An Introduction to Infant-Preschooler Mental Health

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a behavioral health professional or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

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Faculty Disclosure

Contributing faculty, Julie Torok-Mangasarian, MA, LMFT, RPM, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for health and mental health professionals currently treating or interested in treating children younger than 5 years of age.

Accreditations & Approvals

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Course Objective

The purpose of this course is to offer health professionals a basic understanding of the complex relationship and evidence-based approach to the psychological assessment and treatment of children younger than 5 years of age, commonly called infant-preschooler mental health.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define and discuss the tenets of infant-preschooler mental health.
2. Identify common risk and resiliency factors for children younger than 5 years of age.
3. Compare and contrast various attachment styles.
4. List and describe common screening and assessment tools used in infant-preschooler mental health.
5. Evaluate evidence-based interventions for children younger than 5 years of age.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Quality early childhood mental health practices utilize evidence-based, relationship-focused approaches to promote cognitive, developmental, emotional, and social growth. These practices are not specific to any one discipline; infant and preschooler mental health practitioners come from a myriad of professions. Infant-preschooler mental health is often a subspecialty spanning from child development to psychiatry.

Early childhood mental health practices and principles are rooted in research and theory from areas such as neuroscience, epigenetics, attachment, prenatal/perinatal psychology, psychiatry, and health care. Research in these areas indicates that the most advantageous time for intervention is at the beginning of life, particularly due to the rapidity of brain growth and development during this period. The best outcomes for young children occur when families are supported in their mental, emotional, and social well-being during pregnancy, birth, infancy, and early childhood. Infant-preschooler mental health generally relies on relationship-based approaches to facilitate growth in infants and toddlers by addressing and supporting primary attachment and caregiving relationships.

HISTORY AND BACKGROUND OF INFANT MENTAL HEALTH

Infant-preschooler mental health is a relatively new concept in the world of mental health. The term "infant mental health" was originally coined in the late 1960s by Selma Fraiberg while working with medically fragile infants in Ann Arbor, Michigan [1]. Fraiberg worked with a multidisciplinary team consisting of nurses, pediatricians, case managers, and mental health clinicians to best serve the families with whom she worked.

Today, infant-preschooler mental health continues to be a collaborative and multidisciplinary approach to serving, nurturing, and supporting young children and families. In pediatrics, an infant is 1 to 12 months of age. However, there is a general consensus in the field of mental health that children up to 3 years of age are considered "infants." By adding preschooler into the moniker, children from the ages of 0 to 5 years are included in the broad-based field of study.

Infant-preschooler mental health is based largely on the works of several psychoanalysts, pediatricians, and researchers who began thinking about and examining infants and young children in a new way in the 1950s and 1960s. Prior to this time, many professionals advocated that infants and children be treated as small adults, with little to no attention paid to role of attachment and bonding in the development and formation of lifelong health and wellness. It is due to the work of professionals such as John Bowlby, Mary Ainsworth, D.W. Winnicott, Rene Spitz, Harry Harlow, Bruce Perry, Daniel Siegel, Ed Tronick, and Stanley Greenspan (among others) in the fields of neuroscience, psychology, psychiatry, and human development that the role of relationships and positive attachments in promoting healthy development and intervention in the early years of life is widely acknowledged.

THE INFANT-PRESCHOOLER MENTAL HEALTH CLINICIAN

PROFESSIONAL STANDARDS

Because infant-preschooler mental health is such a broad area of study, there are no specific, global criteria to define infant-preschooler mental health practice. Johnston and Brinamen define infant mental health as, "a set of principles, a field of practice, and a state of being" [2]. This definition, although vague, does lend itself well to the inclusive nature of infant-preschooler mental health.

In many states, including Michigan, New Mexico, and California, infant-preschooler credentialing and/or certification programs are available. The requirements for these programs vary by state and/or credentialing association. Additionally, differing funding sources, such as grants and third-party payors, may also have specific requirements regarding the qualifications of professionals providing services for children younger than 5 years of age.

This being said, there are some basic concepts associated with infant mental health that are widely accepted as core practice principles, regardless of discipline or profession. Primarily, practitioners should have an understanding of the social, emotional, and behavioral health needs of young children and their families [3]. To achieve this, practitioners should have a solid base of knowledge in early childhood development to understand both normative and atypical child development in addition to risk and resiliency factors facing this population. Additional competencies include knowledge and understanding of emotional/behavioral disorders; assessment; interventions; community resources and referrals; and organization, collaboration, and communication [4].

CHARACTERISTICS

A mental health clinician interested in treating children 0 to 5 years of age should have a solid foundation in counseling psychology in addition to education and knowledge of attachment theory, child development, and play- and relationship-based interventions. Infant-preschooler mental health clinicians should listen carefully, be sensitive to the unique needs of families, and work collaboratively with parents on behalf of their children. In addition to the basic knowledge and experience necessary to treat young children and families, there are also personal characteristics that may make an individual a more effective infant-preschooler mental health practitioner, including warmth, empathy, caring, curiosity, and reflective capacity. Personal development is also an essential characteristic. Clinicians should have a mature capacity for self-reflection to create and maintain an awareness of personal feelings, experiences, motivations, and reactivity. Personal development should also be sought to increase openness to engagement and collaboration with families, to maintain professional boundaries while balancing the complex needs of families, and to know when and how to refer to services and supports outside the practitioner's scope of practice [5].

Most importantly, infant-preschooler mental health clinicians should also have support and supervision from those experienced and educated in the field [5]. Clinicians should actively seek consultation, reflective practice supervision, and quality clinical supervision. Even clinicians experienced in the field of therapy, counseling, or mental health services should seek specialized support and training to serve the infant-preschooler population.

Interdisciplinary/multidisciplinary collaboration is also an essential part of providing mental health services to this population. Practitioners should have a clear understanding of scope of practice and define a plan for referral or linkage if and when necessary. A "warm hand-off" is the most successful when connecting parents to other agencies and services when needed. Parents left to make their own connections or to follow-up on suggested referrals are often unsuccessful. The more relationships cultivated by the practitioner, the better for children, families, and the community.

KEY CONCEPTS OF INFANT AND PRESCHOOLER MENTAL HEALTH PRACTICE

Every contact with a parent and infant/child should be done with respect to their unique dyad. Consideration should be given to each family's journey, and the infant-preschooler practitioner should care greatly about the unique experience and needs of every family. The parent should be thought of as a partner in the journey from assessment to discharge.

The Michigan Association for Infant Mental Health has listed the following core infant mental health beliefs that are the cornerstone for infant mental health practice [6]:

- 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.
- Early developing attachment relationships may be distorted by parental histories of unresolved losses or traumatic events.
- The therapeutic presence of an infant mental health practitioner may reduce the risk of early relationship failure and offer hopefulness for change.

In addition to the core infant mental health beliefs, there is also a widely accepted list of services that are essential to infant mental health practice. These include concrete resource assistance, emotional support, developmental guidance, advocacy, and early relationship assessment, support, and intervention [6; 7].

Concrete resource assistance consists of a practitioner linking families to resources for clothing, food, medical care, housing, and safety. This assistance to the family serves many functions, but first and foremost, it shows the practitioner's support and commitment to the family.

