THE HANDBOOK OF Training and Practice in Infant and Preschool Mental Health

EDITED BY

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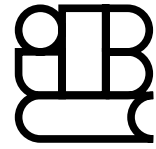

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The Handbook of Training and Practice in Infant and Preschool Mental Health

Karen Moran Finello, Editor

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Alliant International University

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Contents

Preface xi

Part One: General Training and Practice Constructs 1

1 **Returning the Treasure to Babies: An Introduction to Infant Mental Health Service and Training** 3
Deborah J. Weatherston, Ph.D.

2 **Using Direct Observation in Prevention and Intervention Services in Infant and Preschool Mental Health: Training and Practice Issues** 31
Martha Farrell Erickson, Ph.D.

3 **Training in Assessment of Birth to Five-Year-Olds** 51
Karen Moran Finello, Ph.D.

4 **Diagnosis of Mental Health in Young Children** 71
Marie Kanne Poulsen, Ph.D.

5 **Dyadic Therapy with Very Young Children and Their Primary Caregivers** 93
Joan Maltese, Ph.D.

6 **Reflective Supervision in Infant, Toddler, and Preschool Work** 114
Mary Claire Heffron, Ph.D.

7 **A Seminar to Support the Supporter: Promotion of Provider Self-Awareness and Sociocultural Perspective** 137
Graciela "Chela" Rios Munoz, L.C.S.W.

8 **Retraining Clinicians to Work with Birth to Five-Year-Olds: A Perspective from the Field** 162
Mona Maarse Delahooke, Ph.D.

Part Two: Specialty Areas of Practice 179

9 Developing Reunification and Adoption Recommendations for Substance-Exposed Infants and Toddlers in Foster Care 181
Valata Jenkins-Monroe, Ph.D.

10 Play Therapy with Preschoolers Using the Ecosystemic Model 207
Sue A. Ammen, Ph.D., RPT-S, and Beth Limberg, Ph.D., RPT-S

11 Intensive Day Treatment for Very Young Traumatized Children in Residential Care 233
Leena Banerjee, Ph.D., and Lorraine E. Castro, M.A., M.F.T.

12 Kitchen Therapy and Beyond: Mental Health Services for Young Children in Alternative Settings 256
Brenda Jones Harden, M.S.W., Ph.D., and Mawiyah Lythcott, M.S.

13 Delivering Infant and Preschool Mental Health Services in Rural and Remote Areas 287
Deborah A. Harris, M.S.W., L.I.S.W.

Part Three: Training Standards, Systems, and Technology 305

14 Developing Standards for Training in Infant and Preschool Mental Health 307
Karen Moran Finello, Ph.D., and Marie Kanne Poulsen, Ph.D.

15 An Interdisciplinary Training Model: The Wayne State University Graduate Certificate Program in Infant Mental Health 326
Deborah J. Weatherston, Ph.D.

16 The DIR™ Certificate Program: A Case-Based Competency Training Model 343
Serena Wieder, Ph.D.

17 Using Technology as a Training, Supervision, and Consultation Aid 357
Valerie A. Wajda-Johnston, Ph.D., Anna T. Smyke, Ph.D., Geoffrey Nagle, Ph.D., M.P.H., L.C.S.W., and Julie A. Larrieu, Ph.D.

Part Four: Innovative Models of Training and Service Delivery 375

18 Developmental Pathways to Mental Health: The DIR™ Model for Comprehensive Approaches to Assessment and Intervention 377
Serena Wieder, Ph.D., and Stanley I. Greenspan, M.D.

19 The *Relationships for Growth* Project: A Transformational Collaboration Between Head Start, Mental Health, and University Systems 402
Rebecca Shahmoon-Shanok, M.S.W., Ph.D., Faith Lamb-Parker, Ph.D., Ellen Halpern, Ph.D., Megan Grant, Ph.D., Carole Lapidus, M.S., M.S.W., and Charles Seagle, Ph.D.

Part Five: Transforming Practice Across Systems of Care 425

20 The Role of Reflective Process in Infusing Relationship-Based Practice into an Early Intervention System 427
Linda Gilkerson, Ph.D., and Tina Taylor Ritzler, M.A.

21 Apprenticeship, Transformational Enterprise, and the Ripple Effect: Transferring Knowledge to Improve Programs Serving Young Children and Their Families 453
Rebecca Shahmoon-Shanok, M.S.W., Ph.D., Carole Lapidus, M.S., M.S.W., Megan Grant, Ph.D., Ellen Halpern, Ph.D., and Faith Lamb-Parker, Ph.D.

About the Editor 487

About the Contributors 489

Name Index 495

Subject Index 503

To my daughter, Courtney, who has added immeasurable richness to my life.

Preface

The delivery of mental health services to infants, toddlers, preschoolers, and their families involves a complex interweaving of skills that straddle disciplines and test boundaries. Provision of such services is a testament to the strength of practitioners who struggle to balance the necessary knowledge base, application strategies, and self-awareness required by the work. It is a fragile dance, with the practitioner often initiating a conversation that a caregiver does not want to have, testing and retesting boundaries as the work unfolds, and maintaining a steady, yet ever adapting, view of individual children and families. The practitioner must provide constancy in an ever changing world while remaining open to new possibilities in her own work and in the lives of the families served. The dance requires the clinician to adjust her tempo across time—sometimes it is a slow dreamy waltz, at other times a spinning, whirling motion accompanying the child and family on their precious journey of developing and becoming.

In order to be effective, the infant and preschool mental health practitioner must exhibit a wide range of personality characteristics—some deep within, others at the surface—all ready to be called up at the appropriate moment. These characteristics include a sense of humor that allows the clinician to share joy with a family and to lighten dark moments. She must be able to laugh with a family, to laugh with her colleagues, and to laugh at herself. She must be patient, not only with herself and her expectations of her own work but in her expectations of families. She must be able to sit quietly and listen but not be afraid of providing advice when asked. A practitioner must also be enthusiastic and passionate about her work—the dance is different, then, than when a family encounters indifference and apathy.

Compassion must come as second nature but not overwhelm the work. Showing understanding, interest, and concern is crucial, but so is the ability to step back from the work and to maintain direction without being sidelined by overwhelming need. A practitioner must

have boundaries but be able to work in boundary-less fashion—cutting across disciplines, making decisions that are appropriate in her work with one family but not with another family. High-quality supervision is essential to this work. The good supervisor holds the clinician so that continuing progress is possible and acts as the depository for the self-doubt that inevitably arises when doing this complex work.

Infant and preschool mental health is an ever changing, evolving field. This handbook is designed to help the clinician in the journey of professional growth as she works to help young children and families realize their potentials. The handbook is intended to help training programs, agencies, and clinicians determine what skills and clinical experiences are needed to do the wide range of work that makes up this field and decide how to develop those skills and structure the clinical experiences.

The book is divided into five parts. Part One focuses on broad training areas in which a clinician interested in infant and preschool mental health practice must develop skills. Weatherston's chapter provides a wonderful overview of current and historical issues related to training and service delivery, along with key concepts in infant mental health. Other chapters in Part One focus on developing observation skills, designing assessment training, developing diagnostic skills with very young children, providing dyadic therapy, providing (and receiving) reflective supervision, and developing self-awareness and sociocultural perspective. Finally, the chapter by Delahooke examines retraining from the perspective of the practitioner who struggles with putting together key training elements, without the benefit of a comprehensive training program. This chapter is particularly pertinent, as many practicing clinicians who decide to retrain to work with birth to five-year-olds are not able to move to another city and enroll in a comprehensive training program.

Part Two addresses specialized areas of practice, including the evaluation and decision-making process for reunification and adoption, play therapy with preschoolers, and intensive day treatment for very young, traumatized children in residential care. The last two chapters in Part Two focus on the delivery of infant and preschool mental health services outside the traditional mental health arena. Jones Harden and Lythcott look at issues in providing services in homes, schools, day-care centers, and social service agencies. Harris addresses strategies for delivering services in rural and remote areas.

Part Three explores training systems and the use of technology for training, supervision, and consultation. Included are chapters examining the development of training and practice standards within California, the Wayne State University Graduate Certificate Program in Michigan, and the development of the DIR™ Certificate program. Wajda-Johnston and her colleagues have put together a wonderful examination of the struggles they have encountered and the success they have had in developing technology for remote supervision and training.

Part Four includes several innovative models of service delivery and training that rely on collaboration between disciplines and an integrative approach to services to create system change. Finally, Part Five is a thought-provoking examination of programs in Illinois and New York that transform training and practice through the infusion of reflective process and the creation of "ripples" across systems.

As infant and preschool mental health practitioners continue to develop and expand the scope of their practices, they will find many of the chapters in this handbook particularly important to their professional development. The authors are trainers and service providers who are involved with the leading edge of infant and preschool mental health services across the United States. I hope that this book will be useful as a training guide for developing clinicians, a resource for current practitioners, and an inspiration to programs looking to expand their boundaries on behalf of very young children and their families.

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I would like to thank Dr. Natalie Porter of Alliant International University, who encouraged me to move this handbook from concept to product. I am extremely grateful for her support and her help in connecting me to Jossey-Bass. My extraordinary home visiting program staff, whose dedication to young children and families is an ongoing inspiration, also deserve special thanks for their support while this handbook was developed and completed.

The excitement and passion for the field, passed along by visionary leaders who worked tirelessly on behalf of very young children and families long before anyone knew what *infant mental health* meant, continue to motivate all of us and drive our clinical work. The inspired

teaching of these visionary leaders has led us to be better clinicians, researchers, and teachers and to extend the passion for the field to others whom we train. National and international organizations dedicated to infants and young children, including Zero to Three, the International Society on Infant Studies, and the World Association for Infant Mental Health, provide continuing opportunities to share our knowledge, our work, and our dreams for improved practice, research, and training. We have all been professionally and personally enriched by our associations with these organizations and the individuals who constitute them.

Finally, this handbook would not have been possible without the considerable time and energy of the authors of each chapter. Despite heavy schedules full of service delivery, teaching, and research, these amazing authors put together stellar chapters that are thought provoking, educational, and inspiring. I cannot thank them enough for their collegiality and commitment. They are not only brilliant thinkers but are, even more important, sincere and caring individuals. The field will be forever enriched by their work.

Los Angeles, California KAREN FINELLO

The Handbook of Training and Practice in Infant and Preschool Mental Health

PART ONE

General Training and Practice Constructs

CHAPTER ONE

Returning the Treasure to Babies

An Introduction to Infant Mental Health Service and Training

Deborah J. Weatherston, Ph.D.

Imagine that you are an infant mental health practitioner and that you are sitting in a family's kitchen. The young mother, her infant, and her toddler were referred to you by a nurse practitioner who had some concerns about the baby's care and development following the baby's discharge from the newborn intensive care unit. It is about 2 P.M. Dishes are piled high in the sink; food from several meals sits on the counter. It is hot. The windows are shut tight, and although the sun is shining, the shades are drawn as if to protect against the intrusion of daylight. The baby, three months old, cries in the back room. The information that you were given tells you that the baby was premature and had been separated from her mother's care for three weeks before hospital discharge. The twenty-two-month-old toddler, a boy, brings you toys and indicates with a grunt that he wants to climb up on your lap—you, the stranger. His face is smudged with traces of chocolate. He is pale and unsmiling. There are significant developmental questions about both small children. Their mother, a single parent, twenty-four years old, is alone in caring for her children and isolated from family or friends. She seems agitated and surprised that you have come, although you spoke to her yesterday on the phone. She, too, is unsmiling, unable to pay attention to the toddler or to hear the baby's continuing cries. She lights a cigarette, pours a cup of coffee for herself and asks you, "So . . . why are you here?"

This vignette marks the beginning of an infant mental health intervention in which the focus is on early development and relationships between a parent and her two young children. The scene is a familiar one in the world of infant mental health, challenging and complex. What is it that you, in the role of an infant mental health practitioner, will do? What core beliefs, skills, and strategies will guide you to work effectively from an infant mental health perspective? Finally, what training experiences will you need to have in order to offer this family meaningful service support? The intent of this chapter is to introduce the reader to the practice of infant mental health and the experiences that contribute to the growth and awakening of an infant mental health therapist.

WHAT IS INFANT MENTAL HEALTH?

Selma Fraiberg and her colleagues in Michigan coined the phrase *infant mental health* in the late 1960s. It is defined as the social, emotional, and cognitive well-being of a baby who is under three years of age, within the context of a caregiving relationship (Fraiberg, 1980). Fraiberg understood that early deprivation affected both development and behavior in infancy and reminded us that an infant's capacity for love and for learning begins in those early years. She had been trained in a psychodynamic approach to mental health treatment for adults and children, which she adapted for work with parents and young children from birth to three.

Fraiberg was attuned to the power and importance of relationships and understood that how a parent cares for a very young child has a significant impact on the emotional health of that child. She also understood that parental history and past relationship experiences influence the development of relationships between parents and young children. Fraiberg referred to this new knowledge and understanding about infants and parents as "a treasure that should be returned to babies and their families as a gift from science" (1980, p. 3). She spent the remainder of her career returning that gift through training and a carefully crafted approach called *infant mental health service* (Weatherston, 2000).

Four questions are of great significance to the scope of infant mental health practice and to the training needs of infant mental health specialists: What about the baby? What about the parents who care for the baby? What about their early developing relationship and the

context for early care? What about the practitioner? These questions shape the framework for infant mental health practice and training (Weatherston, 2001).

INFANT MENTAL HEALTH PRACTICE

Regarded as a unique approach to the understanding and treatment of infants, toddlers, and families, infant mental health practice embraces the belief that all babies and young children can benefit from a sustained, primary relationship that is nurturing, supportive, and protective (Stinson, Tableman, & Weatherston, 2000; Shirilla & Weatherston, 2002). The developing parent-child relationship should be placed at the center of the therapist's work from the moment a family is referred or asks for help through the period of observation, assessment, and intervention (Lieberman & Pawl, 1993; Lieberman & Zeanah, 1999).

Parents and infants are seen together, often in the intimacy of their own homes, where the infant mental health therapist offers his or her relationship as a therapeutic context for shared observations, careful listening, and empathic response. It is most customary for an infant mental health therapist to work with a family weekly or even more frequently, for a maximum of one-and-a-half hours per visit. Some interventions may be short term or for a crisis response; others may be for assessment purposes. Most continue for three months to one year, and some sustain the work for longer periods of time, depending on the infant's or family's need. The goals are to support the social and emotional development of an infant or toddler, to identify and reduce the risk of disorder or delay, to nurture the emerging caregiving competencies that each parent has, and to strengthen early developing relationships in families.

The stakes are high. Babies and families in crisis cannot wait. Effective infant mental health practitioners observe infants and parents together and wonder about the nature of their interactions and developing relationships (Trout, 1982; McDonough, 1993; Cohen, Muir, & Lojkasek, 1999). Practitioners listen carefully, ask questions that are thoughtful, and gather information about the baby and early care. They may use formal developmental guides or diagnostic criteria, as appropriate. Practitioners invite parental participation throughout the assessment and treatment process, make an effort to establish warm and trusting relationships with parents, and consider parents'

feelings in response to observations and interviews (Hirshberg, 1993). Knowledgeable and skillful infant mental health practitioners organize their understanding in a meaningful and practical way. They listen carefully to parents and are not judgmental. They communicate clearly and invite a supportive partnership with parents (Hirshberg, 1996).

