives may therefore both be important influences on the way an intervention is delivered and its subsequent effectiveness.

Sustainability of Effects

Emmers et al. (2022) concluded from their review of studies of RCTs, that while psychosocial stimulation programs showed high levels of short-term effectiveness in improving child skill development, as a result of the limited research currently available it is unclear to what extent treatment effects persist over time. Similarly, Jeong et al. (2021a, b), who reviewed the short-, medium-, and long-term outcomes of parenting interventions that are delivered during the first 3 years of life in LMICs, found that while trials consistently reported a range of ECD benefits post-intervention, there was a general fading of impacts over time with mixed results short term and mostly inconclusive results for medium- and long-term effects.

However, there is some evidence emerging to suggest that there may be sleeper effects on some aspects of development for some interventions (e.g., Obradović et al., 2019). For example, while the Lady Health Worker (LHW) intervention in Pakistan, delivered between 0 and 24 months, only had small effects on child social-emotional outcomes post intervention (Yousafzai et al., 2014, 2015), Obradovic and colleagues (2019) found intervention participation was one of the predictors of longer term increased preschool executive functions (EFs).

Based on economic models derived from HIC longitudinal studies of early years interventions (e.g., Cunha & Heckman, 2007), Emmers et al. (2022) suggest that if interventions result in a sustained elevation in the level of parenting investments in their children, the intervention impacts on human capital development are more likely to persist over time.

Drawing on longitudinal analyses of early childhood education interventions in HICs, Bailey et al. (2017) concluded that fadeout or persistence over time of positive post-intervention effects on children's cognitive, social, and emotional development can be determined by three distinct processes—skill building, foot-in-the-door capacity boosts needed to respond to windows of opportunity or risk across childhood and adolescence, and sustaining environments. While these processes have not been extensively examined with parenting interventions in LMIC contexts due to limited longitudinal follow-up studies, they warrant investigation to inform the future design and implementation of ECD interventions, including the benefits of addressing environmental factors that affect intervention impacts and their sustainability, and the possible need for other interventions later in development (Emmers et al., 2022; Tomlinson et al., 2021).

Trude et al. (2021), in their follow-up study at adolescence in South Africa and Brazil, found that nurturing care in the home during the preschool years was positively associated with adolescent cognitive development in spite of cumulative risks (including household poverty and crowding, limited maternal education, height, age and mental health and child low birthweight, gestational age, and height). The authors found that among youth with high learning opportunities and responsive caregiving at age 4 years, there were no significant effects of cumulative adversities on adolescent IQ. In addition, there was no evidence to suggest that either responsive care or learning opportunities mitigated all the effects of early cumulative adversities on adolescent psychosocial adjustments or height. However, the findings suggested that (a) some mitigation of negative consequences of early adversities on later cognitive development is possible and (b) that policies and programs designed to increase responsive care and learning opportunities early in life among families exposed to cumulative adversities may promote human development.

Theorized Mechanisms of Change for Parent-Level Interventions to Improve ECD

Evidence on the mechanisms that drive treatment impacts is useful to shed light on the way in which such programs bring about change in the short, medium, and long term (Emmers et al., 2022). Following a theoretical model of human capital formation (Cunha & Heckman, 2007), Emmers et al., 2022 proposed three main pathways in terms of impact for parent level interventions on development: (1) a *direct impact on the child* who learns new skills as the intervenor teaches new interactive activities to the caregiver and the child; (2) an *indirect impact* via *changes in the parent* if as a result of the intervention, for example, the caregiver engages more frequently with the child in stimulating and responsive activities; and (3) an impact on the wider parameters that influence child development (e.g., family harmony, better nutrition, and environmental safety).

Direct Impacts: Child-Level Mechanisms of Change

There is mixed evidence that some parenting interventions may improve development as a result of the way in which the intervention directly improves the well-being of the child. For example, improved nutrition is effective in promoting physical growth and brain development. In their review of ECD interventions targeting neurodevelopment and nutrition, Prado et al. (2019) found that linear growth was associated with increased socioemotional development. Psycho-social stimulation interventions likely involve the child in direct experiences of greater stimulation and learning opportunities, which may be one mechanism of change in these interventions. Increased child engagement, through early learning activities and responsive caregiving, was hypothesized to mediate the relationship between the Sugira Muryango intervention and improved child health and developmental outcomes (Barnhart et al., 2020). Heckman et al. (2020) concluded that treatment effects from a large-scale early childhood home visiting intervention programme (China REACH) on child language, fine motor, and socioemotional skills appeared to result not only from beneficial interaction patterns between home visitors and caregivers, but between home visitors and the children. Furthermore, children from the most disadvantaged home environments benefitted most.

Indirect Impacts: Parent-Level Mechanisms of Change

One of the main ways that parenting interventions are thought to improve child health and development outcomes is by increasing parental capacity to better understand and respond to the developmental needs of the child. Jeong et al. (2021a, b) found that most interventions that were effective in enhancing child developmental outcomes, improved parental knowledge and parenting practices, and increased caregiver engagement and investment in their children. Emmers et al. (2022) similarly concluded that the impact of parent training programs on child development and health outcomes were mediated by parental investments, parenting knowledge, and parental self-efficacy. Their review suggests that gains in linear growth appear to be mediated by improved parental self-efficacy, motivation, feeding knowledge, and practices. Integrated parenting programs were also found to result in improved parental investments in a cognitively stimulating environment, and a healthier diet and can promote changes in beliefs and attitudes about psychosocial stimulation and responsive feeding practices (Emmers et al., 2022).