An infant-preschooler mental health practitioner has the responsibility to provide a safe environment and to be present and genuine with a parent who faces a trying time during pregnancy or is caring for an infant or young child. Practitioners should listen intently, ask careful and sensitive questions, and be emotionally attuned and available.

Practitioners should encourage parents to observe their infant's development, to ask questions, and to engage in positive and playful activities to meet the unique and specific needs and skills of the infant. Parents should be supported in wondering what developmental skills the baby may conquer next. The practitioner should support healthy parent-child interactions and offer encouragement to parents, highlighting their strengths.

Infant-preschooler mental health practitioners are often in the position to offer assistance or to speak on behalf of the infant or parent. For the infant, the practitioner may speak about the need for early care, such as food, nurture, and safety. For the parent, the practitioner may advocate for safe housing, quality child care, and affordable medical care.

As Zeanah and Zeanah state in the *Handbook of Infant Mental Health*, "Infant-caregiver relationships are the primary focus of assessment and intervention efforts in infant mental health" [5]. Practitioners should nurture the relationship with parents and consistently assess both the parent-child dyad and the infant's specific needs in order to develop the most effective interventions possible. These interventions should focus on the current needs of the infant and parent but should also focus on prevention in the future. A parent's own attachment history and current relationships have an impact on the parent-child relationship. Often, the act of parenting awakens old thoughts, feelings, and experiences that should be explored and examined in the context of the practitioner-parent relationship.

PRIMARY ATTACHMENT RELATIONSHIPS

One of the most important relationships in life is that between a child and parent. When infants enter the world, they are completely reliant on others for survival. D.W. Winnecott, developmental theorist and pioneer of attachment-theory, once wrote, "There is no such thing as an infant," meaning that infants do not exist in and of themselves [8]. Conversely, there is no such thing as just a parent. In order to be either of these things, one must be in relationship to the other. Infant-preschooler mental health supports the parent-child dyad as the most influential relationship on the lifelong development of the child. This relationship should be valued and supported in order to impact change. The infant-preschooler mental health practitioner, regardless of discipline, should be attuned to the importance of relationships.

Understanding the importance and complex nature of the attachment bond and the intricate dance of the attachment and bonding process is of utmost importance for infant-preschooler mental health practitioners. Bonding is the term for the tie from parent to infant and is one of the strongest and most important human relationships. Attachment applies to the tie from the infant to parent. Attachment patterns develop in infancy and can be carried throughout the lifespan (as will be discussed in detail later in this course).

Both of these processes are complex and intricate. Small moments of attunement, connection, and availability are the building blocks of these connections. It happens between two distinct people, each bringing his/her own temperament and personality to the interaction and experiences of bonding.

The bonding process consists of interactions and experiences that occur over time. Bonding often starts for parents, especially mothers, during pregnancy. However, bonding has its roots in parents' own relationship and attachment history.

The concept of "ghosts in the nursery," originally developed by Selma Fraiberg and colleagues, speaks to the impact of intergenerational parenting practices, experiences, and events [1]:

> In every nursery, there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening. Under favorable circumstances, these unfriendly and unbidden spirits are banished from the nursery and return to their subterranean dwelling place. The baby makes his own imperative claim upon parental love and, in strict analogy with the fairy tales, the bonds of love protect the child and his parents against the intruders, the malevolent ghosts.

Fraiberg and colleagues introduced this concept to discuss the ease with which parents re-enact their own early relational experiences with their children, potentially unwittingly transmitting child maltreatment from one generation to the next. Counter to "ghosts in the nursery" is the concept that attuned and sensitive caregiving ("angels in the nursery") has an equal impact. These positive experiences can be protective factors in shaping parent-child interactions in a positive manner.

Alicia Lieberman and colleagues expanded on the concept of intergeneration impact on parenting in their article *Angels in the Nursery: The Intergenerational Transmission of Benevolent Parental Influences* [9]:

> Angels in the nursery—care-receiving experiences characterized by intense shared affect between parent and child in which the child feels nearly perfectly understood, accepted, and loved—provide the child with a core sense of security and self-worth that can be drawn upon when the child becomes a parent to interrupt the cycle of maltreatment.

Practitioners should understand and respect the significant impact of early parental care on the long-term emotional health of infants and children. This is done partly by offering developmental guidance, assisting parents in finding joy in their relationship with their child, and supporting parental capacity [7].

As discussed, the infant-preschooler mental health practitioner should always remain attuned and attentive to the individual strengths and needs of each parent. The family's cultural beliefs and expectations should be acknowledged with respect, and the practitioner should follow the lead of the parents, responding with empathy and curiosity.

BIOLOGIC AND PSYCHOSOCIAL FACTORS

Biologic and psychosocial factors have a huge impact on the healthy development of children and families. Family units that struggle with issues such as poverty, community violence, and mental illness are at greater risk for child abuse, neglect, and parental substance use/abuse. Quality, effective interventions can assist in supporting families to be resilient. In some cases, factors such as prematurity, congenital abnormalities, and developmental delays can con-

tribute to parents experiencing symptoms of grief, loss, and depression. These parents often experience the loss of the fantasy of the "perfect child" when a child is born with a defect, illness, or delay. Infants born to adolescent mothers or women in relationships with domestic violence also have unique needs.

Additionally, there may be factors at play that are not at first obvious to the parent or practitioner. Issues such as sensory processing disorders may not be apparent when a child is first referred for treatment; a child could go years without another professional identifying this specific issue. However, the symptoms of undiagnosed disorders can be a primary stressor in a parent-child relationship. Careful consideration should always be made on the best type of interventions and supports offered to families struggling with biologic or psychosocial stressors.

RISK AND RESILIENCY FACTORS

There are many factors, both biologic and environmental, that impact a child's development and mental health. It is the practitioner's responsibility and challenge to be mindful and sensitive to these factors at all stages of the practitioner-family relationship. Understanding and accepting the struggles, experiences, and values of a family can and should take priority at all times. This section will discuss common risk factors faced by children and families served by infant-preschooler mental health practitioners, but the list is far from exhaustive.

INTERPERSONAL/FAMILY VIOLENCE

There are many types of violence that can occur in a family, such as spousal abuse, child abuse and neglect, elder abuse, and caregiver abuse, and many families struggle with one or more types of violence and abuse. Witnessing or experiencing violence is scary and confusing. Children who are exposed to this type of violence may learn that the family unit is a source of harm instead of a source of safety and security [10]. This may lead children to mistrust those responsible for their care and to manifest symptoms of fear, anger, aggression, and poor affect regulation. Because infants and toddlers spend most of their waking hours with adult caregivers, these relationships are essential in shaping the infant's or toddler's view of the world and themselves. In 2022, the U.S. Department of Health and Human Services Administration for Children and Families published their annual report, *Child Maltreatment 2020*, which indicated that the largest cohort of children experiencing childhood maltreatment (in the form of abuse and neglect) were younger than 3 years of age, with infants (younger than 1 year of age) at the greatest risk [11]. In total, 26% of children are exposed to family violence during their lifetimes [43].