Core Infant Mental Health Beliefs

Core beliefs guide infant mental health practitioners to cherish each encounter with infants or toddlers and their families and to think deeply about early developing relationships (Trout, 1987; Stinson, Tableman, & Weatherston, 2000; Weatherston, 2000). These beliefs are the bedrock of infant mental health practice. They shape a practitioner's approach to all infants or toddlers and families who are referred for early services. Some of the most fundamental beliefs are the following:

- Optimal growth and development occur within nurturing relationships.
- The birth and care of a baby 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 life events.
- The therapeutic presence of an infant mental health practitioner may reduce the risk of early relationship failure and offer hopefulness for change.

Key Components of Infant Mental Health Practice

Infant mental health services include a variety of components: concrete resource assistance, emotional support, developmental guidance, advocacy, and infant-parent psychotherapy. Some or all of these components will be appropriate when working with individual infants and families (Fraiberg, 1980; Weatherston, 1997; Weatherston & Tableman, 2002). All provide opportunities to nurture early development and relationships when responding to families.

• *Concrete resource assistance* refers to the meeting of basic needs for food, clothing, medical care, shelter, and protection. The practitioner who feeds or clothes or takes a family to the clinic assures parents and young children that he cares about them and will work to ease their burdens of care.

• *Emotional support* is defined as compassion offered to a parent who faces a crisis during pregnancy or in caring for a new baby or toddler. Alone, or without emotional reinforcement, a parent needs someone who is emotionally available, listens carefully, ask questions sensitively, and holds the many feelings that threaten to overwhelm or confuse.

• *Developmental guidance* is the shared understanding about the baby's development and specific needs for care. The practitioner and parent carefully identify emerging capacities and concerns, reaching an understanding of the uniqueness of each baby through careful observation and words.

• *Advocacy* is the offer of help to parent or infant when they cannot successfully ask for it themselves (for example, a safe place to live, assistance in finding child care, support for a special needs assessment). To speak effectively on behalf of an infant's need for early care or a parent's need for support is often a daunting, but critical, task.

• *Infant-parent psychotherapy* offers a parent the opportunity to explore thoughts and feelings awakened in the presence of an infant or toddler. In the intimacy of the home visit, a parent may share stories of past experiences and significant relationships, major fears, disappointments, and unresolved losses as they affect the care of a baby and the early developing relationship between parent and child.

Crucial to the effectiveness of these service components is the working relationship that develops between each infant mental health practitioner and parent (Fraiberg, 1980; Lieberman & Pawl, 1993; Hirshberg, 1996). Respectful and consistent, the infant mental health practitioner must remain attentive to each parent's strengths and needs. Within the safety of the relationship with the infant mental health practitioner, parents feel well cared for and secure, held by the therapist's words and in her mind (Pawl, 1994). The practitioner listens carefully, follows the parent's lead, remains attuned, sets limits, and responds with empathy. Well held, the parent experiences possibilities for growth and change through the relationship with her infant.

Infant Mental Health Skills and Strategies

Clinicians identify basic skills and strategies that are ingredients for compassionate and effective work with infants and families (Fraiberg, Adelson, & Shapiro, 1975; Blos & Davies, 1993; Pawl, 1994; Proulx, 2002; Barron, 2002; Daligga, 2002; Oleksiak, 2002; Weatherston, 2002). These contribute to the infant mental health practitioner's understanding of the infant or toddler, the awakening or repair of the early developing parent-child relationship, and the parent's capacity to nurture and protect her young child. They help infant mental health practitioners engage and sustain relationships with parents, as they think deeply about the social and emotional health and needs of each parent and very young child (Weatherston, 2000):

Identify and respond to immediate concrete service needs, to the extent necessary and possible.

Meet with the infant and parent together throughout the period of observation, assessment, and intervention, nurturing relationships and using them as instruments of change.

Invite parents to talk and listen carefully to what each parent has to tell you.

Sit beside the parent to observe the infant or toddler's growth and development.

Offer anticipatory guidance to the parent that is specific to the infant or young child, remaining sensitive to the parent's readiness to listen.

Alert each parent to the infant's or toddler's accomplishments and needs.

Create opportunities for pleasurable interaction between parent and infant.

Allow the parents to set the agenda and take the lead.

Identify and enhance the capacities that each parent brings to the care of the infant or toddler.

Speak for the infant and parent on behalf of their developmental and relationship needs.

Wonder about the parent's thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood.

Listen for the past as it is expressed in the present.

Allow core relational conflicts and emotions to be expressed; hold, contain, and talk about them as the parent is able.

Attend and respond to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant, the infant's development, the parent's emotional health, and the early developing relationship.

Identify, treat, and collaborate with others in the treatment of disorders of infancy, delays and disabilities, parental mental illness, and family dysfunction.

Use the supervisory relationship as a context for personal and professional development.

Remain open, curious, and reflective.

All of these strategies support key tasks within infant mental health practice: to develop a trusting relationship with each infant and family referred, to identify emerging capacities and risks in infancy and early parenthood, and to construct an intervention that nurtures and sustains the parent-child relationship. Together, these approaches help define the unique specialization of infant mental health (Weatherston, 2000; Weatherston & Tableman, 2002).

Key Tasks of Infant Mental Health Practice: Developing Relationships

Attention to relationship provides the focus for infant mental health practice. The infant mental health practitioner understands that the development of a trusting relationship with each infant and family referred offers the hopefulness for intervention and substantive change. The practitioner also understands that the relationship between parent and infant or parent and toddler provides the focus for treatment rather than the infant alone or the parent in isolation. Finally, the practitioner knows that the supervisory relationship offers multiple opportunities for learning and reflective practice. What follows is a brief discussion of each of these relationships and their importance to infant mental health practice.

THE PARENT-PRACTITIONER RELATIONSHIP. The working relationship between parent and practitioner is fundamental to growth and change within an infant mental health intervention (Lieberman & Zeanah,

1999). A parent in treatment learns about relationships through interactions with the practitioner, who is consistently available, sensitive to the needs of the parent, and emotionally responsive (Lieberman & Pawl, 1993). Within the context of this working relationship with the infant mental health practitioner, a parent has the opportunity to feel supported, protected, nurtured, and cared for.

For some parents, the relationship offers a "corrective emotional experience" (Lieberman & Pawl, 1993, p. 430). For other parents, the relationship provides "moments of meeting" with the practitioner, helping them to discover what is intensely important about interaction and response when there is a basis for mutual trust (Morgan, 1998). The working relationship offers parents opportunities to learn about relationship and to transfer that understanding to new interactions and ways of relating to their infant or young child. It is the relationship between parent and practitioner that offers a context for growth and change between parent and infant.

The working relationship begins with the practitioner's undivided attention to what a parent wants or needs and where the parent wants to begin. The practitioner's invitation to a parent to talk and the practitioner's willingness to listen are hallmarks of best practice. Reliability, consistency, and follow-through are equally important, especially as the relationship is beginning. In addition, the practitioner's sincere interest in the infant or toddler, balanced with concern for the parent's emotional well-being, helps the working relationship develop.

The development of a working relationship takes time and energy. The practitioner needs to be patient, aware of the family's need to move slowly and to develop courage in learning to trust and accept help. The practitioner needs to be willing to reach out, often many times. The practitioner needs to persist in face of many challenges (for example, crowded homes, intrusive visitors, severe disorganization, missed appointments). Often tentative, the relationship between parent and practitioner needs to be carefully constructed and protected.

Resistance may mean that a parent is fearful of entering into the relationship with the infant mental health practitioner. The practitioner thinks about the meaning of the parent's resistance, addresses it with the family, and is often able to reduce the parent's worry as they reach an agreement about their work together. Engaging parents and infants in relationship-based work requires training, practice, and continuing support.

THE PARENT-INFANT RELATIONSHIP. The working relationship between parent and practitioner provides a context in which parent and practitioner are able to consider the parent-infant relationship. Working with parent and infant together, the practitioner has multiple opportunities to observe and wonder about their developing relationship (Trout, 1987; Weatherston & Tableman, 2002). What is the nature of their interaction with each other? Is there a sense of reciprocity between them? How much pleasure does there seem to be? Are they emotionally available to each other, or are there frequently missed cues and misunderstandings? Is there a feeling of warmth or affection between them?

Sensitive inquiry might include questions about the parent's experience of the infant, the meaning of the infant to the parent, what the parent cherishes about the infant, and what is difficult. The practitioner may use what she sees in the interaction to ask about the parent's caregiving experience of the infant or toddler. Or the practitioner may ask questions about other babies or early care experiences that now affect the interaction with this baby. There is no script in infant mental health, only the guiding principle that it is the development of an infant or toddler within the caregiving relationship that provides the focus for the work.

THE PRACTITIONER-SUPERVISOR RELATIONSHIP. There is a third relationship that is significant to the first two: the supervisory relationship. Selma Fraiberg believed that infant mental health could be most successfully taught and explored within the supervisory relationship between a senior staff person and an individual trainee. Her unwavering belief that relationships affect relationships influenced the service that she and her staff developed to guide and support parents and infants (Fraiberg, 1980). This commitment to reflective practice influences the shape of infant mental health practice today (Schafer, 1992).

Respect, mutuality, and safety characterize what is optimal within the supervisory relationship (Shahmoon-Shanok, 1992). It is within a trusting supervisory relationship that an infant mental health practitioner grasps what is fundamental about infant mental health practice: the power and centrality of relationship. All of the work that is carried out with infants, toddlers, and families requires a belief and commitment to relationship. The practitioner's opportunity to be in a sustaining relationship with a supervisor while providing relationship-based services to infants and families is crucial to best practice within the infant mental health field.

In sum, these three relationships form the overarching context for thinking about infant mental health practice: the relationship between parent and practitioner, the relationship between parent and infant, and the relationship between practitioner and supervisor.

Key Tasks of Infant Mental Health Practice: Identifying Capacities and Risks

The ability to identify capacities and risks in infancy and early parenthood is essential to infant mental health practice. For the purpose of this discussion, the emphasis will be on understanding risk factors generally considered in referring and enrolling infants, toddlers, and parents for infant mental health services. However, it is important to keep in mind that risk is understood within the context of capacity. The infant mental health practitioner is always balancing risk with capacity and asking this question: Where does the hopefulness lie?

Most generally, the indications of risk and need for supportive intervention are identified within the infant or toddler, the parent or caregiving figure, the developing parent-child relationship, and the context in which the infant and parent live. In some instances, the risks are constitutional and rest mainly with the infant or toddler. In other instances, the risks cluster around the parent as primary caregiver, often the mother. In many cases, there are worries about both child and parent, including constitutional and maturational factors, psychosocial indicators, and the context of relationship-care (Emde, 1989).

A trainee or practitioner new to the practice of infant mental health becomes familiar with many risk indicators, in order to observe or inquire about them, listen carefully to the parent's concerns, and relate them all, in partnership with parents, to a meaningful service plan. At the same time, the trainee or practitioner keeps in mind the infant or toddler's strengths, parental capacities to provide adequate care, and aspects that offer hopefulness for development and change. The last is often a challenging requirement, but it is extremely important to the early work with a family.

IDENTIFICATION OF RISK: FOCUS ON THE INFANT OR TODDLER. Practitioners learn to appreciate the variety of risks that encompass early development programs. The infants referred may be constitutionally vulnerable babies who cannot wait beyond the first weeks or months of life for prevention or early intervention support. They may be

premature babies, underweight, irritable, difficult to comfort, or difficult to feed. Slow to gain or failing to thrive, they are at high risk for significant disabilities or developmental delays. Others may be difficult to engage, inattentive, unresponsive, withdrawn. Still others may be highly active and hypersensitive, disorganized in their approaches to people or playthings, and unable to send clear signals to tell their caregivers what they want or need. They may be unrewarding babies to take care of and at high risk for problematic care.

Some babies may be referred because of maturational concerns. A health care provider may suspect a delay in one or several developmental domains (for example, slow to sit or crawl, slow to smile or respond, unable to separate). A parent may worry about a disturbance in development, a regression, or a developmental arrest. Still other referrals may be made because of a toddler's behavior (for example, biting, head banging, aggression that is out of control, significant withdrawal, emotional retreat). Infant mental health practitioners must learn to recognize a range of conditions in early infancy in order to become familiar with a range of developmental risks and delays.

IDENTIFICATION OF RISK: FOCUS ON THE PARENT. In a substantial number of cases, a referral may be made during pregnancy or immediately following a baby's birth. The pregnancy may be healthy and the infant may be constitutionally robust at delivery, with capacities to adapt and interact from the moment he opens his eyes. The referral is made because someone is worried about the parent or parents. Will the parent be able to take care of the baby without clinical support?

What factors may concern practitioners? If pregnant, a parent may express strong ambivalence or hostility about the birth of another child. A woman may have considered abortion or adoption up until the delivery of her baby. She may have lost previous pregnancies or delivered a stillborn child. Older children may have been removed to foster care due to substantiated reports of abuse or neglect. All of these factors raise red flags and suggest that the supportive presence of an infant mental health therapist may reduce the risk of rejection of the new baby, a jeopardized attachment relationship, neglect, abuse, or developmental delay.

Other conditions may also place infants and infant-caregiver relationships at risk. The primary caregiver, usually the mother, may appear unprepared for the care of a baby, overburdened, or seriously depressed. She may be inattentive to the baby's needs, unable to be

emotionally present. She may not be able to hold or feed or provide routine care. She may not be able to enter into a loving relationship, provide developmental encouragement, or keep the baby safe. A parent may have a history of early and unresolved losses that make the care of this baby troublesome (for example, extended separations in early childhood, maternal rejection, neglectful care, placement in foster care).

Another parent may be too young, alone in the care of her baby, impulsive or unrealistic in the expectations that she has. Of additional concern is a parent who has a serious mental illness or developmental delay and when faced with the responsibilities of parenthood is not able to provide consistent or contingent care. All of these factors place an infant or toddler and parent at risk. Early referral to an infant mental health service for assessment and treatment may reduce the likelihood of developmental failure, abuse, or parental neglect.

IDENTIFICATION OF RISK: FOCUS ON THE CAREGIVING ENVIRONMENT. The context in which an infant or toddler is raised is an additional and important concern. Homelessness, hunger, joblessness, poverty, alcoholism, and drug use place enormous burdens on families. These factors exacerbate the risks that parents face in taking care of their children and in responding to their needs to be fed, clothed, sheltered, comforted, and kept safe. Any of these conditions may place infants and families in jeopardy and at risk for developmental failures. In combination, they alert infant mental health practitioners to a family's need for immediate outreach, observation and inquiry, careful listening, nurturance, and relationship-focused responses.

Key Tasks of Infant Mental Health Practice: Developing a Plan for Intervention

It is important to understand that from an infant mental health perspective all contacts with an infant and family are integral to the intervention process. The first phone contact, early observations, and formal assessment experiences affect the infant and family and need to be seen as part of a continuum of service to the family (Meisels, 1996). How might the infant mental health practitioner develop a plan through careful observation, assessment, and intervention?