In a review of parenting programmes focused on child psychosocial stimulation in rural China, Emmers et al. (2021) concluded that increasing caregiver engagement in stimulating parenting practices and increasing the parenting knowledge of caregivers were underlying mechanisms of change, with positive impacts on child cognition, language and social-emotional scores. Similarly, Obradovic et al. (2016) found that maternal scaffolding and home stimulation were key mediators of the Pakistan LHW intervention (Yousafzai et al., 2014) effects on children's cognitive development and that family processes which were improved after intervention mediated improvements in child functioning.

Examples of interventions with long-term positive impacts on development also suggest that more sustainable developmental benefits were likely via improvement in parental capacities (e.g., Kagitcibasi et al., 2001). Jeong et al. (2019) analyzed Pakistan LHW study data and found that after controlling for sociodemographic factors and children's prior levels of development, both maternal and paternal stimulation significantly mediated intervention effects on children's longer-term cognitive and socioemotional development (at age 4). While indirect effects were greater for maternal than paternal stimulation, more stimulation by one parent positively predicted later changes in their partner's stimulation. Greater indirect effects were found through maternal than paternal stimulation (Jeong et al., 2019). Jeong et al. (2020) found that paternal and maternal stimulation mediated the relationship between intimate partner violence (IPV) and early childhood development outcomes. This suggests increased paternal and maternal stimulation after intervention may mediate intervention effects on ECD in contexts of family violence.

Another potential mechanism of change is via improved parent–child interactions. For example, a study of parent–child interaction and infant language and social emotional outcomes after a book reading intervention with South African families in a peri-urban township (Murray et al., 2016) found improvements in the quality of carer–infant book-sharing interactions, increased carers' sensitivity to their infant's interests and cues, their elaborations on the book content, and the level of mutual, reciprocal engagement between carers and infants. They also found that the improvements in carer interactions, and particularly the increase in reciprocity, mediated the benefit of the intervention on infant language and attention. In other analyses of Pakistan LHW study data, Scherer et al. (2019) found that greater post-intervention responsive caregiving (targeted by the intervention) was associated with positive child social-emotional development and Brown et al. (2017) also found that maternal care (mother–child interaction quality) mediated the effects of nutrition and responsive stimulation interventions on child growth at 4 years.

Finally, another parent-level mechanism of change is via improved caregiver well-being as a direct or indirect result of the intervention as some interventions that had positive effects on child development and caregiving also improved parental mental health (e.g., Singla et al., 2015; Barnhart et al., 2020; Bliznashka et al., 2021a, b).

There is some evidence that several factors may interact to mediate parenting intervention effects on child outcomes. Bliznashka et al. (2021a, b) found improved child nutrition and maternal–child interactions both mediated intervention effects on child growth and development (Pakistan LHW study, Yousafzai et al., 2014). Prado et al. (2019) found that determinants of neurodevelopment and growth were only partly shared; intervention effect sizes on linear growth were associated with effect sizes on social emotional development. This suggests that neurodevelopmental and growth outcomes of parenting interventions may be mediated by more than one variable. Zhou et al. (2019) reported positive outcomes of the Integrated Early Childhood Development (IECD) programme targeting all five components of nurturing care (child health, nutrition, responsive care, protection, and early learning support). This intervention, delivered in poor areas in four counties of China mainly by the village early childhood development centres and town clinics, was effective in reducing suspected developmental delays in children under 3 years whose parents received the intervention. Zhou et al. (2019) found the effect of the intervention on promoting developmental health was mediated by multiple nurturing care-associated factors, including cognitive stimulation frequency, positive discipline, length-for-age growth, and haemoglobin concentration.

Wider Contextual Factors: Changed Environments

Another potential mediator of parenting intervention effects on child outcomes are improvements in the safety and security of the childrearing environment. Kagitcibasi et al. (2001) found their intervention resulted in less physical punishment alongside more father engagement with the child; Jeong et al. (2020) found that more positive engagement with the child was associated with less IPV; and Jensen et al. (2021) also found improved family functioning and reduced intra-family conflict was associated with increased child engagement in ECD.

Improved household sanitation practices, decreased social isolation of mothers affecting maternal mental health (see Baumgartner et al., 2021), and other changed conditions in the environment may also have mediated intervention impacts on ECD. More research is needed to identify to what extent changes in contextual factors mediate intervention effects.

Issues Raised by These Findings

Cultural, Contextual, and Ethical Considerations

Intervention goals based on models from elsewhere may not align with local community needs and goals, and the design of ECD interventions should be a joint undertaking with the local community. For example, Morelli et al. (2018) raise some ethical issues associated with implementing parenting interventions in LMIC communities with rural and subsistence lifestyles. They questioned the validity of fostering parenting practices that are based on western models of caregiving (e.g., attachment theory) and that invite parents to change their practices and beliefs without sufficient consideration for how this may impact on the child, their family and the community.