PARENTAL SUBSTANCE USE

Concerns regarding the use of substances by parents start prior to gestation. Use of and addiction to substances including alcohol, tobacco, and prescription and illicit drugs could have an impact on parental capacity even prior to conception. Many parents with substance use problems became addicted prior to parenthood and may turn to alcohol and/or drugs as a means to address low self-esteem and poor self-image [12]. Maternal substance use can have a direct and permanent impact on a developing fetus. As an example, the most commonly known and well understood impact of substance use on the fetus is that of alcohol use. Fetal alcohol spectrum disorders (FASDs) occur when the fetus is exposed to alcohol in utero, as alcohol travels in the mother's blood through the umbilical cord and to the fetus. Infants born with FASD may exhibit a host of symptoms, including but not limited to heart, kidney, or bone problems; problems with emotion regulation, attention, and sleep; low birth weight; and facial abnormalities. These types of symptoms also make a child vulnerable to physical and mental health concerns later in life.

Parental substance use also increases the likelihood of childhood maltreatment, even more so after the birth of a child with special needs, colic, or emotional regulation difficulties. In 2017, 30.8% of child victims of maltreatment, or 112,319 children, were identified with a parental drug abuse risk factor [11].

It is important to remember that these numbers are only the reported and substantiated claims of abuse and are therefore likely an underestimation. Not all parents who use substances abuse their children, but parental substance use has been shown to have a negative impact on the nature and quality of the parent-child relationship, often resulting in poor parenting outcomes and unfortunate and negative consequences for the infant-parent relationship.

MATERNAL MENTAL HEALTH

Pregnancy and impending parenthood are naturally stressful and exciting times for many individuals and parent dyads. The experiences of mothers before, during, and after pregnancy have an impact on child development and relational outcomes. Approximately 50% to 75% of new mothers experience feelings of anxiety, fatigue, fear, and sadness [13]. These transient depressive symptoms, often referred to as the "baby blues," are considered relatively normal if they are not excessive and if they resolve in one to two weeks. In *Touchpoints*, T. Berry Brazelton, MD, states [14]:

> A depressed new parent is no longer available to respond to the many cues the baby offers. Nearly all new mothers feel "blue" in the first few days after the birth. They have labored hard and have had to come back down to earth after the initial euphoria. One of the roles of a supportive professional is to differentiate from this natural letdown and a more deep-seated one.

Approximately 15% to 20% of new mothers will develop postpartum depression [15]. The symptoms of postpartum depression are similar to the symptoms of any major depressive disorder. However, due to the unique issues regarding the mother-infant relationship, the adaptation to parenthood following the delivery of a baby, and the impact of the mother's depression on the infant, it is considered a unique mood disorder suffered by postpartum women. A more severe form of postpartum mental disturbance, postpartum psychosis, occurs in 1 to 2 of every 1,000 new mothers [44]. Although postpartum depression has become the most well-known mental illness associated with pregnancy and birth, there are many other illnesses that are directly related to pregnancy, birth, and delivery.

Women who have difficult or degrading birth experiences may also manifest symptoms of post-traumatic stress disorder (PTSD). Delivery or post-delivery trauma can include an unplanned cesarean delivery, long-term separation of infant and mother after birth, medical interventions due to emergency or illness, and lack of caring by medical staff. The reported prevalence of birth trauma is 32%, with up to 6% of woman developing symptoms associated with PTSD [16]. Infant-preschooler mental health professionals can be a support for families who are struggling with maternal mental illness.

DEVELOPMENTAL CONCERNS/SPECIAL NEEDS

When pregnant or expecting a child, parents often fantasize about what their baby will be like, what he or she will look like, and what temperament he or she may have. For a typical pregnancy, this fantasy does not include congenital abnormalities, developmental delay, or serious health problems. When a child is born with such a problem, parents may experience grief at the loss of their fantasy. Adjustment in expectations and the creation of a new vision of the future, including new ways of caring, are necessary [17].

Not all parents struggle with adjustment to an infant with special needs; every parent and family has a unique experience that should be honored and respected. When parents are supported in nurturing and caring for a child with special needs, it enhances the parents' confidence and the child's lifelong view of him- or herself and others. Child psychologist Bruno Bettleheim wrote: "Children can learn to live with a disability. But they cannot live well without the conviction that their parents find them utterly lovable…If the parents, knowing about [the infant's] defect, love him now, he can believe that others will love him in the future" [18].

Children with special needs are at greater risk for abuse, and 13.3% of child victims of maltreatment have a disability [9]. Because children born with developmental or physical disabilities are especially vulnerable to maltreatment, their families may benefit from added support and intervention.

ATTACHMENT DISRUPTIONS

In the 1940s, René Spitz, an Austrian-born psychoanalyst, focused his research on the negative impact of maternal deprivation on child development, which he termed anaclitic depression or "hospitalism." In his research with abandoned or surrendered children, Spitz found that although children had basic needs met in "foundling hospitals," many had significant maladaptive responses to the lack of a secure attachment figure [19]. Some of these children appeared to die as a result of the separation from their attachment figures. Although these studies were conducted 80 years ago, their findings are still relevant today.

Infants and toddlers are impacted greatly by a disruption in their attachment relationships, regardless of the quality of those relationships. Children separated from their attachment figures often appear to slow developmentally and to regress in social-emotional skills and affect regulation.

In the United States in 2020, approximately 170,000 children younger than 6 years of age were in foster care [20]. The stress of foster placement alone is a significant event in the life of child, not to mention the circumstances that warranted removal in the first place. Young children with a history of poor parent-child relations struggle with initiating, accepting, and maintaining quality relationships with substitute care providers. This, particularly in cases of chronic placement changes, can impact the quality and pattern of children's attachments not only in early childhood, but for life. Nationwide, about one-third of foster children experience two or more placement changes each year [52].

Research indicates that adults who were once foster children have a rate of diagnosed PTSD that is twice that of Vietnam veterans [21]. Children in foster care tend to have poor outcomes in regard to health and education as well. Without support and intervention from trauma-informed, relationship-focused professionals, infants and young children impacted by attachment disruptions in any form, especially those exposed to institutionalized care, are at risk for medical, behavioral, and emotional problems.

INFANT, TODDLER, AND PRESCHOOLER BEHAVIORAL ISSUES AND MENTAL HEALTH

Parents and caregivers seek services from infant mental health providers for a variety of reasons. Regardless of whether a parent is seeking treatment or intervention voluntarily or for mandated reasons, the infant-preschooler mental health practitioner should be sensitive to the vulnerability associated with asking for and/or accepting help.

BEHAVIORAL REGULATION

One of the most common reasons parents seek services is behavioral or affective dysregulation by a child. This occurs most often in toddlers or preschool-aged children, but it can occur in infants as well. Parents may have their own concerns or may receive feedback from family members, daycare providers, or early education teachers regarding the behavior or presentation of their child. Behavioral issues common to this age group include frequent or intense tantrums, violent reactions (e.g., hitting, biting), excessive shyness/fear, poor peer interactions, and attention problems.

On some level, many of these behavioral concerns may actually be on the high end of age-appropriate behaviors, and parents seeking services may be unaware of normative child development. It is the practitioner's role to assess and address this issue, if necessary. It is common for parents to have little to no exposure to young children prior to becoming

parents, and they may have a misunderstanding of or unrealistic expectations for their young children. In these cases, education may be the only necessary intervention.