There are several different ways in which the practitioner might work (Stern, 1995). The practitioner may look closely at the infant's

behavior within the context of the parent-infant relationship and work hard to bring about change there. The practitioner may focus on the parent's behavior in an effort to increase sensitivity to the infant or toddler's needs. The practitioner may work at the representational level, alert to the parent's thoughts and feelings about the infant and the meaning of early parenthood and change. In addition, the practitioner may focus on the interaction between parent and infant and their relationship, secure or insecure.

The Fraiberg model of infant mental health service encourages the infant mental health practitioner to consider all of these things as appropriate to an individual infant and parent pair. In addition, the practitioner integrates these in developing an approach that is interactional, behavioral, and psychodynamic (Hofacker & Papousek, 1998).

The infant mental health practitioner often visits families in their homes. Close to the source, the practitioner has many opportunities to watch the infant and parent together, to ask questions, to listen, to support their interactions and offer help within the context of the therapeutic relationship. The practitioner enters without judgment and makes the family comfortable. The practitioner is sensitive to the parent who is vulnerable: the mother who finds it difficult to hold and feed her baby, the father whose baby has multiple disabilities and delays, the foster mother who is caring for two toddlers who were removed from their mother's care.

Carefully following the parent's lead, the practitioner observes who is there and what is happening, asks careful questions, listens, and responds respectfully. A guest, the practitioner does not overwhelm, intrude, or offer judgments prematurely. The practitioner is there to learn what concerns the parents have and how to help them (Weatherston, 1997).

Clinical Questions

The questions raised in the following sections guide practitioners in their efforts to learn what is important when assessing the capacities and the risks of each infant or toddler and family referred for infant mental health or early developmental services. The questions are meant to encourage reflection. They may or may not be asked directly. The practitioner needs to approach each family individually and take great care when interviewing for clinical concerns (Hirshberg, 1996; Trout, 1987; Weatherston & Tableman, 2002).

THE BABY. The infant, small and dependent on a parent for protection and care, is a powerful and essential player in infant mental health practice. What does the baby contribute? How will the practitioner use knowledge and understanding about the baby to support developing competencies and reduce impending disorders or delays?

As the infant mental health practitioner works with the parents and infant together, there will be many opportunities to observe the baby and learn what life is like for them all. What experiences has the baby had that influence caregiving now? What is going well? What are some of the immediate risks?

More specific questions include the following: What does the baby look like? How interested is the baby in people and playthings? How able is the baby to communicate wants or needs? What language capacities are emerging? How adequately are the infant's basic needs for food, warmth, comfort, and protection met? Who cares for, plays with, or responds to the baby? Questions like these may be answered as the infant mental health practitioner sits at the kitchen table, observing parent and child together.

The practitioner may also wonder about the baby's history and early experience. What were the circumstances of pregnancy, labor, and the baby's birth? Has the baby been hospitalized or separated from the mother's care? Has the baby been exposed to domestic violence or trauma? These questions need to be asked with respect and as the parent is able to think about them.

A well-trained practitioner should also be familiar with developmental screening and assessment instruments to strengthen observation capacities. Guides such as the Denver II Developmental Screening Test (Walker, Bonner, & Milling, 1984) and the Ages and Stages Questionnaires (Squires, Potter, & Bricker, 1999) have been designed to help practitioners and parents screen for capacities and risks. The Bayley Scales of Infant Development (Bayley, 1993) and the Washington Guide for Promoting Development in the Young Child (Barnard & Erickson, 1976) are assessment tools that help professionals and parents consider the uniqueness of an infant or toddler's development and answer particular developmental questions.

These formal instruments guide practitioners and parents in focusing on the infant's adaptive and developing capacities, celebrating emerging strengths and describing observed behaviors and delays. In sum, screening and assessment tools provide a structure for

observation and questioning about a baby's progress and concerns that parents and practitioners may have that are related to development, emerging capacities, and risks.

More recently, practitioners from a variety of fields and across disciplines worked together through the Zero to Three Task Force in Washington, D.C., to design a diagnostic framework to address mental health and developmental disturbances for infants and young children from birth to three years of age. The task force published the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* in 1994. This systematic approach to the early identification of developmental and behavioral disorders strengthens the infant mental health practitioner's ability to assess and diagnose infants and toddlers referred for treatment services.

The primary diagnostic categories include traumatic stress disorder, disorders of affect, depression, reactive attachment deprivation, regulatory disorders, and pervasive developmental disorders, to name a few. The recognition of these disorders in infancy and early childhood increases the possibility of early intervention in the first years of life, which reduces risk and makes restoration of health much more likely.

THE PARENT. Infant mental health service is complex. The practitioner needs to observe the parent who is caring for the infant. Initial questions to guide the practitioner include the following: How does the parent look or behave when you are present? How does the parent appear to feel about herself or himself? How well does the parent seem to know the baby? How attentive is the parent to the baby's wants and needs and emotional states? How does the parent respond when the baby is hungry, uncomfortable, or distressed? How able is the parent to interact with the baby in a playful or appropriate manner?

For some families, parental histories of unresolved loss, abuse, or neglect may interrupt the parent's capacity to provide appropriate, nurturing care. These issues place infants and relationships at serious risk. Assessment and intervention require extraordinary sensitivity to the parent, attention to the caregiving relationship, and responsiveness to the parent's own relationship history and intense longing for consistent care (Wright, 1986). Such issues are best explored within a trusting therapeutic relationship, while talking with the parent over a period of time.

A CONTEXT FOR CARE. The context in which an infant or toddler and parent develop is also important to understand and assess. The Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell & Bradley, 1978) contains forty-five items collected by observation and interview. The HOME Inventory helps practitioners consider the emotional and verbal responsiveness of the parent, the organization of the baby's world, opportunities for play, and caregiving routines. Training in the use of the HOME Inventory strengthens the practitioner's skillfulness in observing details of the environment that affect a small child's development and can easily be incorporated into strategies for relationship-based assessment and continuing intervention. The HOME Inventory is a critical observation tool for infant mental health and early intervention practice.

REPRESENTATIONS. The infant may represent many people, past and present, who have been important to the parent (Fraiberg, 1980). The infant mental health practitioner observes and listens carefully, wondering whom the baby might represent to the parent (for example, an abusive uncle, an abandoning mother, a grandparent, a sibling who required attention and care). It may be the representation, rather than attributes of the real baby, that makes the care of the infant or toddler difficult and interrupts the relationship. Over time, and within the context of their working relationship, a parent may share stories that suggest whom the baby represents and what the troubling aspects of the relationship included.

The infant may represent the parent as a small child. Faced with the neediness of a very small infant, the parent may feel all over again her own helplessness and may reenact, quite unconsciously, neglectful or inconsistent or teasing patterns representative of her own early care. Alert to the struggle, the infant mental health practitioner wonders what other baby may have been neglected or hurt, abandoned or teased. The earlier neglect or trauma may never have been spoken about before.

Within the context of the therapeutic relationship, aspects of early care may be more safely reexperienced, feelings attached to them expressed, and representations explored. It is not *this* infant who is causing the difficulty. It is the other infant, the remembered infant, and all that he or she now represents that is posing problems for the caregiver.

By separating the past from the present and talking about it, the infant mental health practitioner addresses the "ghosts" and helps

protect a parent from repeating a hurtful cycle of care (Fraiberg, 1980). It is this experience that awakens possibilities for different interactions with the infant or toddler and provides a context for more positive care. The discovery is often instrumental in effecting change in the quality of the relationship between parent and child (Trout, 1987; Lieberman & Pawl, 1993; Lieberman & Zeanah, 1999).

INFANT-PARENT INTERACTIONS. The infant allows a story to be told. The way in which a parent handles the baby, gestures of care, playful interactions or the absence of interactions suggest to the infant mental health practitioner what is going well but also what some of the conflicts, as yet unexpressed, might be. For example, the parent may cuddle the baby comfortably and stroke his arm as he falls asleep. The practitioner notices how easily the parent responds to the baby's need for a nap and comments on the parent's ability to read the baby's cues correctly.

Alternatively, the parent may leave the baby to cry in a darkened room while she cleans the kitchen. She responds at last, fixing a bottle and propping it, leaving the baby to feed alone. The baby sucks greedily and the parent observes angrily, "She'll eat me out of house and home if I let her." The practitioner may wonder what has happened to put such distance between the two. What demands does the baby make? What does the baby contribute to the difficulty between them?

She may also wonder how lonely and hungry the parent is. How many of her own needs are met and by whom? The infant mental health practitioner may ask, "Can you tell me about the baby and your caregiving routine? What have the first weeks with the baby at home been like for you? Who has been here to help you? Would it be helpful to talk about this?" The practitioner pays careful attention to the interactions, the nonverbal cues and the responses that carry complex messages about the baby, the parent, and the context of care.

Because infants develop within a context of caregiving relationships, the practitioner must learn to look at each infant with an eye on interaction and relationship development. There are many formal scales that invite the study of infants or toddlers in interaction with parents or caregivers. Two that are of particular interest are the Feeding and Teaching Scales from the Nursing Child Assessment Satellite Training (NCAST) Project (Barnard, 1976) and the Massie-Campbell Scale of Mother-Infant Attachment During Stress (ADS) (Massie & Campbell, 1983).

The NCAST captures the essence of interaction and relationship by teaching practitioners to focus on the infant's ability to signal wants or needs clearly as well as the mother's sensitivity and responsiveness to her baby's cues. The ADS assesses the infant's use of the parent-child relationship when under stress and the parent's ability to comfort or respond. These instruments guide the practitioner to look at the infant or toddler within a particular relationship. In a field that prides itself on relationship-based practice, these instruments are particularly useful.

Once trained in the use of these measures, the practitioner is better prepared to examine what the infant and the parent each contribute to the relationship and their developing capacity to signal and respond. In actuality, the practitioner may use these measures as frames of reference when thinking about the child and family. The observation skills that each practitioner develops when learning to use these tools are fundamental to careful infant mental health practice.

Relationship disorders may be identified by referring to the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (1994). In addition to focusing on the young child's presenting symptoms and behaviors, this classification system examines the parent-infant relationship as crucial to the diagnostic profile of the child. Disturbances and disorders are identified within specific interactive patterns and relationships. Relationships may be described as overinvolved, underinvolved, anxious and tense, angry and hostile, or abusive. The use of the classification system supports the practitioner's ability to identify characteristics of a relationship and develop an appropriate service plan.

The next section discusses the preparation of infant and family practitioners to work from an infant mental health perspective. The discussion is introductory and offers general training guidelines and principles. More detailed discussions on training appear later in this volume.

INFANT MENTAL HEALTH TRAINING

What training experiences do practitioners from multiple disciplines need to have to prepare them for infant mental health services? Training requirements are complex. First, practitioners need to build a knowledge base from which to understand infants or toddlers and the adults who care for them, as well as the complexity of early relationship development. Second, they need to develop a wide variety of practice skills appropriate for observation, assessment, and intervention with

children under the age of three and with caregivers whose capacities and needs vary. Third, they need opportunities in which to discuss the details of what they see and hear, a place in which to ask questions about infancy and early parenthood, relationship risks, disorders of development, and strategies for effective work. Fourth, they need individual guidance and opportunities for reflection with a training supervisor who is knowledgeable about early development and relationships and is able to sustain them in their work.

These four training elements—a knowledge base, skill development through direct service experiences, opportunities to question, and reflective supervision—are consistent with the training experiences first proposed by Fraiberg and her colleagues in the Child Development Project in Ann Arbor, Michigan, in the 1970s (Fraiberg, 1980). They reflect the early training guidelines recommended by the Michigan Association for Infant Mental Health in 1983 and revised in 2002 to influence the design of university and community-based programs in the preparation of infant mental health trainees and to strengthen the practice of infant mental health (Michigan Association for Infant Mental Health, 1983/2002).

The training elements mirror the training principles proposed by staff affiliated with the National Center for Clinical Infant Programs in Washington, D.C., who are highly regarded for their leadership in preparing infant and family practitioners (Fenichel & Eggbeer, 1990). They also reflect current thinking among those who are preparing practitioners from multiple disciplines to assess and treat young children with respect to the social and emotional context in which they are raised (Meisels & Fenichel, 1996; Harmon & Frankel, 1997; Lieberman, Van Horn, Grandison & Pekarsky, 1997; Weatherston & Tableman, 2002; Trout, 1987; Fisher & Osofsky, 1997).

Unique in its focus on children under the age of three, on parents, and on relationships, the practice of infant mental health requires specific course work and supervised, clinical training. Graduate students, interns, and professionals from a wide range of disciplines need to learn how to identify capacities and risks in infancy and early parenthood and how to structure relationship-based interventions.

Principles of Practice

Infant mental health principles, stated eloquently by Fraiberg (1980) and restated by Hirshberg (1993), Lieberman and Pawl (1993), Lieberman, Van Horn, Grandison, and Pekarsky (1997), Meisels and Fenichel (1996),

Meisels and Provence (1989), Trout (1987), and Weatherston and Tableman (2002), are integral to infant mental health practice and early development services. They shape the ways in which practitioners approach infants and families and influence the ways in which infants and families may be understood.

Trainees who are new to the field of early intervention or infant mental health will use these principles to guide them in their work. For some, the "rules" will seem odd or inconsistent with previous training they have had. They may struggle to integrate a relationship-guided assessment approach with one that focuses more individually on an infant or the parent of a child. Over time and within the context of supportive training relationships, infant mental health practitioners and trainees from very diverse fields can learn to provide relationship-based assessments and interventions with the following important tenets in mind.

INFANT AND PARENT TOGETHER. First, the trainee watches the baby in the context of a relationship in order to understand who that baby is, what the baby brings into the relationship, what the caregiver provides, and the nature of their relationship with each other. Looking at one or the other alone will yield half of the story. As Winnicott (1965) so beautifully reminds us, "There is no such thing as an infant" (p. 39). By this statement, he meant that there is always a baby and a caregiver. This powerful concept directs the infant mental health practitioner to consider both infant and parent together, not one in isolation from the other.

FAMILIAR SETTING. Second, the assessment occurs in a setting familiar to the baby and to the family—most ideally, the home. The trainee observes the surroundings in which a young child is raised in order to understand what life is like for the baby and the parent, what is going well, and basic wants or needs.

Another argument, eloquently stated by Fraiberg (1980), is the fact that a parent caring for a new baby and overwhelmed by the baby's care may find it difficult to get out of the home. Lack of reliable transportation for many families makes this even more problematic. Some parents and infants may need the trainee to reach out, knock on the door, and enter their home. In addition to better ensuring that the infant and family will be seen for an assessment, visits in the family's own home may be more comfortable and less threatening than those

at an unknown agency. Of additional importance, home visiting may strengthen the working relationship between the practitioner and family, reinforcing the practitioner's interest and offering a basis for greater trust.

TIME. A third important principle involves the number of visits needed to appreciate the problem with the baby or the reason that the infant and family were referred. Fraiberg (1980) advised her staff many years ago that an assessment might occur over four to six visits, including the use of informal and formal strategies. Others suggest four to eight visits (Lieberman et al., 1997). It is important to understand that a thoughtful, systematic assessment takes time. The process requires attention to the concerns that parents have, the opportunity for a relationship to develop with the infant or toddler's parents, structured and unstructured observations, details of the child's development, and family stories, past and present (Greenspan & Meisels, 1996). The trainee needs time to observe, listen, and begin to understand what is going well in a particular family, in addition to what concerns exist and how to be helpful.