Scheidecker et al. (2021) also raised concerns about a Western bias in the scientific evidence on which many parenting interventions are based. Authors argued that there is a need for increased sensitivity to local ways of child rearing that are different but not necessarily deficient. They contended that parenting interventions in LMICs should carefully consider existing practices, beliefs, and developmental goals to ensure intervention efforts fulfil ethical principles of autonomy, beneficence, and justice.

Weber et al. (2021) recommended that in order to facilitate the change communities themselves desire for their children, intervenors should co-develop programmes with communities and cooperate with them in implementation to ensure local beliefs and customs are harnessed and evidence-based and locally adapted practices are promoted.

Training of Interveners, Program Fidelity

The importance of training and supporting interveners to ensure interventions are delivered effectively and with adequate fidelity has also been highlighted; however, such training also has to be feasible and sustainable in terms of cost, especially in low-income contexts (Tomlinson et al., 2018; Yousafzai et al., 2018). Most interventions reviewed in this chapter have involved the training and engagement of local community health workers, lay health workers or community volunteers to meet with caregivers for a minimum duration of times (either in their homes or in clinics or centres) and provide education, demonstration, coaching and other materials to promote and support more nurturing care with their young children. In addition, training should be followed up with effective and supportive supervision to enhance health worker ongoing capacity development and performance. Case examples (e.g., Barnhart et al., 2020; Singla et al., 2015) show that adequately trained and supported community based lay workers can effectively deliver parenting interventions to improve ECD.

Implementation, Scalability, Cost-Effectiveness, and Access

Britto et al. (2018) identified a number of implementation challenges that need to be addressed to enable the scaling up of nurturing interventions for the promotion of ECD. The conduct of feasibility studies may be important to inform scale-up of interventions and the building of local capacity to provide the intervention, but interveners should also address intervention fidelity and quality improvement as well as integrating the intervention into other existing systems. Drawing lessons from a successful case example (e.g. the Philani Child Health and Nutrition Project), Tomlinson et al. (2018) similarly propose that when scaling up interventions, selection, training, and monitoring of staff are fundamental to effective program implementation, and that external community and institutional supports are also necessary. Lucas et al. (2018) found that while the Care for Child Development Intervention (CCD) was effective in improving child growth, health and development and responsive caregiving, and had been integrated into existing services in diverse sectors in 19 countries and 23 sites, only three countries had provided national policy support for integrating CCD into health or other services.

Emmers et al. (2022) provide an economic rationale for different implementation models and their effectiveness stating that “integration of parenting programs into existing community health services, the use of new technologies, and integration of components of the programs can all lead to gains in cost-effectiveness and can benefit program scalability.” While clinic or centre-based programs may be less costly in certain settings, home-based programs may be better at retaining the most disadvantaged children, who are likely to experience higher gains. It is as such concluded that to ensure cost-effectiveness and inclusiveness, it may be optimal to combine clinic/centre-based service delivery with home visits for the most disadvantaged households.

Measurement Challenges

One of the key issues requiring attention in order to better assess the effectiveness of the sort of interventions that have been discussed in this chapter is that of outcome measurement. While outcomes measured across ECD intervention effectiveness studies varied, not all domains of child and parent level outcomes were captured, and some domains (e.g., child social-emotional development) were infrequently measured (Jeong et al., 2021a, b). One consequence of this gap is that we know less about the impact of multifocused ECD interventions, which include responsive caregiving and stimulation on early social-emotional development in LMICs.

Zhang et al. (2021) also called for increased attention to social and emotional indicators. By more routinely quantifying any impacts on infant and early childhood social and emotional well-being, we may better understand how these may relate to other developmental gains, caregiving improvements, and environmental risks targeted by any intervention.

A comprehensive recent review of ECD interventions found that the reporting of the psychometric properties of measures (e.g., reliability and validity evidence, adaptation procedures) was highly variable across studies, with many studies not reporting any such details and, furthermore, that "measures of ECD and parenting ranged widely from validated and adapted assessments to unstandardized measures, which may affect comparability across studies and robustness of findings"(Jeong et al., 2021a, b, p. 39). This was confirmed by a recent review of available ECD measurement tools for children aged 0–3 years, which found that although multiple measurement tools exist "few are designed for multidomain ECD measurement in young children, especially in LMICs and that none were rated strongly across all accuracy and feasibility criteria with accessibility, training requirements, clinical relevance and geographical uptake being poor for most tools" (Boggs et al., 2019).

Munoz-Chereau et al. (2021) reviewed measures of early childhood development for children 0–5 across LMICs and identified a wide range of reliable, valid or adapted measures. They suggested 12 key considerations to guide suitable tool selection but also emphasized the need to not only capture child level data but also to capture the child's environments (including caregiving interactions) in which development occurs, i.e., home and early years settings (See Munoz-Chereau et al., 2021 for more details).

UN agencies are, however, working together to develop and align new measures to track a range of aspects of child development and to monitor the quality of services, and there is now a selection of tools for assessing preschool children (Daelmans et al., 2015) that have been designed explicitly to address some of the existing problems with such measures.

In terms of the specific concerns of this chapter with responsive caregiving, Jeong et al. (2022) concluded that further research is needed to establish the most optimal measures and indicators for measuring nurturing care, particularly in terms of responsive caregiving. Furthermore, there are still few measures that have been developed to address culture-specific behavioural manifestations of sensitivity, and this needs to be addressed going forward (Mesman et al., 2018).