Alternatively, parents may have an overly permissive approach to parenting that could be contributing to behavioral issues or a child's behavioral issues may be an indication of psychopathology. Either situation requires careful navigation by the practitioner working in collaboration with the family to best meet their needs while offering developmental guidance.

In the United States, preschoolers are expelled at more than three times the rate of their school-aged peers, often due to common behavioral issues [22]. However, with quality mental health consultation in the preschool setting, expulsion rates decrease significantly [22]. It is essential that children receive early intervention to assist with mediating poor social and academic behaviors, as a pattern of poor school functioning can have a significant impact on family stress, self-esteem, peer relations, and academic achievement.

EATING/SLEEPING ISSUES

Eating and sleeping issues are also common concerns for parents and caregivers of children younger than 5 years of age and often motivate help-seeking. It is easy to see why, as a child with sleeping difficulties can be a disruption to an entire household and eating problems could easily trigger fear and anxiety that a child's nutritional needs are not being met. When there is not a medical reason for eating or sleeping issues, intervention may be provided by an infant-preschooler mental health professional. This is another opportunity to provide developmental guidance, if needed, but also to explore the role of household and family dynamics on infants and young children. Often, children will manifest symptoms of sleeping and eating difficulties as a result of an underlying issue.

SENSORY INTEGRATION

The senses are the body's way to gather information both internally and externally. The most commonly known senses are those of sight, smell, taste, touch, and sound. But, there are also lesser known senses, such as vestibular senses, proprioception, and interoception [23]. Infants and children with hypo- or hypersensitivity to one or more senses may manifest behavioral or regulatory symptoms. Young children with sensory processing disorders may:

- Resist being held or cuddled
- Seek constant movement
- Be distressed by baths and/or water splashing on him/her
- Fail to establish a predictable sleep/wake pattern or cycle
- Be annoyed by certain fabrics and/or fit of clothing
- Be distressed when moved suddenly and/or head is tipped
- Be bothered by rocking motions
- Have difficulty breastfeeding, sucking, chewing, or swallowing
- Gag or vomit from textured foods or on variety of different foods (i.e., has a very limited diet for age)
- Keep hands fisted and closed most of the time
- Walk on his/her toes
- Be bothered by dirty hands or face
- Be significantly late to gesture, smile, talk, walk, and/or play with toys
- Fail to notice sounds that others do or be sensitive to sounds that do not bother others
- Appear uncoordinated, frequently bumping into things, falling, and/or tripping
- Purposefully fall and/or run into a wall or others
- Fail to crawl before walking

Infant-preschooler mental health practitioners should have a basic knowledge of sensory processing disorders and should make connections with professionals, such as occupational therapists, who can support children and families struggling with sensory processing disorders.

ATTACHMENT STYLES

Much of the accepted research on infant attachment comes from the work of Mary Ainsworth. Using the Strange Situation Procedure, Ainsworth's team was able to examine the behaviors of young children during a structured observation with a primary caregiver, with the ultimate goal of identifying attachment patterns. From this work, both healthy (secure) and unhealthy (insecure) attachment patterns were defined.

Healthy, secure attachment is the ideal pattern of attachment, and it is the most commonly observed type. Healthy, secure attachment is created when parents are available and attuned to the needs of their child, providing consistent care and maintaining a sense of safety and comfort for the child. When secure attachment is observed in a young child, the child may reference his/her parent for reassurance in new situations, take comfort from his/her parent, exhibit reciprocal interactions and joint attention with his/her parent, show emotional involvement, and visibly relax when with the parent. Of course, when observing for attachment, it is important to take into consideration variables that may impact the attachment style, such as developmental delay, attention deficit hyperactivity disorder (ADHD), autism, or brain injury/trauma.

When a child has a secure attachment with an adult caregiver, he/she will develop a mental representation (internal working model) of him/herself as lovable and psychologically coherent [24]. This process is essential for children to develop appropriate affect regulation and empathy. Additionally, secure attachment assists in developing self-esteem and confidence in oneself as a social being.

Insecure styles of attachment are often created when caregivers are unavailable, hostile, unpredictable, or dismissive. Insecure attachments have a variety of subtypes, including avoidant, ambivalent, and disorganized [24]. Children with these attachment patterns may learn to reject parents/caregivers, have difficulties with self-regulation, exhibit compulsive self-reliance, be aggressive, and be easily dysregulated.

Attachment patterns are not concrete; they can be impacted by intervention and support, and unhealthy, insecure attachment styles often require intervention or support to repair. This can be done by supporting the parent-child dyad, by parents receiving treatment for any previous loss, grief, or trauma, and by supporting parents in receiving substance abuse treatment. This can also be accomplished by children moving into homes with securely attached parents and/or caregivers.

INFANT-PRESCHOOLER EVALUATION, SCREENING, AND ASSESSMENT

Over the past 20 years, screening tools, questionnaires, and assessments specific to children 0 to 5 years of age have proliferated. The following is a small sample of tools available to assist practitioners in building a comprehensive foundation for appropriate identification, assessment, and intervention (***Table 1***).

SCREENING AND ASSESSMENT TOOLS

Ages and Stages Questionnaires, Third Edition (ASQ-3)

The Ages and Stages Questionnaires, Third Edition (ASQ-3) is a user-friendly instrument that can be easily completed by parents in 10 to 15 minutes [45]. Practitioners can assist in the completion of the questionnaire, if necessary. This tool focuses on five separate developmental areas: gross motor skills, fine motor skills, social-emotional development, problem-solving, and communication. The tool takes approximately two to three minutes to

ASSESSMENT TOOLS FOR CHILDREN 0 TO 5 YEARS OF AGE
Adult Attachment Interview (AAI) http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf
Ages and Stages Questionnaires Third Version (ASQ-3) **Ages and Stages Questionnaires Social-Emotional (ASQ:SE-2)** https://agesandstages.com
Child Behavior Checklist https://aseba.org
Infant Toddler Social and Emotional Assessment Scale (ITSEA) https://eprovide.mapi-trust.org/instruments/infant-toddler-social-emotional-assessment
Keys to Interactive Parenting Scale (KIPS) https://www.kipscoaching.com
Marschak Interaction Method (MIM) https://theraplay.org
Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R/F) https://mchatscreen.com
Parent Stress Index (PSI) https://www.parinc.com/Products/Pkey/333
Source: Compiled by Author — *Table 1*

score. It provides an opportunity to focus on both a child's strengths and areas for growth. In addition to screening for developmental delays, the ASQ-3 system also includes a list of activities parents may engage in with their children to address developmental areas that may need additional support.

This tool can be completed in the child's home, over the phone with a parent, or as part of a mental health assessment. This questionnaire has become a community standard in many cases, as it is easy to interpret and has a high rate of reliability and validity. The tool can be accessed in both English and Spanish.