WORKING RELATIONSHIPS. Finally, but of singular importance, is the fact that parents must be considered partners throughout the assessment process. The working relationship between each parent and infant mental health trainee is vital to the success of the assessment (Davies, 1992). A parent or caregiver is present, allows the practitioner to be involved, and understands why the infant has been referred. One significant challenge that the new practitioner or trainee faces is earning the parent's trust. Without trust, very little intervention can happen. In relationship-focused service, a working alliance with each parent or caregiver on behalf of a young child is considered essential for best practice.

Translating Principles into Practice

With these ground rules in place, how do trainers or supervisors help trainees reach an understanding of the infants and families referred to them for services? What tools do they need to guide them through the process? What training techniques encourage clinical growth? How can trainers or supervisors move trainees from knowledge to application? What follows is a brief discussion of methods that translate infant mental health principles into practice.

TRAINING TECHNIQUES. An infant mental health trainee or practitioner needs to learn to observe and listen carefully to a family referred for assessment or treatment services. Course work, as well as observation experiences with a typically developing, low-risk infant and family, prepares a practitioner-trainee to assess strengths and risks when an infant or toddler and family is referred for assessment or treatment. In instances where there is no formal training program or where it is not possible to observe a low-risk infant and family, the training supervisor plays a particularly important role. Experienced in providing relationship-based assessments and treatment services, the training supervisor will need to guide practitioners as they develop the art of careful observation, listening, and relationship-focused practice.

In all instances, the practitioner-trainee must learn how to define the relationship (Schafer, 1995; Zeanah et al., 1997). This means that the practitioner-trainee will try to observe and understand the infant and parent within the context of their relationship with each other. This will help the practitioner appreciate the dynamics of interaction moment to moment and to contain the feelings expressed or aroused. In order to do this, the trainee needs to observe the infant and parents together. For many, this is a unique requirement.

Students and professionals are customarily trained to work either with children or with adults. By contrast, practitioners within the field of infant mental health are taught to work with the infant and parent together (Fraiberg, 1980; Trout, 1982; Lieberman & Pawl, 1993). In relationship work, the presence of the parent is considered vital in understanding the infant (Hirschberg, 1993). Of equal importance, the presence of the infant is a powerful contributor to understanding the dynamics of relationship within families and caregiving responses, both nurturing and problematic.

When possible, trainees may arrange to visit parents and infant in the home, at a time that is convenient for the family. In instances where home visiting is not possible, trainees will work with parents and infant in an office, playroom, or center-based program. Regardless of the location, trainees must be taught to approach families with kindness and respect, keeping in mind the centrality of the therapeutic relationship to the success of assessment and treatment.

These expectations are consistent with infant mental health practices as described by Fraiberg (1980), Lieberman and Pawl (1993), Wright (1986), Weatherston and Tableman (2002), and Trout (1987). They are most important when a parent expresses concern about the

development of an infant, when a professional is worried about the caregiving capacity of a parent, or when an agency suspects a relationship disturbance or disorder due to serious neglect or abuse or placement in foster care.

THE SUPERVISORY RELATIONSHIP. The supervisory relationship is crucial to the development of clinical competency within the field of infant mental health. Whether enrolled in a formal training program or learning about infant mental health practice on the job, a practitioner new to the field of infant mental health needs a supervisor who will guide and support the integration of knowledge about infancy and early parenthood with best practice skill.

Because relationships affect relationships, the supervisory relationship offers the trainee a context for clinical growth that shapes the trainee's capacity to offer the same to the infants and families served. Secure in the relationship with a trusted supervisor, the trainee is encouraged to think deeply about infants and families and services within an infant mental health framework. The trainee also learns to reflect on personal aspects of infant mental health work. Over time, and within the context of the supervisory relationship, the trainee or practitioner new to the field integrates principles with practices of infant mental health.

"So . . . why are you here?" the young mother of two small children asks. Her question is a pointed and poignant one. The answer is complex. The infant mental health practitioner is there to support the social and emotional well-being of an infant and toddler within the caregiving relationship with their mother. The task is an ambitious one. It will require patience and persistence on the part of the practitioner, as well as careful observation, sensitive inquiry, and thoughtful response. It will require courage on the part of the parent to be present and to enter into a working relationship with the practitioner on behalf of her young children and herself. The practitioner will listen carefully, understand the parent's agenda, communicate clearly, and invite a supportive relationship with the family.

Once the relationship is under way, parent and practitioner will begin to acknowledge what is going well and what is not, what the children's developmental capacities are and where the risks lie, what the mother's caregiving strengths are and where the concerns lie.

Together they may wonder about the mother's feelings related to the care of two small children and the changing responsibilities of parenthood. They may discover core relational conflicts, old hurts, and unresolved losses that make the care of her children difficult. Their work together may take many months. Parent and practitioner will need to remain open, curious, and reflective. In sum, they will embark on a journey together, looking for the "treasure" that Selma Fraiberg (1980, p. 3) so artfully described—new knowledge and understanding "returned to babies and their families as a gift from science."

References

Barnard, K. (1976). *Nursing child assessment satellite training project: Learning resource manual.* Seattle: Department of Health, Education, and Welfare, Health Resources Administration.

Barnard, K., & Erickson, M. (1976). *Teaching children with developmental problems: A family care approach.* St. Louis: Mosby-Year Book.

Barron, C. (2002). Nurturing a family when there is a nonorganic failure to thrive diagnosis. In J. Shirilla & D. Weatherston (Eds.), *Case studies in infant mental health: Risk, resiliency and relationships* (pp. 105–120). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Bayley, N. (1993). *Bayley Scales of Infant Development—Second Edition (BSID-II).* San Antonio: Psychological Corporation.

Blos, P., & Davies, D. (1993). Extending the intervention process: A report of a distressed family with a damaged newborn and a vulnerable preschooler. In E. Fenichel & S. Provence (Eds.), *Development in jeopardy* (pp. 51–92). Madison, CT: International Universities Press.

Caldwell, B. M., & Bradley, R. H. (1978). *Home observation for measurement of the environment.* Little Rock: University of Arkansas at Little Rock.

Cohen, R., Muir, E., & Lojkasek, M. (1999). *Research summary.* Toronto: Hincks-Dellcrest Centre.

Daligga, B. (2002). Margrete and her babies: Creating a holding environment for a cognitively impaired mother and her children. In J. Shirilla & D. Weatherston (Eds.), *Case studies in infant mental health: Risk, resiliency and relationships* (pp. 137–152). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Davies, D. (1992, April). *Beginning an infant mental health case.* Paper presented at the Michigan Association for Infant Mental Health Conference, Ann Arbor, MI.

Diagnostic classification: 0–3. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (1994). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Emde, R. (1989). The infant's relationship experience: Developmental and clinical aspects. In A. J. Sameroff & R. N. Emde (Eds.), *Relationship disturbances in early childhood* (pp. 33–51). New York: Basic Books.

Fenichel, E., & Eggbeer, L. (1990). *Preparing practitioners to work with infants, toddlers and their families.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Fisher, C., & Osofsky, J. (1997). Training the applied developmental scientist for prevention and practice: Two current examples. *Social Policy Report, 11*(2), 6–18.

Fraiberg, S. (Ed.). (1980). *Clinical studies in infant mental health.* New York: Basic Books.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. *Journal of the American Academy of Child Psychiatry, 14,* 387–421.

Greenspan, S. I., & Meisels, S. (1996). Toward a new vision for the developmental assessment of infants and young children. In S. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 11–26). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Harmon, R., & Frankel, K. (1997). The growth and development of an infant mental health program: An integrated perspective. *Infant Mental Health Journal, 18,* 126–134.

Hirshberg, L. (1993). Clinical interviews with infants and their families. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 173–191). New York: Guilford Press.

Hirshberg, L. (1996). History-making, not history-taking. In S. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 85–124). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Hofacker, N., & Papousek, H. (1998). Disorders of excessive crying, feeding and sleeping. *Infant Mental Health Journal, 19*(2), 180–201.

Lieberman, A. F., & Pawl, J. H. (1993). Infant-parent psychotherapy. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 427–443). New York: Guilford Press.

Lieberman, A. F., Van Horn, P., Grandison, C., & Pekarsky, J. (1997). Mental health assessment of infants, toddlers, and preschoolers in a service program and a treatment outcome research program. *Infant Mental Health Journal, 18,* 158–170.

Lieberman, A. F., & Zeanah, C. H. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment* (pp. 555–574). New York: Guilford Press.

Massie, H., & Campbell, B. K. (1983). *Attachment during stress.* San Francisco: Children's Hospital and Medical Center.

McDonough, S. (1993). Interaction guidance: Understanding and treating early infant-caregiver relationship disturbances. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 414–426). New York: Guilford Press.

Meisels, S. (1996). Charting the continuum of assessment and intervention. In S. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 27–52). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Meisels, S., & Fenichel, E. (Eds.). (1996). *New visions for the developmental assessment of infants and young children.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Meisels, S., & Provence, S. (1989). *Screening and assessment: Guidelines for identifying young disabled and developmentally vulnerable children and their families.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Michigan Association for Infant Mental Health. (1983/2002). *Training for infant mental health specialists: Suggested guidelines for teaching institutions.* East Lansing: Michigan Association for Infant Mental Health.

Morgan, A. (1998). Moving along to things left undone. *Infant Mental Health Journal, 19*(3), 324–332.

Oleksiak, C. (2002). Risk and resiliency: Failure to thrive in the first year. In J. Shirilla & D. Weatherston (Eds.), *Case studies in infant mental health: Risk, resiliency and relationships* (pp. 41–50). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Pawl, J. H. (1994). On supervision. *Zero to Three, 15*(3), 21–29.

Pawl, J. H., & Lieberman, A. F. (1997). Infant-parent psychotherapy. In J. Noshpitz (Ed.), *Handbook of child and adolescent psychiatry* (Vol. 1, pp. 339–351). New York: Basic Books.

Proulx, G. (2002). Learning to see her son: A baby and his mother. In J. Shirilla & D. Weatherston (Eds.), *Case studies in infant mental health: Risk, resiliency and relationships* (pp. 15–25). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Schafer, W. (1992). The professionalization of early motherhood. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook* (pp. 67–75). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Schafer, W. (1995). *Clinical training seminar.* Course materials. Wayne State University, Detroit, Michigan.

Shahmoon-Shanok, R. (1992). The supervisory relationship: Integrator, resource and guide. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook* (pp. 37–41). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Shirilla, J., & Weatherston, D. (Eds.). (2002). *Case studies in infant mental health: Risk, resiliency and relationships.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Squires, J., Potter, L., & Bricker, D. (1999). *Ages & Stages Questionnaires: A parent-completed, child-monitoring system* (2nd ed.). Baltimore: Brookes.

Stern, D. (1995). *The motherhood constellation.* New York: Basic Books.

Stinson, S., Tableman, B., & Weatherston, D. (2000). *Guidelines for infant mental health practice.* East Lansing: Michigan Association for Infant Mental Health.

Trout, M. (1982). The language of parent-infant interaction. In J. Stack (Ed.), *The special infant* (pp. 265–282). New York: Human Sciences Press.

Trout, M. (1987). *Working papers on process in infant mental health assessment and intervention.* Champaign, IL: Infant-Parent Institute.

Walker, C., Bonner, B., & Milling, K. (1984). Denver Developmental Screening Test. In D. J. Keyser & R. C. Sweetland (Eds.), *Test critiques* (Vol. I, pp. 239–251). Kansas City: Test Corporation of America.

Weatherston, D. (1997). She needed to talk and I needed to listen. *Bulletin for Zero to Three, 18*(3), 6–12.

Weatherston, D. (2000). The infant mental health specialist. *Bulletin for Zero to Three, 21*(2), 3–10.

Weatherston, D. (2001). Infant mental health: A review of relevant literature. *Psychoanalytic Social Work, 8*(1), 39–69.

Weatherston, D. (2002). The red coat: A story of longing for relationships, past and present. In J. Shirilla & D. Weatherston (Eds.), *Case studies in infant mental health: Risk, resiliency & relationships* (pp. 187–199). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Weatherston, D., & Tableman, B. (2002). *Infant mental health services: Supporting competencies/reducing risks* (2nd ed.). Southgate: Michigan Association for Infant Mental Health.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment.* Madison, CT: International Universities Press.

Wright, B. (1986). An approach to infant-parent psychotherapy. *Infant Mental Health Journal, 7*(4), 247–263.

Zeanah, C. H., Boris, N., Heller, A., Hinshaw-Fuselier, S., Larrieu, J., Lewis, M., Palomino, R., Rovaris, M., & Valliere, J. (1997). Relationship assessment in infant mental health. *Infant Mental Health Journal, 18*(2), 182–197.

CHAPTER TWO

Using Direct Observation in Prevention and Intervention Services in Infant and Preschool Mental Health

Training and Practice Issues

Martha Farrell Erickson, Ph.D.

When I arrived for my home visit last week with Tina and her baby, Tina's dad answered the door and quickly excused himself to go back to the den where he was watching TV. Three-month-old Nathan was sitting in his infant seat on the living room floor, squirming and fussing. Tina was slumped on the couch about six feet away, talking on the phone. She motioned for me to sit down and continued talking on the phone for another few minutes while Nathan continued to fuss more loudly. He smelled like he had a dirty diaper.

As these case notes from a home visiting program demonstrate, when we work with infants and families, we are observing constantly—with our eyes, our ears, and even our noses. Whether using standardized observation systems or more naturalistic approaches, we use observation to guide us in determining a child's and family's strengths and needs. And we use observation to help us decide how best to work with a family and whether our efforts are paying off. But as even a simple vignette like this one can reveal, drawing meaning from our observations can be complicated.

Consider, for example, what your first thoughts were when you read that vignette about Tina's family. Perhaps you found yourself

thinking what a neglectful mother Tina was to let her baby sit and cry in a dirty diaper while she talked on the phone. And you might be right. But what if Nathan had only started to fuss when you walked in the door? And what if Tina's phone call was particularly serious or disturbing—news about a close friend's death or illness, for example. Or what if this behavior is unusual for Tina, and she ordinarily is very responsive to Nathan's needs?

In a similar vein, you may think that Tina's father is rude to leave the room right after the home visitor enters—and insensitive to ignore Nathan's cries. But would you feel differently if you knew that Tina had told him emphatically that he should stay out of the way during home visits so that she could have the privacy she needs?

This chapter addresses those subtleties and complexities of observation, with an emphasis on principles and strategies for making sense of what we observe and for applying observation in a thoughtful way in prevention and intervention services. Specifically, this chapter focuses on critical issues that must be addressed to ensure that practitioners observe what is most important to the health and well-being of young children and their families. In addition, these critical issues are important in ensuring that practitioners know how to use observations effectively to support optimal development.