Future Research

The literature examined in this chapter suggests that future research should focus on a number of key areas:

What Works for Whom, Under What Conditions (i.e., What Factors Moderate the Effectiveness of Interventions)

A range of mixed-method studies are needed in LMICs to investigate what factors explain the heterogeneity of intervention impacts, including developmental age of child, parent characteristics and other household or environmental factors, intervention components, delivery, timing, and duration.

What Program and Delivery Components Are Key to Effectiveness

Research is also needed to better understand what program and delivery components are critical to increase effectiveness, scalability, and adherence to parenting interventions delivered at scale, e.g., what factors affect parent/caregiver engagement and retention in the intervention; what factors increase intervention provider fidelity in program delivery; what training, supervision, and support is needed for community health workers (CHWs) to deliver ECD+ interventions effectively and whether ECD+ interventions could be integrated within existing delivery platforms such as HIV, nutrition, or mental health platforms (Tomlinson et al., 2017).

How Sustainable Are Any Gains Made Post Intervention and Under What Conditions Are Such Gains Achieved?

Further follow-up evaluations are needed to obtain a better understanding of the short-term, medium-term, and long-term effects of early childhood parenting interventions (Jeong et al., 2021a, b). Future studies should investigate fadeout, whereby promising post intervention impacts on early development fade out in the medium term but may reemerge in the longer term (Emmers et al., 2022). Follow-up studies are also needed to (a) inform better intervention design and implementation, (b) clarify which environmental/contextual factors reduce or enhance intervention effectiveness over time, and (c) identify when subsequent interventions may be needed to maximize and sustain gains in child development outcomes over the life course (Emmers et al., 2022; Tomlinson et al., 2021).

Mechanisms of Change

Future research should examine further how specific interventions work, and what are the essential components? Research is also needed to examine whether integration of different program components can work together to amplify the impacts of each component. For example, there is limited research into parenting interventions aiming to improve ECD which include violence prevention (Jeong et al., 2020; Efevbera et al., 2018).

A Focus on the Social-emotional Outcomes of Interventions to Enhance Caregiving

While many studies assessed child cognitive, language and motor development, fewer studies measured social emotional or "non-cognitive skills" (both post intervention and over time), crucial for lifelong development (Heckman, 2006) and synonymous with infant and early childhood mental health. Emmers et al. (2022) conclude that we do not know enough about the potential role parenting interventions can play in fostering social emotional and language development. Therefore, they argue that more in-depth evaluations of this are warranted, including studies that examine the mechanisms behind the observed impacts on these dimensions of development. This could aid future intervention design.

Development of Suitable Measurement Tools for Use in LMIC Contexts

Emmers et al. (2022) highlight the need for the development and validation of intuitive, unbiased, and cost-effective (observation-based) ECD assessment tools, which can be used to evaluate the impacts of parenting interventions on ECD outcomes. More research is also needed to identify the most optimal measures of each component of nurturing care, in particular of responsive caregiving, early learning and safety and security.

Guidelines for the Delivery of Effective Intervention in these Contexts

The research suggests that interventions that are multifocal and integrate responsive caregiving, health, nutrition, safety, and security and education are more likely to be effective and sustained in their impact. Some key messages from extant research include:

- ECD interventions that include responsive caregiving components are more effective in fostering development than single-focus interventions (e.g., to improve nutrition) (Jeong et al., 2021a; Emmers et al., 2022).
- To nurture thriving individuals and communities, interventions should specifically tar-

get determinants of neurodevelopment and not simply linear growth (Prado et al., 2019).

- Programs should be targeted at "malleable, fundamental parental investments during windows of opportunity for child development" (Emmers et al., 2022, p. 143).
- Parenting interventions to reduce risks and enhance responsive caregiving to support child development should engage fathers and other caregivers given that children in these contexts are not exclusively cared for by mothers (Bornstein & Putnick, 2012; Jeong et al., 2019; Betancourt et al., 2020).
- More priority also needs to be given in interventions to protecting children from harm, especially preventing violence against children, in LMICs where development is compromised by cumulative risk factors (Jensen et al., 2021; Jeong et al., 2020; Mikton et al., 2014)
- Embedding interventions that foster all domains of nurturing care into existing community health services, supported by adequate training, and ongoing mentoring, support and supervision of workers who deliver these programs is recommended (Tomlinson et al., 2018; Yousafzai et al., 2018).
- Scalable interventions with long-term treatment impacts should be designed and implemented as a priority to achieve ECD improvements for large numbers of children in LMICs at risk of poor development (Emmers et al., 2022; Richter et al., 2017).
- Finally, we need to be aware that parenting interventions to support development early in life are not enough on their own when a child grows up in a context of multiple adversities. Tomlinson et al. (2021) argue that we need to take an ecological approach that also focuses on enabling environments that go beyond the immediate sphere of the individual child to address core determinants of health and well-being, including inequities. Effects of interventions may fade when other environmental adversities have not changed (e.g., poverty, violence, and education), and later developmental phases are as such likely to require further intervention to build on and maintain benefits from earlier programs.