Ages and Stages Questionnaires, Social-Emotional (ASQ:SE-2)

The Ages and Stages Questionnaires, Social-Emotional (ASQ: SE-2) is a reliable, parent-completed tool with an exclusive focus on children's social and emotional development. This tool can be completed in conjunction with the ASQ-3 or as a standalone tool to provide an in-depth look at a child's social emotional functioning [46]. This questionnaire can be used for children 3 months to 5.5 years of age. If children score above the cutoff on the questionnaire, further assessment should be sought to identify if the child would benefit from further services.

Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R/F)

The Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R/F) is valuable in identifying symptoms associated with autism spectrum disorder (ASD) to assist a practitioner in identifying the need for further screening and treatment planning. The M-CHAT-R/F is designed to be completed by parents of children 16 to 30 months of age [47]. The checklist consists of 23 yes/no questions. It takes minimal time to administer and score, even with the follow-up questions associated with positive ASD responses.

Parent Stress Index

The Parent Stress Index (PSI) is a valid and reliable screening tool designed to assess the amount of stress in the parent-child relationship. The PSI-4 is the fourth edition of this inventory, with 120 questions focusing on three major domains of stress: child characteristics, parent characteristics, and environmental factors [48]. This tool can assist in treatment planning, goal setting, and prioritizing of services.

Understanding the views and stressors of parents can assist a practitioner in providing additional supports and services to overwhelmed, anxious, or angry parents. Supporting parents in the complex and complicated job of parenting has a direct and profound impact on children. Using the PSI can assist practitioners with quickly assessing a parent's current state of stress and can guide the practitioner in offering appropriate resources and supports.

OBSERVATIONAL EVALUATIONS AND ASSESSMENTS

An essential part of the assessment process is observation of the child and primary care provider(s). The information obtained during observation can guide the selection of the most applicable and appropriate services to support families and young children. Gaining first-hand knowledge of the parent and child dyad can shape the course of treatment and help identify strengths that parents may not be aware they have. Additionally, direct observation can provide a baseline for attachment relationships, assisting the professional in identifying the areas for interventions and support.

Keys to Interactive Parenting Scale

The Keys to Interactive Parenting Scale (KIPS) assesses the quality of parenting behavior for families with young children 2 to 71 months of age. This scale focuses on 12 behaviors related to effective parenting [49]:

- Sensitivity of responses
- Supports emotions
- Physical interaction
- Involvement in child's activities
- Open to child's agenda
- Engagement in language experiences
- Reasonable expectations
- Adapts strategies to child
- Limits and consequences
- Supportive directions
- Encouragement
- Promotes exploration and curiosity

These behaviors are supported by research indicating they promote healthy child development and overall well-being.

In order to use the KIPS, a professional must be trained on how to assess the caregiver-child interaction utilizing the 12 key parenting behaviors. The practitioner administering the KIPS assesses a caregiver (e.g., parent, other family member) interacting with a child for an interval of 15 to 20 minutes. Scoring takes approximately 10 minutes.

Marschak Interaction Method

The Marschak Interaction Method (MIM) is a structured assessment technique for observing the overall quality and nature of relationships between caregivers and children. It consists of a series of simple tasks designed to elicit behaviors in four primary dimensions (challenge, structure, engagement, and nurture) in order to evaluate the caregiver's capacity to [25]:

- Set limits and provide an appropriately ordered environment (structure)
- Engage the child in interaction while being attuned to the child's state (engagement)
- Meet the child's needs for attention, soothing, and care (nurture)
- Support and encourage the child's efforts to achieve at a developmentally appropriate level (challenge)

The MIM takes 20 to 60 minutes to complete and is usually videotaped for review. There are sets of tasks designed to be used in each of four age groups: infant, toddler, preschool/school age, and adolescent. The MIM can also be used with prenatal mothers.

The MIM provides an opportunity to see both strengths and areas for growth in a parent-child relationship. It is, therefore, a valuable tool in planning for treatment and in determining how to help families strengthen their relationships.

While the MIM provides useful information about the way the caregiver and child interact, it is not a standalone assessment tool and should be used in conjunction with other reliable and valid screening tools before decisions about treatment, intervention, or case planning are made.

COLLATERAL INTERVIEWS, CHECKLISTS, AND ASSESSMENTS

Understanding what and who the child represents within the context of the family provides invaluable information to a professional. This can shape how and when interventions are used as well as how to offer developmental guidance and support to families with young children.

According to the American Academy of Child and Adolescent Psychiatry, when assessing the mental health of infants and toddlers, the parents may be interviewed with or without the infant or toddler present. The assessment format should be responsive to the needs of the family and should allow the clinician to explore the parents' explicit and implicit concerns (including the reason for the referral), the child's current difficulties, and the impact of the child and his or her symptoms on each parent, the parental couple, and the family as a whole.

(https://www.jaacap.org/article/S0890-8567(09)62592-2/pdf. Last accessed August 16, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

Adult Attachment Interview

The Adult Attachment Interview (AAI) was developed as a research tool to assess the attachment patterns of adults [26]. The primary developer, Dr. Mary Main, was a student of Mary Ainsworth at the University of Baltimore and participated in the study and research of the Strange Situation. From this research came the idea that adult attachment patterns may have a direct impact on infant attachment patterns. The development and use of the AAI has proven this to be true. The interview is structured to illicit responses from parents on their own attachment history. The interview takes parents back to their early childhood and walks them through their primary attachment relationships, ending in questions regarding the parent's thoughts of the future [26]. This interview can be helpful in the assessment process to identify relational areas for intervention and treatment. However, the AAI is designed for research purposes and does not have a specific, set use or instructions for treatment planning or assessment.

Working Model of Child Interview

The Working Model of Child Interview is a structured interview in which the interviewer follows a specifically designed outline to gain insight into a parent's internal representation or working model of their relationship to his/her child [27]. This interview was designed by Charles Zeanah and colleagues, who define the purpose of the interview as having "individuals reveal as much as possible in a narrative account of their perceptions, feelings, motives, and interpretations of a particular child and their relationship to that child" [27]. The interview is carefully crafted to minimize the interviewer's interpretative comments, allowing for interviewees to share their internal working model regarding their child and their relationship to their child. There are 19 questions in the interview, several of which have follow-up or clarification questions to encourage and support parents in elaborating on their answers. Like the AAI, the Working Model of the Child Interview has been used in research to learn more about the parent-child dyad, and there are no instructions for incorporation into clinical practice.

Infant-Toddler Social and Emotional Assessment Scale

The Infant-Toddler Social and Emotional Assessment Scale (ITSEA) was designed to assess for social-emotional problems and competencies in infants and toddlers and can assist in identifying children with deficits or delays in social-emotional domains. It provides a comprehensive profile of problems and competencies in the domains of externalizing, internalizing, dysregulation, and competence, as follows [28]:

Externalizing

- Activity/impulsivity
- Aggression/defiance
- Peer aggression

Internalizing

- Depression/withdrawal
- General anxiety
- Separation distress
- Inhibition to novelty

Dysregulation

- Sleep
- Negative emotionality
- Eating
- Sensory sensitivity

Competence

- Compliance
- Attention
- Imitation/play
- Mastery motivation
- Empathy
- Pro-social peer relations

The ITSEA is available in English and Spanish and can be used by parents with a limited education and is culturally informed. The information collected from the ITSEA can assist in intervention planning for quality treatment.