The chapter also identifies the basic knowledge necessary for effective use of observation, strategies for training practitioners and determining their competence in the use of observation, and issues to consider in supervising practitioners in their use of observation with families and young children. The chapter concludes with a discussion of observation as intervention, drawing examples from Seeing Is Believing™, an approach that involves videotaping parents and children and then engaging parents in guided self-observation, with an eye toward enhancing parental sensitivity and supporting the child's learning and development.

GENERAL ISSUES RELEVANT TO OBSERVATION TRAINING AND PRACTICE

Because observation is such an omnipresent and ordinary part of our daily lives, it is easy to underestimate the importance of rigorous observation training for practitioners who plan to use observation to make decisions about the children and families they serve. But there are many issues that come into play when we use intentional observation to

better understand such things as behavior, development, strengths, needs, and the effectiveness of intervention. Although issues are varied and sometimes complex, they are summarized here in three categories: *what* we choose to observe, *how* we choose to observe, and *how we make sense of* what we observe.

What We Choose to Observe

Observation is never completely objective. Subjectivity enters from the outset in terms of what we choose to observe. For example, if ten people were asked to go into a child-care center and jot down what they saw, some might describe the physical environment, some might take note of the number of people in the room and their ages and appearances, and others would describe the interactions they observed among the people. Even among those who described interactions, some might focus on affect, some on language, some on physical activity, and some on all of the above. Some would emphasize negative or troubling things, whereas others would highlight the positive. Similarly, in the opening vignette for this chapter, the home visitor could have chosen to describe how tidy and carefully baby proofed Tina's apartment was—or how much the baby had grown since her last visit.

Because, by its very nature, observation is a wide-open process, the choice of what to observe is influenced by a host of factors. These include but are not limited to the observer's theoretical orientation, the purpose of the observation, the observer's beliefs about what is most important to observe to achieve that particular purpose, and even more personal factors, such as the observer's mood or state of mind. What is important in promoting effective use of observation in mental health practice is to make observational factors—biases, if you will—conscious to the practitioner.

As discussed in later sections of this chapter, it is important to be thoughtful and intentional about choosing what to observe. That first decision about observation must be grounded in the best possible knowledge about what is most important to the health and well-being of the child and family and what will inform good decisions about how to support the child's optimal development. Also, as discussed later, it is important to stay open to new discoveries and insights that may lead to different decisions about what to observe. Observation is a dynamic process with the potential to lead a practitioner in new directions with new possibilities. Effective use of observation demands

a fine balance of planning (grounded in knowledge of behavior and development) and flexibility (reflecting openness to discovery).

How We Choose to Observe

A second set of issues revolves around the method of observation. A first important principle is that the method needs to match the purpose. For example, if you are trying to determine if a child's aggressive behavior toward playmates in his child-care center is decreasing, it might be best to observe for an hour every other day during free-play time and count the child's acts of aggression. But if you are trying to understand more broadly how the relationship is developing between a new mother and her infant, it might be best to do a more naturalistic, narrative observation of their interactions across a variety of situations, looking for patterns and sequences of behaviors in both mother and child.

There is a wide range of observation methods available for use in infant and preschool mental health, but describing those varied methods is beyond the scope of this chapter. (For an excellent discussion of different methodologies, as well as practical training exercises, see Boehm & Weinberg, 1997.) There are three broad categories of observation methods that deserve mention here.

First is the category of formal systems, some of which have been standardized on large populations. These may be especially useful when doing systematic assessments of change over time or trying to see how one child or family compares with other children or families of similar age or circumstance. Examples of formal observational measures relevant to infant or preschool mental health include the following:

- The Neonatal Behavioral Assessment Scale (Brazelton, 1973) is designed to assess the responsiveness, soothability, and adaptability of a newborn. It requires specialized training.
- The Home Observation for Measurement of the Environment (Caldwell & Bradley, 1978, 2001) measures the quality and quantity of stimulation and support available to a child in the home environment.
- The Nursing Child Assessment Satellite Training Program (Barnard, 1979) is widely used to assess parent-child interaction during feeding (birth to twelve months) and teaching situations (birth to thirty-six months). It requires specialized training to achieve reliability.

- The Child Behavior Checklist (Achenbach & Edelbrock, 1983) is a measure designed for use by both teachers and parents to rate a child's behavior based on their everyday observations of that child across a variety of situations. Originally developed for school-age children, a later version was designed for children between ages one and a half and five.
- The Parent Behavior Progression rating scales (Bromwich, 1983) are completed by the practitioner after observing a parent and then are used as a guide for intervention aimed at enhancing parental understanding and sensitivity.
- The Parent Infant Relationship Global Assessment Scale (Green, Shirk, Hanze, & Wanstrath, 1994) is a ninety-point scale to assess the quality of the relationship between an infant and a caregiver on a continuum from "well-adapted" to "grossly impaired."
- The Parent-Child Early Relational Assessment rating scales (Clark, 1999) are used to assess the quality of affect and behavior in parent-child interactions, based on observation of videotaped feeding, free play, and a structured task.
- The Functional Emotional Assessment Scale (Greenspan, 1997) is a system to assess the emotional functioning of an infant or young child, yielding information to help clinicians, educators, and parents design an individualized treatment plan and measure progress.
- The Ounce Scale (Meisels, Marsden, Dombro, Weston, & Jewkes, 2003) is an infant-toddler assessment package that includes observation records, family albums, and developmental profiles organized around social interactions, feelings about self, communication, problem solving, and physical coordination.

Beyond such structured rating scales and observation systems, less formal, naturalistic observation methods are used widely in early childhood mental health settings. One common form of naturalistic observation, used often in clinical settings or home visiting programs, involves keeping a narrative record of child behavior or interactions among two or more people without intervening or directing the interaction. Narrative observation is particularly useful when trying to understand what is going on for a particular family, an individual child, or group of children. Within the context of relationship-based programs (for example, home visiting programs for parents and

infants), informal, naturalistic observation often is less intrusive than more structured methods of observation, although taking notes while observing can be disconcerting to adults.

One variation of informal, naturalistic observation is semistructured observation. This typically involves setting up a particular situation within a natural environment. For example, the observer might provide a particular set of toys and watch to see how the child responds to them or might suggest that a parent try a different feeding position and observe to see how that works for the child compared with the usual way of feeding. (As discussed later in this chapter, informal or semi-structured naturalistic observations can be videotaped and used effectively as an intervention to help parents better understand and respond to their children's needs.)

Depending on the purpose of the observation, a practitioner may choose not to keep a narrative record but to count specific behaviors of interest (for example, the number of times a preschooler hits her playmates). One common method is *event sampling,* which involves observing for a period of time (for example, thirty minutes) and counting how many times a certain behavior or set of behaviors occurs. Another method is *time sampling,* which means checking at regular intervals of time (for example, every five minutes) to see *if* a certain behavior is occurring. Time sampling might be used, for example, to measure a preschool child's attentiveness during story time or positive engagement with peers during free play. With both event sampling and time sampling, it is critical that the behaviors of interest are operationally defined in very clear terms. (For more extensive descriptions and examples of these and other useful observation methods, refer to Boehm & Weinberg, 1997.)

Whatever observation method is used, another consideration is whether and how to keep a record of the observation. Many times, professionals will take notes while observing. This is fine if you are in an observation booth and cannot be seen by the person being observed or if you are observing an infant too young to realize that he or she is the object of your attention. But if you are observing an older child or—as is often the case in infant mental health—observing parent-child interaction, taking notes can make the person being observed self-conscious. Observing without taking notes may be less intrusive, but it leaves you to rely on your memory of what happened—and as any judge or attorney can attest, memory is not very reliable. And without a careful record of what is observed, it may

be difficult to analyze sequences of behavior or try to understand the dynamics of relationships.

Another increasingly popular way to record observations is by videotaping. This can be one of the most effective ways to analyze behavior because it allows an opportunity to review a situation multiple times or to have colleagues or supervisors see the situation even though they were not physically present.

However, videotaping may bring out an awkwardness and self-consciousness in many people, which can compromise the validity of the observations. To use videotaping as an observational tool requires a high level of trust between the practitioner and the persons being observed. For example, parents who agree to be videotaped while interacting with their infant need to feel confident that they will not be judged. They need to know that the mental health practitioner will use the information gleaned from the observation to support them and their child in building the best possible relationship.

How We Make Sense of What We Observe

Regardless of the observation method used or the means used to record the observation, probably the most challenging issues relevant to observation training and practice have to do with making sense of what we observe. This section addresses five essential considerations in trying to draw meaning from observations in infant and preschool mental health practice. (These considerations are not unique to infant and preschool observations. They are also applicable to uses of observational systems in other arenas.)

THEORETICAL PERSPECTIVES. Going into an observation, most practitioners have some theoretical perspective, even if they are not able to articulate it. In other words, practitioners have some preconceived idea about what is important to watch and what will matter for the young child's development. Some theories are relatively elaborate, well-established, and supported by research. Attachment theory (for example, Bowlby, 1969; Ainsworth, Blehar, Waters, & Wall, 1978) is prominent in the area of infant mental health and would lead an observer to focus carefully on how the baby is signaling her needs, how the parent is reading and responding to the baby's cues, and the extent to which the baby is using the parent as a place of refuge and a secure base from which to explore. A practitioner coming from the

theoretical perspective of social learning might focus more on how an adult is modeling appropriate behavior for a child, and an observer from a behaviorist perspective would look more at how an adult is reinforcing a child's behavior.

Theoretical perspectives are a helpful way to organize observations and to attempt to understand behavior. But even a good theory has its limitations and if used too rigidly may lead an observer to overlook important information. For example, in a recent case conference an infant mental health case manager showed a videotape of a young mother trying hard to engage her baby in face-to-face interaction, while the baby persistently looked away. Coming from the perspective of attachment theory (the theory, by the way, that guides much of my own work), the practitioner concluded that the mother was intrusive and that the baby seemed to be on a path toward an avoidant attachment. However, two physicians and a psychologist in the conference noticed some unusual behaviors in the baby that led them to question that interpretation. The baby showed a strong startle reaction every time the mother gently shook a rattle in front of her (in other words, the baby did not habituate to the stimulus); the baby listed to one side, appearing to have asymmetrical weakness; and the baby appeared to gaze off into space much of the time, avoiding any eye contact, not only with the mother.

While observing the same mother-infant interaction as the case manager, these professionals suspected possible neurological problems in the baby and saw the young mother as desperately (and not inappropriately) wanting to make a connection with this hard-to-reach baby. Further assessment was needed to figure out what was going on in this situation and what might be helpful to the baby and mother. This example illustrates the importance of helping practitioners to become cognizant of the primary theoretical perspectives that guide their observations and at the same time stay open to alternative interpretations. It also illustrates the value of getting multiple perspectives, particularly from colleagues in different disciplines that complement your own.

TIME. Regardless of observation methodology or theoretical perspective, time is a critical factor to consider before drawing meaning from what you observe. In infant and preschool mental health practice, time enters into observation in several ways. Because young children are growing and changing rapidly and their behaviors typically are highly variable, it is important to pay careful attention to the frequency and

duration of behaviors, as well as patterns of behavior over time and across situations.

This means that practitioners need to be cautious about interpreting behavior without observing multiple times and across multiple situations. This is true not only for infants and young children but also for the parents and other caregivers who are part of their lives. For example, as noted earlier in the opening vignette about Tina and her baby, it would be unfair to conclude that Tina is a neglectful mother based on one brief observation of her baby fussing while she finishes a phone call.

DEVELOPMENT. Again, because infants and young children are growing and changing rapidly, it is essential to consider behaviors through the multiple lenses of developmental ages, stages, and issues. For example, at the most basic level, the behavior of a one-year-old who screams and cries when mom moves out of sight will have a different meaning than the four-year-old who does the same. But if that four-year-old has a significant developmental delay, the intense separation anxiety may be more understandable. Or to pose another scenario, if a typically developing four-year-old recently has experienced a frightening accident, intense separation anxiety may not be surprising. However, referring back to the issue of time (as discussed previously), you would hope to see that child's anxiety subside gradually over time so that he could return to more typical responses to ordinary separations.

In similar ways, development is a consideration when observing and interpreting adult behavior. For example, a seventeen-year-old mother determined to show her parents that she can make her own decisions may be overly defensive about her home visitor's parenting suggestions. She may even go out of her way to interact with her baby in a way that is contrary to what she thinks the home visitor wants. Although this may trigger real concerns for the baby's health and well-being, it is not unusual behavior for an adolescent. A developmental perspective on the teen mother's behavior can inform how the home visitor tries to support the young mother in finding her own strengths, setting positive goals for herself and her child, and working toward more autonomy without negating the ongoing importance of the support of her own parents.

CONTEXT. When making sense of any observation, one of the most important considerations is context. Context is a broad concept with several facets, some more obvious than others. On the most concrete

level, context includes the physical environment. With a TV blaring loudly in the background, you're not likely to get a very meaningful observation of how a six-month-old responds to daddy when daddy sings the song they learned at parenting class.

The very presence of an observer becomes an important element of context. It is natural to behave somewhat *un*naturally when we know someone is watching us. Only the youngest of infants is immune to the inhibitions that come from self-consciousness about being watched; and even babies may be distracted by an observer in ways that change their behaviors. But the effect of an observer can be reduced if the observer is as unobtrusive as possible and has built trust with the person or persons being observed so that they gradually become more natural and at ease.

A third and more subtle aspect of context has to do with the observed party's understanding of expectations. For example, one young mother in a hospital-based program for new parents was observed to be very interfering with her baby's attempts to scoot across the floor and get a colorful rattle. Each time the baby got close, the mother would move the rattle a few more inches away. But after a careful review of the videotape of this interaction, it became clear that the mother thought the group leader wanted her to try to get her baby to move as far as possible across the floor. The mother's behavior was therefore appropriate in the context of her understanding of expectations, although it was not sensitive to the baby's cues.

Sometimes there is an "invisible context"—that is, expectations that stem from messages and experiences beyond the immediate situation. For example, during a home visit, Lisa hesitated for quite a while after her baby, who had been playing quietly in his playpen, began to cry. Lisa looked agitated and confused, then finally jumped up and said, "Oh, I just can't listen to him cry. I've got to go get him even if I spoil him." A subsequent conversation revealed that the invisible context was that in her head Lisa was hearing her own mother and boyfriend warning her not to "turn that boy into a sissy" by picking him up every time he cries. She was torn between her own gut instincts and the messages she was hearing from others.

HYPOTHESES VERSUS CONCLUSIONS. With all things considered—theoretical perspectives, time, development, and context—caution is still the byword when trying to draw meaning from observation. Observation is used best to form hypotheses, which then can be tested

by further observations and information gathered in other ways from other sources.

For example, the physician who suspected a neurological problem in the baby described earlier in this chapter was forming a hypothesis about the meaning of that baby's and mother's behavior. The next step was to begin to test that hypothesis by doing a neurological assessment on the baby and observing the baby's behavior over time and across different situations. At the same time, the case manager could work supportively with the young mother to help her experiment with ways to connect with her baby through gentle touch, sight, sound, taste, and even smell. And because that mother was open to being videotaped with her baby, the case manager could have the mother watch the tape with her, using the Seeing Is Believing approach (Erickson, 1999) to engage the mother in forming and testing her own hypotheses about how to build a relationship with her baby, whatever the results of neurological testing.