Limitations of This Chapter

There are several areas of IECMH intervention in LMICs, which we have not addressed in this chapter, either because the size of the undertaking is beyond the scope of this chapter or they are covered elsewhere in this volume. We have not addressed interventions with families of young children affected by war and displacement. We have not made an in-depth examination of interventions to improve caregiving of institutionalized infants and young children. Other chapters have addressed this topic in more depth. We have specifically focused on ECD interventions with parents, but some children in LMICs receive large amounts of early care from other kinship or local caregivers, e.g., an example from China detailing the experiences of infants and young children whose mothers travel elsewhere to work (Emmers et al., 2021) and an example located in Bangladesh that focuses on the challenges of parents needing to work long hours (Elsey et al., 2020). We have not addressed these issues in this chapter, but emerging research in LMICs suggests that policies and interventions to improve the quality of this caregiving and/or provide families with access to alternate centre-based care options more supportive of child development warrants focus (Elsey et al., 2020).

We have not surveyed the availability or effectiveness of any therapeutic IECMH interventions or services for infants and young children in LMICs. The enormity of the need for effective interventions that can be scaled up in resource poor contexts to address the caregiving needs of many infants and young children has precluded a focus on more resource intensive interventions targeting individual parent child dyads with identified IECMH disorders, e.g., clinical services. Some of these are explored in LMIC contexts (e.g., South Africa) in other chapters in this volume.

Finally, an important limitation of this chapter is that it is written by authors who are all from

HICs. Recognizing that context is critically important for work of this nature, we acknowledge that far more needs to be done to support local clinicians and researchers to tell the stories of their communities.

Summary and Key Points

Infants and young children growing up in LMICs, face multiple risks to their development. Evidence reviewed in this chapter shows that millions of these young children are developmentally compromised across all domains of development. The provision of nurturing care, in particular responsive caregiving and stimulation, by their caregivers has been found to be severely limited in many contexts, especially where poverty, limited education and violence are common, and interventions to support them in this task are critical. Evidence indicates that these interventions with caregivers should not only increase their capacities to ensure child survival (by improving protection, nutrition, and health) but also enable their child to thrive through responsive caregiving and stimulation, which fosters all domains of development, including cognitive, language, physical, and social-emotional development. Interventions with caregivers are most effective and show more promise for sustainable impacts on development, when they address all components of nurturing care-safety and security, nutrition, early learning, responsive caregiving, when other environmental risks are also addressed, and follow-up interventions at later developmental stages are provided. Engaging other caregivers especially fathers, in any intervention, is also emerging as an important contributor to intervention effectiveness in improving caregiving and child development.

As such, in LMICs, where infant and early childhood social emotional development may seem less critical than survival, effective interventions should involve educating, supporting, and enhancing the capacity of caregivers with limited resources to better understand and respond to the multiple needs of their infants. When investments are made in these interventions, development benefits result not just for individual children but also communities and countries.

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Theoretical, Clinical and Ethical Challenges for Infant Mental Health in Our Changing and Turmoiled World

Miri Keren

The twenty-first century is an era of huge biotechnological advances, digitalization and artificial intelligence. In this concluding chapter, we wish to point out the potential impact of these changes on our core theoretical concepts and clinical tools, which have been described in this handbook. Are we entering a revolutionary epoch? As we will describe further, it seems we do, and consequently we, mental health clinicians and researchers, may need to revisit our traditional theories of the development of parenthood, caregiving, human psychic functioning, intimacy, friendship, and peer relationships, on which are based our therapeutic models and to think about the potential ethical dilemmas we are already facing.

Parenthood, Pregnancy, and Procreation and Pregnancy May Become Distinct and Independent Processes

In vitro fertilization (IVF) pregnancies have become common practice for infertile couples, one-sex couples, single women pregnancies, and more recently surrogate pregnancies. Their pitfalls lead to complex societal, legal, and ethical conflict, where the parent may wonder "Am I the parent of this baby, and the child may ask "Who are my "real" parents?". The following example illustrates such a complexity:

> A baby girl, fruit of an IVF pregnancy, was born prematurely because of a complicated heart condition. As part of her medical and genetic workup, it became obvious that the baby does not belong to the woman who delivered her! A "human error" happened at the lab and raised a long- lasting debate at the Family Court about who is the "real" mother? The one with the womb, or the "biological" one with the fertilized egg and genes? The womb is also biological…Who is the "real" father? Has the pregnant woman's husband any right at all to claim fatherhood more than the "biological" father has? What is the best interest of the baby, in terms of her/his future uncertainty about her/his origins and identity?

Since the first IVF baby in 1978, the IVF process has become more sophisticated and nowadays, there is the option of adding a screening step, named pre-implementation genetic screening (PGS) for diseases. Inherent to this screening is knowing the embryo's genetic map, including sex. Should parents be given the information and the choice to implement or not to. Are there guidelines for the doctors' decision-making? Does the society have a role in defining such guidelines? In 2011, the American Food and Drug Administration (FDA) banned the gender selection procedure (Dahl, 2011). On the one hand, the American Medical Association pub-

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lished a position paper (Murphy, 2012), arguing that if the motives for selecting traits in children through prenatal interventions are not objectionable in themselves, if the interventions are safe and effective, and if no social harm comes from their use, it is possible to defend the selection of traits in children and maybe even, sometimes, call it an obligation (Savulescu, 2001). On the other hand, one may argue that having more children in affluent nations with high level lifestyles will increase the burden we place on the planet ecosystem and that the amount of money it takes to raise a child in the developed world might have been donated to reliable aid agencies with considerably greater impact, perhaps saving the lives of many children (Andes, 2021). Last but not least, the potentially dangerous use of traits selection by societies/cultures with discriminating agendas is easy to imagine.