Child Behavior Checklist

The Child Behavior Checklist (CBC) was first developed by Dr. Thomas Achenbach and is used for evaluating maladaptive behavioral and emotional problems in young children (1.5 to 5 years of age) [50]. The checklist can be completed by parents, day-care providers, or preschool teachers who know the child well. The form is commonly used and identifies 99 problem areas. The form has a strong evidence base and is culturally informed. To effectively utilize this tool, a professional should have training on use and scoring.

ASSESSMENT AND DIAGNOSIS

When assessing an infant or child for mental health services, it is important to complete a comprehensive biopsychosocial evaluation. This process will take into account age-appropriate screening tools, collateral interviews, and observations in addition to collecting a variety of information on a child's environment and history.

Obtaining the family history of a child is essential for the assessment process. Understanding a family's unique culture and make-up helps the professional conceptualize the child's needs and strengths within the context of his/her family. Gathering information on the cultural background of the family, including immigration and acculturation, is important for conceptualizing needs and strengths. Information about the parents' functioning and attachment history will also assist with case conceptualization and identification of needs. Understanding any intergenerational transmission of abuse, neglect, or other unhealthy parenting styles or beliefs can shape the treatment process.

An assessment should also focus on the child's prenatal experience. Attention should be given to the mother's pregnancy experience, including physical or emotional stressors during pregnancy, as maternal stress can have a negative impact on fetal development. How did the parents feel about the pregnancy?

Was there any trauma related to the conception? Was there a long history of problems with conception or miscarriage prior to the pregnancy? Stressed new mothers are also at risk for postpartum depression, which can lead to child maltreatment and negatively impact the child's attachment style. Fetal exposure to drugs, alcohol, and domestic violence are also important factors.

A child's first days in the world can also impact his/her well-being. Gaining information on birth and birth trauma for both the infant and mother are important. How long did the child stay in the hospital after birth? Were the parents able to hold their infant immediately after birth? Were there any physical, developmental, or neurologic concerns at birth?

Carefully gathering information on trauma history within the family and specifically for the infant will also help formulate an approach to working with a family. Gathering information on parents' maltreatment history will help a professional identify familial patterns or intergenerational concerns. Understanding the role of violence, aggression, gender roles, and expectations of childhood within a family will assist the professional with navigating the needs, strengths, and concerns of the family.

When assessing a family, obtaining reports from key collateral sources is also informative. Connecting with daycare providers, preschool teachers, grandparents, and/or significant support persons in the life of a family can shed light on areas for intervention and parental strengths. This may also assist in understanding a family's community and social environment, which can have a significant impact on functioning and overall well-being.

When considering an assessment form for use with the infant-preschooler population, it is important to keep in mind that the form should include:

- Demographics (including cultural considerations)
- Reason for referral/assessment
- Perinatal/prenatal issues
- Medical/physical history
- Attachment history (e.g., hospital stays, day care, foster placements)
- Developmental history (e.g., motor, communication, toileting)
- Family history (including attachment and relationship history)
- Observation (parent-child)
- Clinical summary/narrative

PSYCHOPATHOLOGY

The idea of psychopathology in infants, toddlers, and preschoolers can be disagreeable to some, as it is disturbing to think of mental illness in young children. Psychopathology is about identifying children who fall out of the normal range of childhood behavior within the context of development and environment. With many diagnoses, early identification is the key to successful intervention and treatment, mitigating long-lasting or severe psychopathology.

There is not yet a consensus on the classification of psychopathology in early childhood [29]. There continues to be concern that diagnosing mental health disorders in early childhood "overpathologizes" normal variations and individual differences of childhood [29]. However, a valid and reliable classification system for early childhood disorders could assist children and families in obtaining the services and treatments needed.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association) and the International Classification of Disease (ICD) (World Health Organization) systems are the most widely used psychiatric classifications systems used around the world. These systems can be applied to infants and young children but were created without significant consideration of the unique behavioral and emotional problems associated with these developmental stages.

Because of the limitations of classification systems like the DSM and the ICD as they apply to infants and toddlers, a task force, Zero to Three, was created by the National Center for Infants, Toddlers, and Families in 1987. This task force, consisting of professionals in the fields of infant development and mental health, created the *Diagnostic Classification of Mental Health and Development of Infancy and Early Childhood* (DC: 0–3) in 1994 as a multiaxial system for disorder classification of young children [30]. In 2005, the revised version was published to reflect advances in disorder classification and increased emphasis on the effects of relationship characteristics, psychosocial stressors, and contextual factors on infant-toddler mental health and development [30]. In 2016, the *Diagnostic Classification of Mental Health and Development of Infancy and Early Childhood* was revised and expanded to include children up to 5 years of age [30]. The DC: 0–5 guides professionals to use diagnostic criteria for effective assessment and treatment planning for existing and newly introduced disorders. This manual has grown in popularity and is now a common tool for classification of early childhood mental health and developmental disorders.

COMMON EVIDENCE-BASED TREATMENTS AND INTERVENTIONS

There are a variety of interventions and treatment models with evidence supporting their use in early childhood. When selecting interventions, it is important that professionals understand their validity and reliability rates. Interventions should also be chosen that take into account developmental age, culture, and parental strengths and areas for growth. The list of interventions described in this section is far from exhaustive and is just a sampling of interventions designed for children younger than 6 years of age.

ATTACHMENT AND BIOBEHAVIORAL CATCH-UP MODEL

The Attachment and Biobehavioral Catch-Up (ABC) Model was developed by Dr. Mary Dozier and associates to address and improve the regulatory capabilities and caregiver-child relationships of infant and toddlers who have experienced early childhood maltreatment and/or disruptions in care [31]. The ABC Model helps caregivers reframe how they view a child's behaviors, assisting them in approaching parenting with a trauma-informed paradigm. The goal is to assist caregivers in providing consistent, responsive care to young children to help them regulate their emotions, affect, and behavior.

The ABC Model is a structured, evidence-based approach whereby weekly one-hour sessions are provided for 10 weeks in the caregiver's home. Support and guidance is provided in the moment by the trained professional to focus on target behaviors. This intervention uses video feedback.

The ABC Model is rated a 1 on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale. The California Clearinghouse independently reviews evidence-based treatments for child welfare, and a rating of 1 indicates that the program has the strongest research evidence among those interventions rated [32].

NON-DIRECTIVE PLAY THERAPY

Play therapy is based on the theory that a child's language is play. It is a common intervention for children older than 3 years of age who are dealing with grief/loss, depression, anxiety, attachment issues, behavioral and emotional regulation issues, and divorce, among other issues. The toys in the playroom (therapy room) are considered the words of the child's language, used to express inner experiences and perceptions. A comprehensive definition of non-directive play therapy is provided by Dr. Gary Landreth [33]:

> Play therapy is defined as a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development.

Non-directive play therapy can be used for a variety of different mental health or behavioral concerns. Research has supported this approach to treat concerns such as trauma, sadness, worry, fear, grief, and adjustment.