BASIC KNOWLEDGE NEEDED BY PRACTITIONERS USING OBSERVATION

Consistent with the critical issues outlined in the previous sections, there are several areas of basic knowledge necessary for valid, fair, and effective use of observation for prevention and intervention services in infant and preschool mental health. These areas of basic knowledge are summarized here in three broad categories, one having to do with observation in the generic sense, the other two being more specific to the field of infant and preschool mental health.

Observable Behavior Versus Inference

To use observation strategies effectively in any context, it is essential to know how to discern between what is observed *(objective)* and what is inferred *(subjective)*. For example, you could observe a child running toward his father and away from his playmates with a frown on his face. But if you said the child was angry or frightened, that would be an inference. It is not wrong to make inferences; it is just important to know when you are doing so.

An inference should be treated as a hypothesis. And that hypothesis should be tested, taking into account the kinds of factors discussed in the earlier section of this chapter dealing with how to make sense

of observations. (This area of basic knowledge also is addressed in a subsequent section on observation training.) Especially when keeping written records of observations, it is important to indicate clearly those statements that are inferential. For record-keeping purposes, inferences can be set apart by keeping them in the margins, using a highlighter to separate them from observations, or qualifying them with language such as, "It seemed that the child might . . ." or "she appeared to be . . ."

Knowledge of Infant and Child Development

In infant and preschool mental health settings, effective use of observation requires a solid understanding of infant and child development. The practitioner needs to know general sequences of development in the domains of language, cognition, gross and fine motor skills, and social-emotional behavior. The practitioner needs to recognize the hallmarks of a healthy infant-caregiver relationship (for example, mutual gaze, vocalizing, shared attention, reciprocity, and secure base behavior) and needs to know the developmental meaning of key behaviors, such as separation protest in an eight-month-old or negativism in a two-year-old. A competent observer also needs to be aware of signs that development is not on track and—most important—needs to know when to seek an outside opinion or refer a child for further assessment.

Knowledge of Critical Factors in Child-Caregiver Relationships

Because child-caregiver relationships are so central in infant and preschool mental health services, practitioners also need to understand key caregiver behaviors that have been shown to shape a child's learning and development. When observing child-caregiver interaction, practitioners need to be especially alert to the following aspects of adult behavior in relation to the child:

- Sensitivity and responsiveness to infant cues
- Respect for the child's emerging autonomy
- Clear, developmentally appropriate communication
- Authoritative guidance and discipline—that is, neither permissive nor authoritarian (for example, Baumrind, 1971)

It also is important to listen to how the adult talks about the child and her relationship with the child. What assumptions does the caregiver make about the child? In other words, how does the caregiver interpret the child's behavior and what conclusions does she draw about the child? For example, at a recent parenting group one new mom, frustrated that her three-week-old baby cried so much, complained, "She's just crying to try to be the center of attention." Another mom countered, "But crying is the only way she has to tell you she needs something. That must be frustrating for a little baby."

On a deeper level, these assumptions say something about a parent's state of mind with respect to attachment, another important concept for practitioners to know. It bodes poorly for a parent-child (or caregiver-child) relationship when the adult is dismissing of a child's attachment needs. And as attachment research demonstrates, a dismissing state of mind often represents the way the parent learned in childhood to protect herself when caregivers were unreliable or unavailable (Erickson, Korfmacher, & Egeland, 1992). (It is beyond the scope of this chapter to summarize the research on parental state of mind. For a practice-oriented discussion of this and related concepts, see Chapter Four in Erickson & Kurz-Riemer, 1999.)

PERSPECTIVES ON TRAINING AND DETERMINING LEVELS OF COMPETENCE

Training practitioners to use observation effectively is a dynamic, ongoing enterprise that should begin early in preservice education and continue with careful supervision and case consultation in the workplace. Although the basics may not be hard to teach, the nuances of observation—especially in the complex realm of human behavior and relationship—are such that even the most seasoned professionals benefit from sharing observations with colleagues or consultants. See, for example, the classic work of Esther Bick (1964), a pioneer of infant observation in psychoanalytic training, and more recently, Deborah Weatherston and colleagues at the Merrill Palmer Institute (Weatherston, 2002), who have made intensive observation a core component in their training of infant mental health professionals.

At a minimum, training and methods of determining competence in observation should include the following:

- An introduction to different methods of observation
- Practice in choosing a method appropriate to the task or question

- Exercises designed to sharpen observation skills and achieve accuracy of recording, including establishing inter-rater agreement with experienced observers watching the same situation
- Exercises in separating observable behaviors from inferences (drawing a line down the middle of a page, for example, and writing inferences on the right side across from the observation that led to the inference)
- Activities that engage the learner in testing hypotheses (or inferences) by gathering additional information through further observation or other means
- Discussions that identify and explore alternative inferences or explanations

Beyond training in those basic observation skills, additional more complex training will be required by practitioners wishing to use observation as intervention, as discussed in the final section of this chapter.

SUPERVISION ISSUES

Because observation is an imperfect science and plays such an important role in making decisions about children and families, ongoing supervision or case consultation is important at all levels of practice and experience. Supervision needs to address all of the skills mentioned in the preceding section on training. But supervision is more challenging in many ways, complicated by the fact that the practitioner often is using observation in real-life situations (for example, home visits) that the supervisor may not be able to observe directly.

Supervisors therefore need access to as much detailed information as possible so that they know what their supervisees observed. Prior to a supervision session, it is helpful to review case notes, including narrative notes of observation sessions with inferences separated from observations as described earlier. When observations have been videotaped, reviewing the tapes together is an excellent use of supervision time; for the supervisor, it is the next best thing to being there.

A supervisor's task is to help the practitioner to be as accurate as possible in observing those behaviors of greatest importance to the child's mental health and to use those observations as effectively as possible to generate and test hypotheses about how to support and

encourage the child and the caregivers. One important role for the supervisor is to be alert to and help the practitioner become alert to any sources of bias that compromise the accuracy and effectiveness of observation. These sources of bias could include (but are not limited to) these:

- Situational variables, such as a crowded, run-down apartment that could distract the practitioner from seeing the strengths in a parent's relationship with the child
- The practitioner's state of mind, which could reflect, for example, current or past stressful events or relationship experiences that interfere with the worker's ability to see the child or family objectively
- Halo effects, which may lead a practitioner to overlook needs or problems in a child or family who triggers a generally warm, positive response in the worker (The reverse of this—what I call the "dirty halo effect"—can happen too, when child or family strengths are obscured in a situation that triggers a negative response in the practitioner.)

Whatever the sources of bias (and supervisors have their own biases too!), effective observers and supervisors actively seek second and third opinions from colleagues and consultants. Especially when making important decisions about treatment approaches, referrals, or placement, observers should gather corroborating evidence from others who work with the family and stay open to the possibility that others may disconfirm their assessments. In short, supervisors and practitioners do their part in making their agencies open, learning organizations.

OBSERVATION AS INTERVENTION

Observation is not only the domain of mental health practitioners; it is also a powerful tool for parents and other caregivers who help shape the mental health of an infant or young child. Recent years have seen exciting developments in the use of observation as intervention, particularly as video technology has become more widely available in offices and homes. By engaging parents and other caregivers in watching videotapes of themselves and their children, mental health

practitioners help those caregivers sharpen their observation skills, enhance their understanding of their children's behaviors, and build on their own strengths in addressing the emotional needs of their children.

Some practitioners use these approaches in a clinical setting. Susan McDonough's Interaction Guidance (2000) is one example of this clinical use. Others use similar strategies in the context of home visits, as have my colleagues and I since 1986 when we launched the Steps Toward Effective, Enjoyable Parenting (STEEP™) program (Erickson & Egeland, 1999; Erickson, Egeland, Simon, & Rose, 2002; Egeland & Erickson, 2004).

We call our observation-as-intervention approach Seeing Is Believing (Erickson, 1999), a strategy for guided self-observation to build on parenting strengths. Originally developed as a core strategy within the broader STEEP program (which includes parent-infant group sessions and home visits from pregnancy through the child's second birthday), Seeing Is Believing (SIB) has been adapted for use in other programs throughout the United States and abroad. These programs include home visiting for new parents by public health nurses; a hospital-based program in Tacoma, Washington, that uses the full STEEP program to serve high-risk families whose babies are in the neonatal intensive care unit (NICU); an Australian program for mothers with severe postpartum depression; and clinic-based services for parents and young children referred to a child guidance center in Germany. The remainder of this section describes the SIB approach and uses examples from our work to illustrate the concept of observation as intervention.

Implementing Seeing Is Believing

From the beginning of our work with a family, we offer SIB as a way for parents to learn to understand their baby and build the best possible relationship with the baby. We also tell parents that the video we make will be theirs to keep, providing a keepsake documenting their child's early years and the things they and their child did together. Although it is up to parents to choose whether or not to be videotaped, in our experience most parents respond very positively—largely, we believe, because we make special efforts to be nonjudgmental and to enter into the taping and subsequent viewing in a spirit of shared discovery.

Typically, we tape for just a few minutes during a home visit, usually in a basic child-care situation, such as feeding or bathing, or in a play situation. To set up the play situation, we might ask the parent what things they and their baby most enjoy together. Alternatively, we might offer some age-appropriate toys or just find safe, interesting household objects that the parents have on hand and say, "Let's see what your baby likes to do with these things." The key is to capture or create a situation rich with opportunities for interaction.

Right after taping (or if that's not possible, on the next visit), we watch the tape with the parents and use open-ended questions to help them discover what their baby is telling them. For example, we might start by asking very broadly, "What did you notice in this tape?" Next, we focus on certain aspects of the interaction, saying things like, "What do you think your baby was telling you here? You seemed to know just what your baby needed at that point; how did you know? What do you think your baby enjoyed most during this time? How do you think your baby was feeling at that point?"

(The Seeing Is Believing training video and companion manual [Erickson, 1999] explain the strategy in more detail and offer practice exercises for professionals who want to learn to implement SIB. Training also is available on-line through the University of Minnesota, and in-person trainings for agencies or professional organizations can be arranged by contacting the University's Irving B. Harris Training Center for Infant and Toddler Development, e-mail ibharris@umn.edu.)

Insights and Discoveries Through SIB

Over the years, we have shared many aha! moments with parents who, by stepping outside their relationships with their children and watching themselves from that third-person perspective, have discovered new things about their children or themselves. For example, one new mom recognized that she was overwhelming her baby with too much touching and kissing. She accurately read her baby's cues as saying, "Mom, get out of my face!"

Another mother, deeply depressed but not yet willing to confront it, was motivated to seek help when she saw on videotape how hard her baby was working to engage her to no avail. A father who felt awkward and ill at ease trying to dress his squirming baby was thrilled to see on tape how his baby loved gazing into his eyes. And a mom and dad who could see almost nothing but the apparatus that was keeping their

premature newborn alive felt new hope when they saw their tiny baby respond to their gentle touch.

The SIB videotaping approach also has led to new insights and discoveries among the professionals who use it in training and reflective supervision. Using a parallel process of shared discovery—just like the process practitioners use with the parents—supervisors and front-line workers use videotaped observations to discover strengths even in the most troubled families, identify needs that might have been missed in the midst of a home visit, and figure out together the best way to support families and children.

Sometimes we discover that we have inadvertently led a parent astray with a well-intended message. I remember, for example, a videotape of a father struggling to read a book to his ten-month-old, holding the baby tightly while she squirmed and fussed to get down on the floor with her older sibling. The father had taken to heart his nurse's "prescription" to read to his baby for ten minutes each day. But an overriding message about following the baby's cues had not come through. The tape ultimately became a useful lesson for both the nurse and the father about the importance of sensitivity to infant cues, as well as the value of introducing books as something to enjoy together rather than the focus of a power struggle.

All in all, observation is at the heart of infant and preschool mental health practice, whether used informally or in a more standardized, systematic way. Observation also is powerful when used as an intervention strategy with parents and other caregivers who exude such strong influence on a young child's social and emotional development.

Whether used for assessment, intervention, or both, effective observation requires careful attention to a host of contextual factors that shape the behavior of the observed, as well as sources of bias that shape the interpretations of the observer. Careful training, ongoing supervision, and the ready seeking of second and third opinions are paramount to the successful use of observation to analyze behavior and to plan and evaluate treatment.

Even the most experienced professionals are wise to engage in consultation with others to keep their observations sharp, useful, and relatively free from bias. Because *some* bias is always present—even in terms of what a person chooses to notice—the process of supervision around observation can be used as a rich opportunity for personal

and professional growth, in turn passed on to the children and families who look to us to support them in achieving and maintaining optimal health and well-being.

References

Achenbach, T. M., & Edelbrock, C. (1983). *Manual for the Child Behavior Checklist and revised child behavior profile.* Burlington: Department of Psychiatry, University of Vermont.

Ainsworth, M.D.S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Barnard, K. E. (1979). *Instructor's learning resource manual.* Seattle: NCAST Publications, University of Washington.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monograph, 4*(1, pt. 2).

Bick, E. (1964). Notes on infant observation in psychoanalytic training. *International Journal of Psychoanalysis, 45,* 558–566.

Boehm, A. E., & Weinberg, R. A. (1997). *The classroom observer: Developing observation skills in early childhood settings.* New York: Teachers College Press.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books.

Brazelton, T. B. (1973). *Neonatal Behavioral Assessment Scale.* Philadelphia: Lippincott.

Bromwich, R. M. (1983). *Parent Behavior Progression, revised.* Northridge: California State University.

Caldwell, B. M., & Bradley, R. H. (1978). *Home Observation for Measurement of the Environment.* Little Rock: University of Arkansas at Little Rock.

Caldwell, B. M., & Bradley, R. H. (2001). *Home Observation for Measurement of the Environment* (Rev. ed.). Little Rock, AR: Home Inventory LLC.

Clark, R. (1999). The Parent-Child Early Relational Assessment: A factorial validity study. *Educational and Psychological Measurement, 59*(5), 821–846.

Egeland, B., & Erickson, M. F. (2004). Lessons from Steps Toward Effective, Enjoyable Parenting (STEEP): Linking theory, research and practice for the well-being of infants and parents. In A. Sameroff, S. McDonough, & K. Rosenblum (Eds.), *Treating parent-infant relationship problems* (pp. 213–242). New York: Guilford Press.

Erickson, M. F. (1999). *Seeing Is Believing: Videotaping families and using self-observation to build on parenting strengths.* Minneapolis: Irving B. Harris Training Center for Infant and Toddler Development, University of Minnesota.

Erickson, M. F., & Egeland, B. (1999). The STEEP program: Linking theory and research to practice. *Zero to Three, 20*(2), 11–16.

Erickson, M. F., Egeland, B., Simon, J., & Rose, T. (2002). *STEEP Facilitator's Guide.* Minneapolis: Irving B. Harris Training Center for Infant and Toddler Development, University of Minnesota.

Erickson, M. F., Korfmacher, J., & Egeland, B. (1992). Attachments past and present: Implications for therapeutic intervention with mother-infant dyads. *Development and Psychopathology, 4,* 495–507.

Erickson, M. F., & Kurz-Reimer, K. (1999). *Infants, toddlers and families: A framework for support and intervention.* New York: Guilford Press.