Surrogate pregnancies, another application of the IVF technique, have also become common practice and raise psychological, medical, ethical, and legal issues. Indeed, surrogacy involves new parties in the process of reproduction and creates psychological and medical risks, as well as ethical and legal issues (Amorado et al., 2021; Tsai et al., 2020; Yau et al., 2021). At the psychological level, the situation may be complex with questions about emotions, rights, and responsibilities of both sides that determine the emotional environment in which the future child will grow. Surrogate pregnant women tend to feel disappointment or even grief when the relationship with the intended parents does not fulfill their expectations (Teman & Berend, 2018), or turn their backs in case of failed treatments or pregnancy loss (Berend, 2010). From the child's standpoint, there may be two mothers ("Tummy Mommy" and "Mommy" as some say). The medical risks to the surrogate mother and/or to the fetus (including low birth weight, increased risk of multiple gestation, and preterm birth, hypertensive disorders of pregnancy, postpartum hemorrhage, and gestational diabetes) are also significant (Phillips et al., 2019), though not more than traditional pregnancies (Yau et al., 2021).

Finally, ethical and legal issues concerning the surrogate's autonomy, agency, rights and duties, as well as risks of coercion and exploitation, are very concerning. A recent survey (Hodgson et al., 2021) among intended parents and surrogate women revealed poor understanding regarding medicolegal aspects of consent in these complex situations, emphasizing the need for more specific published guidance for primary and secondary healthcare professionals encountering these babies in the early postnatal period.

Four types of relationship between the parties have been identified (Gunnarsson Payne et al., 2020):

1. The open type: R*egular, caring, and intense contact* between the intended parents and the surrogate emerge mostly (but not exclusively) in contexts where power disparities are relatively low, and where cultural narratives of surrogacy tend to match the expectations and socioeconomic status of the surrogate.
2. The restricted type: *Very limited* or no face-to-face contact pre-birth and just one meeting during delivery. Such relationships are mostly or fully controlled by the intermediaries (agency, doctors) and/or intended parents.
3. The structured type: Contact before and after the birth is regulated by the contract, including lifestyle rules and behavioral restrictions during pregnancy, and rules governing viewing, handling, and future relationships with the child.
4. The enmeshed type: Difficulty to keep clear boundaries, high emotionality. The expectations of both sides are often unfulfilled or divergent.

One may ask which one of these is in the infant's best interest. In any case, social support, marital harmony, and state anxiety have been shown as significant factors among both the intended mothers and the surrogate mothers (van den Akker, 2007). Thus, psychological screening and support prior to, during, and following surrogacy is indicated. Should it be provided automatically? Should it be mandatory?

From the research lens, preliminary data about altruistic surrogacy (Söderström-Anttila et al., 2016) show that most altruistic surrogacy arrangements are successfully implemented and most surrogate mothers are well motivated and have little difficulty separating from the baby born as a result of the arrangement. The perinatal outcome of the children was comparable to standard IVF and egg donation and there is no evidence of harm to the children born as a result of surrogacy. Family relationships within the surrogate's own family seem to be good and the children are not negatively affected as a result of their mother's decision to be a surrogate (Jadva & Imrie, 2014). To our best knowledge, no study about the outcomes of commercial surrogacy has been published.

Pregnancies with No Need for Humans?

Once IVF and PGS techniques have been mastered, the missing link for ectogenesis, i.e., extracorporal gestation, is the creation of a very sophisticated artificial womb, from the beginning to the end of pregnancy. In 2005, Henri Atlan, a physician, biologist, and philosopher, former member of the French National Committee of Medical Ethics described (Atlan, 2005) how the potential development of an artificial womb will start with "pure" medical aims, but may lead to huge societal changes. Such an artificial womb would be a kind of a biological incubator, sophisticated enough to fulfill the functions of the uterus (including the implantation phase), the placenta and the nutritive maternal functions, as well as the various stimulations usually provided by the pregnant woman. For the moment being, only during the first 5 gestational days and from the 24th week on, extracorporeal gestation is feasible. Still, teams from Japan and US have started to work on the Ectolife project (https://www.youtube.com/watch?v=O2RIvJ1U7RE), under the umbrella of medical reasons (such as infertility due to uterine diseases). Indeed, such a sophisticated artificial womb could then be used by the society for avoiding abortions of unplanned and undesired pregnancies, for avoiding pregnancy and delivery, avoiding premature births. Will the inner feeling of parenthood stay the same? Will humans want to be parents? Will the prenatal bonding and postnatal attachment processes be the same? Obviously, we do not have answers to these questions, but I think we need to reflect on them and on their implications for our core concepts of parenthood, family, attachment, sexuality.

Furthermore, with the combination of an artificial womb, ectogenesis and preconception genome selection (PGS), "perfect babies" could be designed. The ethical implications of these processes have been recently reviewed (Notini et al., 2020). Indeed, though it is still utopic, we may imagine how these advanced biotechnologies combined with stem cell cultures, could lead to the capacity of creating babies totally unrelated to human parents, like Aldous Huxley predicted in his famous book "Brave New World" (Huxley, 1932). He describes a world where the notions of family, mother, and father disappear, and sexuality is totally separated from procreation. The society/politicians decide what types of humans is in its "best" interest, cloning becomes the mode of procreation.