The toys in the playroom are carefully chosen, with special attention to including items that can be used in a multitude of ways. Items for creative expression (e.g., crayons, paints, construction paper), real-life toys (e.g., dolls, play money, medical kit), and aggression-release toys (e.g., soldiers, wild animals, clay) should be among the toys chosen for a playroom. (See the ***Appendix*** for a more complete list of toys and objects to include in a play therapy room.)

Non-directive, child-centered play therapy is based on the following eight principles [34]:

- Develop a warm, friendly relationship with the child.
- Accept the child unconditionally, without wishing the child were different in some way.
- Establish a feeling of permissiveness in the relationship so the child feels free to express him- or herself.
- Recognize and reflect the feelings of the child to create understanding.
- Respect the child's innate ability to solve his or her own problems and offer the opportunity to return the responsibility to the child.
- Do not attempt to direct the child's actions or conversation, but allow the child to lead the way.
- Recognize the gradual nature of the child's process, and try not to rush counseling.
- Establish only those limitations that are necessary to anchor the child's experience in counseling to the world of reality.

One of the main goals of non-directive play therapy is to support and allow the child to communicate his or her inner thoughts and feelings. Within a play session, and over the course of sessions, themes emerge in the child's play, giving the therapist insight into the child's experiences, thoughts, feelings, and interpretations of his/her world.

Filial Therapy

Filial play therapy was developed by Drs. Louise and Bernard Guerney in the 1960s as a treatment for children with behavioral, emotional, and social problems. Filial therapy is a form of family play therapy focusing on supporting parents to become primary change agents as they learn to conduct child-centered play sessions with their own children [34]. Like nondirective, child-centered play therapy, filial therapy follows the eight basic principles of play therapy [34]. This approach has been used with empirical support in children 3 to 12 years of age and occasionally with older children who have experienced trauma. Research is being conducted in utilizing the filial therapy model with younger children [35].

The essential features of filial therapy are [36]:

- The importance of play in child development is highlighted, and play is seen as the primary avenue for gaining greater understanding of children.
- Parents are empowered as the change agents for their own children.
- The client is the relationship, not the individual.

- Empathy is essential for growth and change.
- The entire family is involved whenever possible.
- A psychoeducational training model is used with parents.
- Tangible support and continued learning are provided through live supervision of parents' early play sessions with their children.
- The process is truly collaborative.

In order to utilize filial therapy as an infant-preschooler mental health intervention, a clinician should be trained and proficient in child-centered play therapy. Additionally, proper training in filial therapy should be gained in order to utilize it as a tool.

CHILD-PARENT PSYCHOTHERAPY

Child-parent psychotherapy (CPP) is a relationship-based intervention for trauma-exposed children 0 to 6 years of age. CPP is a culturally informed treatment, focused on strengthening the parent-child dyad to restore and protect the mental health of children. The goals of CPP are to improve the emotional attunement of the parent-child dyad and enhance interactional patterns [37]:

> It targets for...unmodulated or dysregulated parental or child behaviors, particularly symptoms of violence-related trauma that include externalizing problems such as aggression, defiance, noncompliance, recklessness, and excessive tantrums, and internalizing problems such as multiple fears, inconsolability, separation anxiety, difficulties sleeping, and social and emotional withdrawal.

Over the course of CPP treatment, the parent and child are guided and supported in creating a joint narrative of the traumatic events experienced by the child. Additionally, the parent and child are guided to identify and address traumatic triggers that contribute to dysregulated behaviors and affect [10].

More can be found on CPP by reading *Don't Hit My Mommy! A Manual for Child-Parent Psychotherapy with Young Witnesses of Family Violence* [10].

DIRFLOORTIME

DIRFloortime is a treatment approach developed by Dr. Stanley Greenspan as a relationship-focused play intervention that promotes growth in a child's social, emotional, and developmental abilities by following the child's lead and challenging the child's capabilities. The definition of DIR is [51]:

- **D**evelopmental: This part of the model focuses on a child's emotional and intellectual developmental stage (not the child's chronologic age). The child's abilities to regulate, respond, and communicate are assessed, and opportunities for growth and maturation are developed.
- **I**ndividual differences: This part of the model focuses on the unique ways in which each child experiences and processes the world as well as each child's ability to regulate, process, and respond to sensory experiences. This component will assess where the child is on the continuum of sensory seeking to sensory avoidant.
- **R**elationship-based: This part of the model focuses on the essential role of parents, caregivers, teachers, and others in the life of a child. Supportive coaching and learning relationships are cultivated to assist significant support persons in implementing individualized, developmentally appropriate interactions to promote growth.

The DIRFloortime model is often used with children who have an ASD or who have other developmental disabilities. This comprehensive framework lends itself to a multidisciplinary approach by including team members such as occupational or speech therapists in the intervention.

INFANT MASSAGE

Touch is an essential component in relationships and attachments. Infant massage can be used as a nurturing and attachment-promoting technique to improve relationships. It can be particularly helpful for foster and adoptive parents trying to build or repair a child's ability to attach. Additionally, infant massage also offers physiologic benefits for infants struggling with colic, gas, and sleeping issues.

Dr. Tiffany Field, founder of the Touch Research Institute at the University of Miami Medical Center, has completed many research projects on the value of touch and infant massage. In one research study, 20 preterm infants were massaged in the hospital, three times per day, for at least 15 minutes per massage. These infants gained 47% more weight and left the hospital on average six days earlier than their non-massaged counterparts. Additionally, the infants who received massages were noted to be more alert, more active, and showed significantly more mature neurologic development [39].

Vimala McClure, the founder of the International Association of Infant Massage, writes [40]:

> When I massaged my baby with a fully present mind, relaxed body and open heart, he appeared to relax and was happier for the rest of the day. When I stopped massaging him for two weeks, the change was noticeable. He seemed to carry tension with him and to express more general irritability and fussiness, with painful attacks of colic keeping us up for hours in the night. From that point on I decided that massage would remain a permanent part of our lives.

Infant massage can also lead to increased parental confidence and capacity. Parents who massage their infants report an increased ability to read the infant's cues and to feel a sense of increased nonverbal communication. This intervention can be especially important for fathers, mothers with depression, and caregivers who have been away from the infant for an extended period of time.

THERAPLAY

Theraplay is a treatment method developed by Ann Jernberg and Phyllis Booth in the late 1960s. Theraplay is an attachment- and relationship-focused, play-based therapy intervention designed to increase a healthy emotional connection between child and parent. The MIM is used as an assessment tool prior to the use of Theraplay; the CBC and PSI are also often given prior to initiation of the intervention. In the text *Theraplay*, Jernberg and Booth state, "Our model for treatment is based on attachment research that demonstrates that sensitive, responsive caregiving and playful interaction nourish a child's brain, form positive internal representations of self and others, and have a lifelong impact on behavior and feelings" [25]. Theraplay focuses on four essential qualities within the parent-child relationship: structure, engagement, nurture, and challenge [25].