Green, B., Shirk, S., Hanze, D., and Wanstrath, J. (1994). The children's Global Assessment Scale in clinical practice: An empirical evaluation. *Journal of the American Academy of Child and Adolescent Psychiatry, 33,* 1158–1164.

Greenspan, S. I. (1997). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International Universities Press.

McDonough, S. C. (2000). Interaction guidance: An approach for difficult-to-engage families. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 485–493). New York: Guilford Press.

Meisels, S., Marsden, D. B., Dombro, A. L., Weston, D. R., & Jewkes, A. M. (2003). *The Ounce Scale: An observational assessment for infants and toddlers from birth to 3½ years.* Parsippany, NJ: Pearson Early Learning.

Weatherston, D. J. (2002, January–June). Observation and reflection: Infant mental health training experiences overview. *Signal, 10*(1&2), 1–4.

CHAPTER THREE

Training in Assessment of Birth to Five-Year-Olds

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One major area of training that is particularly important is that of assessment. This chapter will address some issues that cross the spectrum for working with children between birth and five, while noting that assessment training needs may vary considerably depending on the kind of work one does. If the practitioner's primary role will be conducting comprehensive evaluations to determine developmental delays in toddlers, the practitioner will have different training needs than those of someone who will be administering standardized tests to five-year-olds as part of a longitudinal research protocol.

This chapter will focus primarily on training for the first kind of role, differentiating *assessment* from *testing.* Core areas of knowledge that are critical for anyone planning to develop expertise in comprehensive approaches to early assessment will be addressed, along with best practice issues related to training, supervision, and the ongoing maintenance of skills. Suggestions will also be made for programs that are developing training in assessment, and ideas will be shared for evaluating competency in providers.

GENERAL ISSUES RELEVANT TO ASSESSMENT TRAINING AND PRACTICE

From both the practice standpoint and a training perspective, it is somewhat easier to begin assessment training by focusing on school-age children, then moving to the preschool level, and finally to the infant and toddler level. Unfortunately, most preservice individuals do not have the time in their curricula to develop assessment expertise in this manner. In most graduate training programs, elective course offerings are somewhat limited, and even if a wide selection is available, most students must focus their interests on a few courses.

In addition, many mental health professionals who are already in practice but are interested in retraining to work with very young children come from the adult mental health world. Moving from conducting therapy (and often very limited formal assessment beyond interviewing) with adults who are invested, paying clients to conducting comprehensive assessments with two-year-olds and their families can be quite a challenge. Finding appropriate training that will fit into a busy practitioner's schedule adds a further challenge.

Finally, many of the professionals providing services to very young children and their families are in "non-mental health" disciplines, such as occupational therapy, speech therapy, and early intervention, or in mental health disciplines (for example, social work or marriage, child, and family therapy programs) that may not include assessment training in their preservice curricula. Training programs in infant and preschool mental health must consider all of these varied needs when designing curricula.

The following sections will examine some of the major areas that must be included in assessment training to produce competent, well-rounded clinicians. Problems and decisions that must be made by individual programs, based on the workforce they are preparing, will also be raised.

Assessment Training Within or Across Age Groups

A primary concern among training programs is how to best provide training in infant, toddler, and preschool assessment. Should training and course work be divided into the infant-toddler (birth-to-three) period with a separate focus on the preschooler (three-to-five age group), or should training be provided across the spectrum from birth

to age five? There are obviously benefits and disadvantages to each training decision.

Among the primary benefits of an age group split is the fact that such a division permits more time and focus on developmental, family, and diagnostic issues pertinent to each age group. Because there is such rapid developmental change between birth and age three, it is clear that considerable training time is needed for a practitioner to become comfortable in interpreting behavior, developing relevant interview questions, and making family-sensitive, developmentally appropriate interpretations of extensive and varied assessment information while working with toddlers. A focus on learning how to assess infants and toddlers permits a strong emphasis on developmental characteristics and ranges of behavior within the period between birth and age three.

A division by age groups also allows greater focus on specific relevant test instruments for training. Instruments such as the Bayley Scales of Infant Development—Third Edition (BSID-III) (Bayley, 2005) require extensive training and practice in order for examiners to become fluid and comfortable with administration, scoring, and interpretation. Because this is one of the most commonly used, well-validated, and comprehensive instruments currently available, training in administration with the BSID will probably be most salient to the vast majority of professionals who plan to conduct comprehensive assessments of infants and toddlers for research or clinical purposes. Training in the administration of formal instruments such as the Bayley Scales also allows a great deal of crossover to instruments that are less complex to learn to administer. Some training programs may choose to expose students to a wider range of test instruments and screening tools rather than providing comprehensive training utilizing a specific tool.

For those individuals most interested in working with preschoolers, a primary focus on the preschool-age group permits a similar focus on developmental characteristics and typical behaviors. It also allows for instruction with a number of formal test instruments designed specifically for preschoolers. Training might include the well-validated Wechsler Preschool and Primary Scale of Intelligence—Third Edition (Wechsler, 2002), the Miller Assessment for Preschoolers (Miller, 1982), the McCarthy Scales of Children's Abilities (McCarthy, 1972), the Kaufman Assessment Battery for Children (Kaufman & Kaufman, 1983), the Gesell Developmental Schedules—Revised

(Knobloch, Stevens, & Malone, 1987), the Bracken measures (Bracken, 1998, 2002), and a variety of other more informal tools. Diagnostic issues and diagnostic systems most relevant to three- to five-year-olds may also be more fully explored.

Clearly, however, preschool-aged children with serious developmental delays will require different assessment and diagnostic strategies because the floors on most formal tests designed for preschoolers do not extend below the age of two. Consequently, practitioners working with this age group will need to become familiar not only with key characteristics of the preschool period but also with characteristics of the infant-toddler period. They will also need to develop an understanding of assessment strategies for infants and toddlers in order to most effectively provide comprehensive assessment services for preschoolers with delays.

This need for overlapping training between key age periods may be the greatest disadvantage to dividing assessment training by age groups. A further practice consideration is the reality of life in smaller communities or clinical settings that may not require such narrow specialization.

Training in the Use of Screening Tools Contrasted with Comprehensive Assessment Training

An additional training consideration is the difference between the need for training on more basic issues of screening very young children compared with the training needed to become competent comprehensive assessment specialists. For some practitioners, learning the basics of screening (particularly in developmental arenas), along with a clear understanding of behavior and development, will be sufficient for the scope of their practices.

In many places, formal assessment is reserved for initial diagnostic purposes, specialty clinics (for example, follow-up clinics for premature infants), and educational program decisions. In these arenas, specialists may be hired and additional training provided to them as needed, based on the age of the children being seen, the test instruments that have been adopted, and the type of assessment built into the clinical setting.

Evaluation with a standardized instrument to obtain a score for eligibility purposes (for example, certain education programs) or as part of a standard research protocol to map growth over time is one facet

of assessment. A comprehensive assessment for diagnostic purposes or to plan treatment will require a broader kind of training and integration of skills.

Complexities Inherent in the Assessment of Young Children

There are a variety of issues that must be considered when training individuals in the "how-tos" of assessment. Most of what superb clinicians consider critical information to the assessment and intervention process reaches far beyond what is captured by the average test protocol that is designed to measure cognitive functioning. Such information includes family strengths and risk factors, parenting characteristics and beliefs, child medical and health issues, neurodevelopmental issues, temperament, regulatory behaviors, adaptive behaviors, behavioral concerns, speech and language skills, functional levels in all areas, sibling relationships, family relationships, peer functioning, community stressors, and economic resources available to the family.

In addition, the clinician must learn to juggle the assessment of child skills as operationalized by a formal test instrument with the ability to quietly gauge a caregiver's ambivalence or intrusiveness into the process, the child's ability to ignore distractions in the environment, and the child's interest in novel activities. Such factors may actually provide a more comprehensive picture of child functioning and may provide greater insight into a plan for intervention.

While conducting a formal assessment, the clinician must read the body language of both child and caregivers for cues about what is not being said in the room. Keeping young children on target, learning to move at each child's individual pace, and paying attention to distractions such as the setup of the room all become critical factors that must be considered in order to assess optimal functioning in very young children.

Simultaneously, the clinician must be able to adapt to the unusual events that may occur during the assessment of very young children. For example, the two-and-a-half-year-old who needs to use the potty needs to use it NOW. Testing will have to take second place to this high demand, or the clinician will need to be prepared to switch into cleanup mode because the toddler had to wait too long. A very young child is not invested in an assessment process as an adult (that is, paying) client might be. Two- to four-year-olds have no need to be

anywhere else, nor do they care that the clinician might have such a need. A fine line must be walked between engaging in a battle for power and being a clinician who assumes the role of the adult in charge.

Further there must be a clinical "fit" between the personality of the adult working with young children and that individual's comfort level in this arena. Professionals who work with very young children must genuinely like the age group and experience pleasure in making adaptations for the quirkiness of the period. Children sense when adults are at ease and so do their parents.

Every assessment is a unique experience, and the person doing these assessments must enjoy the challenges inherent in such uniqueness. There are professionals who are very comfortable working with children under the age of one but who do not enjoy the wildness of many four-year-olds. This is an important "goodness-of-fit" issue that training programs should require students to face.

Issues of Time in Assessment

Many clinical agencies have stopped conducting formal assessment due to time constraints. Quality assessment requires considerable time. The interview process itself may require several hours as the examiner gathers information from the young child, parents, other family members, other professionals in the community, and other agencies involved with the child and family.

Administration of a single standardized protocol may take forty-five minutes, an hour, or two hours, depending on the child's age, pace, and time needed to warm up. Observations scheduled in the child's home, school, or other locations require both travel and observation time and may need to be scheduled multiple times. Interpretation of complex data and writing a clear report do not occur quickly.

Some agencies that provide infant mental health services expect the assessment process to take six to eight weeks. While the assessment is ongoing, intervention has already begun as the child and family begin to work with the clinician and develop a relationship of trust. The most optimal type of service delivery is, therefore, a seamless system in which the clinician who will be providing the treatment services is the same one who conducts the assessment. A red flag should go up if a practitioner spends forty-five minutes with a young child and family and claims to have completed a comprehensive assessment.

Who Should Assess?

Determining who should conduct assessments with very young children will depend on state licensing issues, the purpose of the assessment, ethical scope of practice issues, and the program in which the professional is employed. Many research programs train research associates to conduct assessments with specific protocols built into the design of the research study. Such testing occurs primarily to map progress over time and is concerned more with obtaining a reliable standardized score than with the integration of complex child and family data into an understandable report. Training to administer and score individual test protocols will be less comprehensive than that needed to provide the type of comprehensive clinical assessment services linked to intervention and treatment plans.

In many clinical service programs, diagnostic assessment for mental health service is discrete from evaluations conducted for other purposes. In other programs, a comprehensive assessment may include individual evaluations by three or more disciplines—speech and language, psychology, nursing, nutrition, and occupational therapy may all use their own protocols and complete separate reports. Early intervention specialists, including early childhood educators and home visitors, may use a variety of screening tools to measure the progress of a young child over time and to determine the need for a more comprehensive evaluation. An interdisciplinary perspective is critical in training and in practice so that professionals are able to share expertise across lines of practice. Such collaboration requires time but reduces stress on young children and their families and reduces the diagnostic and intervention burden on individual professionals.

Practitioners who are most likely to be conducting formal, comprehensive assessments of very young children for diagnostic and treatment purposes include psychologists (primarily the training will be in applied developmental and school psychology programs, although clinical psychologists often do this work) and occupational therapists, who across the United States are commonly trained to conduct developmental assessments with instruments such as the Bayley Scales of Infant Development. A variety of other mental health practitioners, including licensed clinical social workers, marriage and family therapists, and psychiatrists, may also conduct diagnostic assessments for mental health treatment and intervention with very young children. This leads to the next issue of core knowledge that is needed by anyone assessing very young children.

BASIC KNOWLEDGE NEEDED BY PRACTITIONERS CONDUCTING ASSESSMENTS OF YOUNG CHILDREN

There are a number of basic concepts and areas of knowledge that are crucial for clinicians as they are building skills in assessment. These skill bases include the following areas:

- Understanding the development of very young children and their families, including the role of resiliency and risk factors in development
- Understanding normal sequences of development, including signs of developmental lag
- Differentiating emerging skills from those that are well established
- Understanding the role of neurodevelopmental factors on child functioning
- Developing observational skills, particularly those related to behavior in very young children
- Differentiating typical behaviors from pathological ones
- Understanding what background information is relevant to the assessment and how to gain such information
- Building collaborative relationships (with families, colleagues, and other professionals)
- Developing interviewing skills, including how to formulate questions and have meaningful conversations with both young children and their caregivers
- Learning to read cues given by children and their families
- Using assessment as a relationship-building experience
- Learning how to work with very young children (for example, using the appropriate tone of voice, being the authority, being flexible yet assertive)
- Learning to be sensitive in working with very young children and their families
- Understanding how assessment data will be used and how to select appropriate assessment strategies to serve the purpose of the assessment (including understanding multiple purposes of assessment)

- Understanding how to sequence test items, how to assess fluidly and without constant reference to a test manual
- Learning to incorporate cultural issues relevant to the child's development into assessment
- Developing an understanding of family belief systems about child development, child behavior, education, and intervention
- Developing report-writing skills
- Moving from assessment to diagnosis
- Developing appropriate, usable recommendations and treatment plans

In other words, comprehensive assessment requires an ecological perspective in which there is an interweaving of individual child characteristics with family, cultural, and societal factors. It is crucial to assess all factors in order to gain a clear understanding of who the child is and how the child is currently functioning within the family and social context in which he or she lives. Because these factors are so complex, beginning the learning process by focusing on typically developing young children can greatly assist the developing practitioner to hone skills and learn to measure abnormality from a solid grounding.

Using Developmental Knowledge in the Assessment Process

A primary body of knowledge that requires focus and incorporation into any good training program is an understanding of basic developmental concepts. Ideally, every trainee would have a comprehensive course in infant, toddler, and preschool development before beginning a course in assessment with this age group. For many graduate programs, already full of requirements, this may not be feasible. In these cases, the best we can do is to incorporate a comprehensive look at development into the training of students who are learning to do assessment.

In order to evaluate young children, the practitioner must be skilled at gauging where a child's developmental level lies and where to begin the process. Informally, one must be able to "screen" while watching young children as they play, interact in the waiting areas of clinics and

schools, and move into the examining room. The trainee must learn to be an astute observer of development and a quick interpreter of levels of functioning across a wide span. It is not uncommon for very young children who are being assessed for the first time to be functioning well below their chronological age. The examiner must be able to quickly adapt, even after having begun a standardized protocol with a basal that is too high for the child being assessed.

Sometimes an age correction must be made for prematurity; this concept must be incorporated into the developmental knowledge base of typical and atypical developmental features. It is also important to keep in mind that those doing preschool assessment will often be assessing severely delayed children who are functioning more like infants and toddlers. For this reason, it is not sufficient to understand only preschool development if one is to be well trained to do preschool assessments.