Parenting and Growing-Up in the Digital and Artificial Intelligence Era

Two processes linked to the smartphones have been identified: technoference, meaning the interruptions of social interaction due to technology interference, and immersion (McDaniel & Coyne, 2016), meaning the users' absorption in their digital devices and withdrawal of attention from the environment, turning the gaze away from the present person, being "absent present" (Coyne et al., 2019; Gergen, 2002). Immersion is the most problematic component, as it has been linked with decreased feeling of social connection, increased distraction, less enjoyment from direct communication (Dwyer et al., 2018), and decreased empathy during direct conversations (Misra et al., 2016). More specifically related to parenting, there is an increased awareness of the potential detrimental impact of parents' preoccupation with their smartphone while caring for their babies or young children and is termed "distracted parenting"(Elias et al., 2021; McDaniel & Coyne, 2016; Myruski et al., 2018). Indeed, distracted parenting has been shown to impinge on parental sensitivity and responsiveness (Abels et al., 2018; Braune-Krickau et al., 2021; Wolfers et al., 2020). Digital parenting is defined as how parents need to be engaged in regulating their children's relationship with digital media (parental mediation) plus how parents themselves incorporate digital media in their daily activities and parenting practices (Mascheroni et al., 2018).

Two types of parental mediation have been defined: Restrictive mediation (reduces exposure and risks but limits the child's opportunities to develop mastery and digital literacy) is more common among lower income and educated parents. Enabling mediation (co-use, active monitoring, and technical restriction), aimed at empowering children's digital literacy) is more common among higher income and educated parents. Parents tend to prefer restrictive mediation but inconsistently, as they often use touchscreens as babysitter or as a system of reward and punishment for the child's behavior (Chaudron et al., 2015). The pervasiveness of the Internet and mobile media is giving rise to an emergent form of parenting, called "transcendent parenting" (Lim, 2016), and includes sharenting, i.e., the oversharing of children's pictures and personal information on social media, the increasing reliance on parenting apps for advice, and the use of wearable devices in order to calculate babies' health data and behavioral patterns, as well as to monitor the child's whereabouts. Together, these practices concur to an unprecedented datafication of children's lives: "Intimate surveillance "(Leaver, 2017) as well as commercial dataveillance. The danger is the impingement on the children's rights to privacy, as well as the right to be forgotten and to remove content they might feel constraining later. In the light of all these, we suggest to view media consumption in the same way as food consumption.

It is all about moderation and choosing the right content. Do not be afraid to use technology as it is undeniable that there are many new gadgets and applications which are useful for your kids. Just be mindful and know when it is the right time for a time-out. Further research is need. As it is hardly feasible to find a control group of parents who do not use smartphones, future studies could at least systematically compare responsiveness and sensitivity among parents with high level of absorption in their smartphones with parents with low level of absorption, systematically compare the effects of technoference versus absorption on parental sensitivity and mediation, be longitudinal, from infancy to preschool or even beyond, compare the effect on mothers and on fathers' responsiveness and sensitivity, detection of factors that are linked with high levels of parental and child's immersion, and study the aspects of smartphone use that can be beneficial to the parent–child relationship.

Last but not least, I invite you to reflect on the increasing role of robots and Artificial Intelligence. Japan has the highest number of industrial robots in the world. Over a quarter of a million robots are employed in an effort to reduce the high labor costs and support further industrial mechanization, as well as a solution to Japan's declining birth rate and shrinking workforce. Japanese engineers work on developing increasingly sophisticated robots with different functions, including a talking office receptionist, a security guard and even a primary school teacher. The newest model of domestic helper, AppriAttenda, is aimed at encouraging couples to have more than one child while doing less home chores! The characteristics of the humanoid Japanese robots include abilities such as blinking, smiling, or expressing emotions such as anger and surprise. One of the newer Japanese robots, HRP-4C, is a female robot programmed that walks, talks and, with the help of 30 motors, can move its legs and arms. Its facial expressions are driven by 8 facial motors: it can smile, blink, pout, and express anger or surprise.

Daring to Imagine Robot Caregivers: Can Artificial Intelligence Mimic the Attachment System?!

Could a robot be a good-enough caregiver, with balanced frustration and gratification, emotional attunement, sensitivity and responsiveness, mentalization and reflective functioning, empathy? Can the robot caregiver be programmed to be "good enough," thus teaching the young child to deal with frustration? A few years ago, the question was raised by a group of bold clinicians (Andries et al., 2018), and today, the company AvatarMind iPAL® Robot Family is already selling the device for Senior care and children's educational programs.