The core characteristics of Theraplay are [25]:

- Interactive and relationship-based
- A direct, here-and-now experience
- Guided by the adult (e.g., parent)
- Responsive, attuned, empathetic, and reflective
- Geared to the preverbal, social-emotional, right brain level of development
- Multisensory, including an extensive use of touch
- Playful

In terms of structure, it begins with parents providing a safe and secure environment for their children. During the intervention, the parent is supported in organizing a predictable experience for the child. The parents should be seen as a source of safety and be trustworthy and reliable. The parents should provide attuned, playful experiences to increase joyful, shared emotional involvement. This occurs when parents are able to accurately read and respond to a child's signals, modifying activities to gain engagement and positive responsiveness from a child.

The parents should respond empathetically to a child's needs, providing a warm, open, and comforting experience for the child. The parent should be reassuring and gentle; this quality promotes positive attachment behaviors.

The parents should encourage the child to challenge themselves and to strive for mastery. The parent should act as a secure base while encouraging the child to take developmentally appropriate risks.

Because this intervention is attachment informed, it is useful with children in foster care and adopted children. It is also useful for children with difficult temperaments, parents who have been separated from their children, parents who experienced a lack of quality parenting, and parents and families living in stressful environments.

REFLECTIVE PRACTICE FACILITATION AND/OR SUPERVISION

Reflective practice facilitation is the development of one's awareness of thoughts, feelings, and responses and the impact of these thoughts, feelings, and responses on young children and families. This approach speaks to the practitioner's ability to be present and mindful of the relationships at play in the life of a young child.

Reflective practice is about contemplating issues both internally and within a family, without judgment. The ability for a practitioner to be reflective often comes from the support and encouragement of a mentor. This support and encouragement often comes in the form of reflective practice facilitation/supervision/consultation.

The working definition of reflective practice facilitation from the California Center for Infant-Family and Early Childhood Mental Health is [41]:

> ...an individual or small group integrative experience that supports the practitioner to explore ways to apply relevant theories and relevant knowledge bases to clinical situations; to model an appreciation for the importance of relationships that are at the core of infant-family and early childhood mental health; to reflect on the experiences, thoughts, and feelings involved in working with infants, young children, and families; to understand the parents' culture and the parents' and infants' interpersonal perspectives; and to explore possible approaches to working effectively with infants and families. It is acknowledged that dynamics in the reflective practice facilitation relationship will in turn influence practitioner/family relationships, and thus that the reflective facilitator embodies ways of being that are considered best practice for infant-early childhood mental health practitioners.

Administrative and/or clinical supervision differs from reflective practice supervision in that these types of supervision have a specific focus on reviewing and enforcing policies and procedures, monitoring productivity, evaluation, and documentation review. This is not to say that administrative and/or clinical supervision cannot be reflective in nature. In reflective practice facilitation, however, the focus is on the emotional exploration of the work with infants and toddlers. Additionally, reflective practice facilitation focuses on the parallel process and exploration of relationships (e.g., parent-child, practitioner-supervisor, practitioner-parent).

Quality reflective supervision is a consistently scheduled relationship-oriented practice that invites the sharing of emotional content and attends to the feelings, observations, and experiences of the supervisee. Reflective supervision supports and strengthens the process of integrating emotion and reason in the work with infants, toddlers, and families.

The Michigan Association for Infant Mental Health outlines the following points as paramount to reflective practice supervision [38]:

- Form a trusting relationship between supervisor and practitioner.
- Establish consistent and predictable meetings and times.
- Ask questions that encourage details about the infant, parent, and emerging relationship.
- Listen.
- Remain emotionally present.
- Teach/guide.
- Nurture/support.
- Apply the integration of emotion and reason.
- Foster the reflective process to be internalized by the supervisee.
- Explore the parallel process and allow time for personal reflection.
- Attend to how reactions to the content affect the process.

CONCLUSION

This course aimed to provide a brief introduction to the foundational concepts and principles of infant and preschooler mental health, highlighting the complex and important role of relationships and attachments in early childhood. The hope is that this course provided the first step in understanding infant-preschooler mental health as a broad-based, collaborative, and multidisciplinary approach to serving, nurturing, and supporting young children and families. To do this, infant-preschooler mental health practitioners utilize evidence-based approaches and practices to promote social, emotional, and cognitive growth in young children. Each interaction with a young child and family should be done with an understanding of the importance of primary attachment relationships, biologic differences, and culture on family functioning. As stated by the Center for Infant-Family and Early Childhood Mental Health, [41]:

Every individual who touches a baby should be trained to understand the basic concepts of infant-family mental health and early development. Everyone who interacts with preschoolers and their families should be trained to understand the basic concepts of development and mental health of infants and young children, as well as the practitioner's role in supporting parents in their responsibilities to protect, nurture, and guide their children.

RESOURCES

WEBSITES

The Adverse Childhood Experiences Study
https://www.cdc.gov/violenceprevention/aces/resources.html

Alliant Infant-Preschooler Mental Health Certificate
https://www.alliant.edu/psychology

California Center for Infant-Family and Early Childhood Mental Health
http://cacenter-ecmh.org

Center on the Developing Child at Harvard University
https://developingchild.harvard.edu

Child Trauma Academy
https://childtrauma.org

Infant Massage USA
https://www.infantmassageusa.org

Michigan Association for Infant Mental Health
https://mi-aimh.org

Napa Infant-Parent Mental Health Fellowship Program
https://cpe.ucdavis.edu/autism-spectrum-disorder/napa-infant-parent-mental-health-fellowship

National Child Traumatic Stress Network
https://www.nctsn.org

Floortime
https://www.floortime.org

Theraplay
https://www.theraplay.org

Brazelton Touchpoints Center
https://www.brazeltontouchpoints.org

Zero to Three
https://www.zerotothree.org

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APPENDIX: TOYS/ITEMS FOR A PLAY THERAPY ROOM

The play therapy room should be comfortable, and the toys should be accessible and able to be used in a variety of ways. Comfortable floor seating, such as cushions or a bean bag chair, is highly recommended. It is important not to include anything in the room to which one has a personal connection or would be upset if it is broken, lost, or taken.

RELATIONSHIP/INTERACTIVE TOYS AND MATERIALS

- Toy camera or real camera without film
- Mirror
- Flashlight
- Binoculars
- Telephones
- Drums/maracas/tambourine

FANTASY MATERIALS/DRESS-UP

- Cape, hat, boa
- Purse, bag
- Lone Ranger/black mask
- Badge
- Crown, magic wand
- Play dishes/food/tea set
- Play money
- Medical kit

THEMATIC/FANTASY TOYS

- Wild animal families
- Domestic animal families
- Dinosaurs/dragons
- Dolls/doll clothes
- Baby items (e.g., rattle, bottle, blanket)
- Dollhouse/furniture/family dolls
- Cars/rescue cars/transportation items
- Toy soldiers/army/war items (e.g., cannons, fences)
- Play tools (e.g., hammer, wrench, screwdriver)

EXPRESSIVE TOYS/ITEMS

- Crayons, markers, pencils
- Colored paper
- Paint
- Play-Doh, clay
- Puppets/stage
- Blocks
- Whiteboard/chalkboard
- Crepe paper
- Cotton balls
- Play or real medical items (e.g., bandages, stethoscope, blood pressure cuff, pulse reader)
- Bubbles/balloons
- Bean bags or other items to toss
- Newspaper/butcher paper
- Inflatable punching toy (e.g., Bop Bag)
- Soft swords or knives

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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