We may be bewildered by this perspective. Children think differently! For instance, children visiting a science center located in a major Western Canadian city (Meghann et al., 2011) were randomly selected to participate in an experimental setup. A total of 184 children ages 5–16 years (*M* = 8.18 years) with an approximate even number of boys and girls participated. Content analysis revealed that a large majority would consider a friendship with the robot and participate in friendship-type behaviors with it. Significant sex differences in how children ascribe characteristics of friendship to a robot were also found. Regarding the age at which children consistently and correctly categorize things as living or non-living, a very recent study (Goldman et al., 2023) tested children's animacy judgments about robots with a Naïve Biology task. The 3- and 5-year-olds were asked if robots, animals, or artifacts possessed mechanical or biological internal parts. Two robots were used: a humanoid robot (Nao) and a non-humanoid robot (Dash), while one robot behaved in a goal-directed manner (i.e., moving toward a ball) and one robot exhibited non-goal-directed behavior (i.e., moving away from a ball). Children of both age groups correctly attributed biological insides to the animal and mechanical insides to the artifact. The 3-year-olds seemed confused about what belonged inside both robots and assigned biological and mechanical insides equally. In contrast, 5-year-olds correctly assigned mechanical insides to both robots, regardless of the robot's morphology or goal-directedness. This study is important as it shows how confusing a robot may be for very young children as their cognitive capacity to differentiate between living and non-living but moving creatures is very limited.

Still, we need dare to think about the pros! For example, in extreme situations such as abandonment and abuse, one may argue that a robot-caregiver with a highly sophisticated artificial intelligence may be a better solution than for the child than experiencing multiple and changing caregivers in foster care or in orphanages. A robot kindergarten teacher may be better than a low-functioning teacher.

The cons are quite obvious. For instance, robots might be able to classify emotions and respond with matching expressions but rearing a child requires cultural attunement, the child's temperament, and so on. If children begin to personify robots as living creatures, they are susceptible to develop robotic understandings of humans, bereft of moral standing. If robots are able to understand human behavior and respond emotionally to us, we, and especially children, may develop misplaced trust in robots. May babies be aware that there is no genuine human heart beating under that well-constructed robotic exterior? Does it really matter?! What types of parents would robot-cared children become?

The Role of IMH Clinicians in This Revolutionary Context

We suggest to reflect with an open mind on these new types of relationships and to investigate topics, such as will parenthood continue to be a value in itself? Will pregnancy and motherhood continue to be an essential part of womanhood? Can infants develop a real and preferential attachment relationship with a robot caregiver? What our developmental theories and theoretical concepts will become?

Will humanoid replace humans or will humans use humanoids for positive aims? How should we integrate digitalization and robotics in our research and practice (documenting, updating medical records, synthesizing information (e.g., chatGPT). Could a robot be an Infant Mental Health clinician?!

It seems we have no choice but to reflect with an open mind and raise the theoretical, clinical implications and the ethical dilemmas created by the more and more "bold" biotechnologies. These emerging technologies may raise unique ethical problems that differentiate them from earlier technological developments (Herket, 2011). In responding to this evolving challenge, ethicists must give greater weight to macroethical perspectives and approaches, rather than the more traditional focus on microethics. Several innovative new concepts have been suggested and are being developed to address this challenge. A WAIMH pro-action could be to revise our Infant' Rights Declaration and to develop a WAIMH Code of Ethics as a road map for clinicians and researchers, adding the dimension of ethics of biotechnologies to the focus on Justice and Care (Spicer et al., 2023), that are the tenets of the Diversity-Informed Tenets for Work with Infants, Children, and Families, the WAIMH Position Paper on the Rights of Infants, and the Code of Ethics now required for Endorsement in Infant and Early Childhood Mental Health by the Michigan Association for Infant Mental Health.

Summary and Key Points

In this concluding chapter, I have tried to look at the potential impact of the revolutionary biotechnical advances in the field of procreation and the gradual entry of Artificial Intelligence in our lives. As the foundational issue of infant mental health is multiperson and multicontext relationships, these advances have a huge potential impact on our professional field. Basic notions of womanhood, parenthood, and family may need to be revisited. Relationships are very much impacted by the digital devices that have become the norm. Both parents and infants grow in a world where Artificial Intelligence takes a growing place and adds to the relational contexts to which infants, toddlers adapt in their first 5 years of life. Most infants grow in multiperson diverse contexts (triads, and kinship networks, neighbors, early childhood family carers, community villages, etc., to which infants adapt to during their first 5 years of life. Will robots be programmed to deal with the diversity of system influences? Will robots be programmed to respond to the infant's nonverbal communication behaviors, such as eye tracking, pupillary dilation (whole new gang of researchers studying the social neurophysiology of pupil dilation in social, emotional infant initiations? Then there are all the relationships issues related to interventions, preventions and conflicts between parents and carers and programmed actions of the robot? Who is supposed to be in charge? Are robots programmed to individuals/families, rather than preprogrammed according to some one's version of what parenting is, what family is. Relationships are not just with biological parents, and in some cultures that is more a rule than an exception. So, as Hyde points out, homo sapiens is a cooperative breeding species, such that any adult (female or male) can care for the young of the species. When those relationship dynamics are deficient or absent, then we signs of deprivation, such as sustained withdrawal behavior (Guedeney & Fermanian, 2001).

Last but not least, the extent to which genetic manipulations and AI challenge for infant mental health in developed countries may be very different in underdeveloped countries, as well as in dictator-ruled countries.

To conclude, we seem to enter a biotechnical era full of challenges with many potential implications for our domain of Infant Mental Health. We need to keep our eyes and mind open, rather than to stick rigidly to our core concepts, as well as to speak aloud about the ethical aspects of digitalization, artificial intelligence, and new ways of procreation.

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