Because much of the focus of clinics that serve infants, toddlers, and preschoolers is on atypically developing children, one's view of the world may become skewed if this is the only exposure received. It is therefore crucial to be exposed to typically developing young children to better understand the wide variations in "normality" in very young children. This helps practitioners avoid the tendency to pathologize developmentally typical behaviors in infants, toddlers, and preschoolers.

Spending time with typically developing children is also extremely helpful to the practitioner in quickly gaining a baseline understanding of the development of motor skills, language, adaptive skills, social and emotional skills, and cognitive skills. A variety of books, videotapes, and other resources can be very useful in providing trainees with additional examples of development beyond a textbook covering the basics of early development.

Developing Appropriate Interview Skills

Another critical piece of assessment training should include helping practitioners to develop more sophisticated interviewing skills. Learning how to ask questions about a young child within the flow of a natural conversation is an art. Sitting in front of a family with a clipboard and ten pages of form questions makes the individual look like a census taker instead of a clinician and does not help families feel at ease. Good clinical practice must allow time for sensitive information to unfold. The clinician must recognize this and understand that some

information given at initial meetings may "change" over time as trust is established. An important part of this is working to ensure that families do not have to retell their stories multiple times to each professional who works with them.

It is also important for trainees to learn how to apply their knowledge of development in their work with young children and to use questions to verify initial impressions about behavior. For example, a critical part of assessment is differentiating emerging skills from skills that are a part of a young child's repertoire. The practitioner must be able to look at children at different ages and be able to interpret whether they have attained a specific skill, are struggling to get there, or are not even close to it. Then the practitioner must be able to hypothesize as to why this may be occurring. Asking the right questions of parents helps the practitioner determine this information and determine what families view as problematic.

In order to ask the right questions, one must be able to formulate possible hypotheses, plan the phrasing of the questions, and put out gentle queries that a parent will understand. A good example is the perennial question regarding speech in young children: How many words does your one-year-old have? Do we mean clear, understandable words that someone in the grocery store can interpret (for example, mama, milk, doggie, ball); syllabic "words" that overlap with one another (for example, "mi" meaning me, milk, Mick the dog, and Millie the sister); or early grunts and sound utterances that may surely be a type of communication by the baby but are being counted by an eager parent as words.

If trainees are not taught to be quite specific in the questions they ask parents, they may get responses that do not make sense to them but make perfect sense to a parent. Trainees must also learn the art of gentle query—if a response does not seem to make sense, carefully asking the parent to give more information about it will help the examiner gather more appropriate information. In addition, when this is done right, the parent truly becomes an invested partner in the assessment process.

Training in Test Administration and Interpretation

Although there is controversy in some areas of the United States regarding the use of standardized tests, most clinicians will find these tests to be quite useful as long as they do not become the only marker

of a young child's function and progress. Most training programs with a focus on comprehensive assessment will incorporate training that uses at least one of the major standardized test batteries. Decisions about how many different batteries to use in training will depend on the length of time available for training, the experience of the trainees, and the location where training is occurring.

Important aspects of training in test administration include decision making about appropriate tests. This will include an examination of standardization issues, applicability to the problem being evaluated, and cultural sensitivity. Clinical decisions are often based on the types of assessments being conducted. If the purpose is to evaluate a young child for developmental disability and program planning, a different test will be needed than if children are being screened to determine the need for other kinds of referrals. Trainees must be able to differentiate among the uses of tests, understand standardization issues, evaluate cultural appropriateness, and make informed decisions about which test should be used.

If training uses specific test batteries for instruction, trainees will need to be taught the basics of administration, including sequencing items, scoring items, and understanding basal and ceilings on the tests (or subtests). Extensive practice is generally required until clinicians become comfortable and can fluidly administer a standardized test without constant reference to the manual. Supervised practice, either through the use of one-way mirrors or by reviewing videotapes, is an important element of training.

Finally, all practitioners need to be taught how to interpret test data, integrate them with other information, determine diagnoses when needed, formulate appropriate recommendations based on findings, and provide written and oral feedback to families and other professionals. Again, supervision is a crucial element in each phase of the learning process.

Training Specialists to Write Coherent and Cogent Reports

Report writing is an art that requires training, practice, and assistance to perfect. The primary feat of the report writer is to integrate extensive, complex information about a young child and the child's family into a coherent, understandable, concise report. Such a report must leave disciplinary jargon behind. Anyone who reads the report should be able

to see the young child come alive while reading it and should be able to understand what is being said regarding the child's current functional level, strengths, potential deficits, and recommended strategies for intervention. Every report should be prepared while being mindful of what it would feel like to be the parent reading this report. The words and phrasing must be carefully selected to convey the appropriate information in a sensitive fashion.

Finally, the competent practitioner must be prepared to provide feedback about what is included in the report orally to other professionals and to parents and family members. This includes coaching and practice in how to give diagnostic information and how to appropriately conduct a feedback session with a family. All of these areas require practice under competent supervision. Report writing is a bit like learning to ride a bicycle. It requires a great deal of assistance in the beginning, a gentle hand as one progresses, and finally encouragement as the emerging skill becomes part of the repertoire.

MODELS OF TRAINING

Based on all of the previous issues, training programs will develop assessment training within models that are most suited to the needs of the communities that they serve and the type of professionals that they are training (for example, clinical diagnosticians, school psychologists, developmental researchers, early interventionists). The type of training model that will be most useful to the practitioner will depend on the ultimate practice goals of that individual.

Graduate course work, currently somewhat rare, is probably one of the most desirable venues for training. In such courses, the focus will likely be on the development of observational skills, administration and interpretation of formal assessment data, interview skills, writing skills, and feedback skills. The type of instruments selected for training, along with the decision about whether to divide such training by age groups, will be made by each university training program.

Training in the assessment of birth to five-year-olds is most commonly found in graduate programs focusing on applied developmental psychology, school psychology, and infant mental health. The vast majority of child clinical psychology training programs do not include training in the assessment of very young children.

A second common arena for assessment training is in supervised internships. Some training programs with a focus on very young

children and a formal internship program include assessment as part of the training experience. Under supervision, interns may observe other, more experienced clinicians and postdocs while they assess very young children. The interns may also be given opportunities to work clinically to develop this area of expertise under the tutelage of experienced clinicians. Supervision of such work is an inherent part of the internship process. The internship also generally includes seminars that may have a focus on assessment and diagnostic issues, which will strengthen the intern's attempts to build skills in this area. Because internships are usually a focused and intense time within a clinical setting, the allowance for an individual to build skills across a period of nine months to two years under supervision is a strength of this model for training.

A third possible model for training in assessment is a clinical site (for example, agency, hospital, school), where the practitioner who is seeking specific training in assessment might work directly under the supervision of an infant or preschool mental health specialist. This is the model of most postdoc training, whether through a formal postdoctoral position or an informal arrangement for supervision. Such a model is frequently adopted by licensed mental health practitioners who retrain to develop expertise in the provision of clinical services to very young children and their families. This model may also be used by practitioners to gain on-the-job experience or to fill in gaps in training once they are employed within child clinical agencies.

Finally, a blend of models is possible. For example, a graduate student might be enrolled in a course on infant or preschool assessment while simultaneously working as an intern at an agency where assessments are conducted under supervision or while gaining experience at a clinical site under a master clinician. Some faculty who teach courses in assessment integrate community clinical experiences with which they are involved into their students' training through direct observations, videotapes, one-way mirrors, or coassessment experiences.

In addition to comprehensive training in formal methods of assessment, many practitioners, particularly those from non-mental health disciplines will be best served by a broader examination of general screening strategies, general assessment issues (including the evaluation of risk and resilience in children and their families), interviewing techniques, and interpretation of assessment report data. This type of broad training can be provided through workshops, intensives, and continuing education forums. Memberships in state, national,

and international organizations focused on very young children will provide practitioners with an avenue for further training sponsored by such organizations and advertised to their membership.

A SAMPLE TRAINING COURSE IN ASSESSMENT

To serve doctoral students in the clinical psychology program at a local university, I set up a collaborative arrangement with one of the faculty at a local university children's hospital. The students were enrolled in a yearlong graduate course in infant and preschool assessment. Course work involved readings, lectures, discussions, and videotapes of development, family issues, and assessments.

The primary test battery used to train the students was the Bayley Scales of Infant Development—Second Edition (BSID-II) (Bayley, 1993). Because it was not feasible to provide BSID-II kits to every student for practice, each student used a Bayley manual to learn items, sequences, and scoring. All students learned about the basics of administration and scoring with the Bayley Scales.

Students who were more interested in preschool assessment focused their own application on preschoolers. They used either the BSID-II with three- to three-and-a-half-year-olds or the Wechsler Preschool and Primary Scale of Intelligence—Revised (WPPSI-R) (Wechsler, 1989), the Kaufman Assessment Battery for Children (K-ABC) (Kaufman & Kaufman, 1983), or the McCarthy Scales of Children's Abilities (McCarthy, 1972) with children between three and a half years old and five years old.

Once each month, the class went to the hospital clinic for observation of assessments, discussion, interdisciplinary training, and team practice in assessment of typically developing young children from volunteer families recruited specifically for this training experience. Children of varied ages, between six months and five years, were recruited to participate in the class so that students could observe typical behaviors and begin to develop assessment skills with this age group.

The course was pieced into primary sections: learning to make observations, interpret them, and write about them in a report format; learning to gather interview data in a family-sensitive manner; practicing test administration and scoring in teams; practicing test administration and scoring individually; and learning how to integrate complex information into logical, family-friendly reports. Class

meetings outside the hospital clinic focused on these issues sequentially, while requiring students to demonstrate their ability to apply information through a series of assignments.

For example, each student was required to observe a child under the age of five in the child's home, to ask the parents questions about the family and the child's developmental and medical history, and then to provide a written report about these topics. Prior to doing the assignment, we spent several weeks discussing development and how to structure observations.

At the hospital clinic, all students observed a master clinician work with volunteer families during the first third of the year. They were also given the opportunity to ask any questions that they had while the family was present. After the family left, the students had at least thirty minutes to discuss what they had observed and any issues that had come up. At the hospital, students also had seminars on diagnostic systems for very young children and interdisciplinary issues, provided by the appropriate discipline (for example, a speech therapist conducted one of the seminars on evaluating speech and language in young children).

During the last two-thirds of the year, teams of students were responsible for working with the volunteer children and families directly. The teams did the interviewing, conducted the assessments, and clarified whether the child's behavior in the hospital clinic setting matched the family's view of how the child usually behaved. Those students whose primary interest was in preschoolers were given the opportunity to work with children in that age group.

By the end of the year, every student was required to conduct one comprehensive, independent, practice assessment with a child and family outside the hospital clinic. They had to gather all appropriate assessment information, utilize a standardized test instrument with a young child, and write an integrated report, with appropriate recommendations. The students were also asked to provide a videotape of a segment of the assessment, along with a self-critique of what they saw as their own strengths and weaknesses and what they learned from the experience. All students were advised to recruit typically developing young children for class assignments in order to limit the amount of information they would have to sort through during the learning process.

The course design turned out to be a wonderful blend of academic course work and clinical experience that enriched the learning process.

Word of mouth led to wait lists for the course, and it was continually highly rated by the students who participated. Many of the students from the course continued to develop their infant, toddler, and preschool mental health skills in clinical agencies following graduation.

SUPERVISION ISSUES

Supervision is critical in developing competency in the assessment of very young children. This must occur on every level—from developing appropriate interview questions to conducting an assessment to writing a report to providing feedback to families. Such supervision may occur in a variety of ways, including on-site supervision in the room or through one-way mirrors, remote linkages through telecommunications (see Chapter Seventeen), and videotapes brought to a supervisor for review. Feedback may be given on reports as they are being prepared, and a master clinician may be a wonderful addition to a feedback session with a family.

The practitioner who is just beginning to conduct assessments may arrange for periodic check-ins by an assessment specialist, observations and feedback by other professionals, or videotape reviews. Skills may be kept up-to-date through continuing education workshops on assessment and attendance at clinical and research meetings focused on infants, toddlers, and preschoolers. Clinicians may also participate in the updating of standardized tests. For example, the Psychological Corporation looks for clinicians and clinics that are willing to participate in new standardizations and will provide test materials and training to the clinician.

Locating competent, well-trained assessment specialists to provide clinical supervision is a continuing problem that some are working to address in innovative ways (see Chapter Seventeen). For some practitioners who are living in small remote locations, it may be necessary to travel to a nearby city for training and supervision. Sending videotapes for review by experienced clinicians is one possible avenue for those beginning clinicians who cannot arrange on-site supervision of their work.

Whenever possible, a portion of the initial independent assessments that a new clinician conducts should be observed by an experienced assessment specialist. This permits the new clinician to receive the valuable advice and feedback that the master clinician provides in a timely, efficient fashion. It also allows feedback on a variety of levels:

interviewing strategies, test administration, room arrangement and management of test materials, handling of child behavior, analysis of information still needed, data interpretation, reporting, and feedback to families. Through supportive supervision, a beginning clinician's skills can grow and blossom.

DETERMINING COMPETENCE IN ASSESSMENT

Anecdotal stories about real assessment experiences demonstrate serious concerns that currently exist in this field related to examiner competency. Families have been distressed to read reports generated by computer programs that reference the wrong child (in one case, a severely delayed, blind infant who the computer report indicated was functioning at age level and was doing sighted tasks). Early intervention program staff members have reported "assessments" of toddlers by psychologists lasting fifteen minutes. Young children who were being evaluated for program eligibility have been coached through items, thereby raising their scores and making them ineligible for services.

Clinicians have reported, with pride, that they learned how to evaluate toddlers with the BSID-II by reading the manual over a weekend. Some clinicians discount parent and other professional opinions, indicating the view that what they have seen in a few hours of formal assessment represents all there is to the child (along with a surprising level of arrogance regarding their own skills). Other clinicians have refused to allow parents to be present while a one- or two-year-old is assessed, despite the young child's obvious distress.

All of these examples of questionable competence in working with very young children illustrate problems in the field related to training and clinical understanding of what quality assessment should entail. Such practices indicate a lack of understanding of early child development and infant-toddler needs and understandably generate suspicion in parents and other professionals regarding the examiner's competence. These practices have also been shown by at least one study (Gould, 2001) to lead to less parental investment in assessment findings and greater unhappiness about program placement decisions.

Both training programs and trainees need to have an understanding of the minimal competencies that clinicians must have in order to move to the next level of assessment training and practice. Training

programs must be able to evaluate strengths and weaknesses of individual trainees and assist them in rounding out their skills.

Those who are providing training also need to be able to critically measure goodness of fit for this work and to help individuals who do not find a fit move into an arena in which they are more comfortable and competent. Programs have a responsibility to ensure that individuals who are trained in assessment of young children understand their limitations. This includes the trainee's understanding of her own need for practice and ongoing supervision as she begins conducting independent assessments.

Employers who are searching for a clinician to provide assessments must be able to evaluate which training and clinical experiences are directly applicable to the assessment of very young children. The employers need to be able to assess fit for the work and the clinician's sensitivity in working with young children and their families. In addition, employers need to build in a mechanism for ongoing skill development, supervision, and support, particularly for new clinicians.

Finally, clinicians themselves need to be able to look critically at their own skills and determine what areas need improvement. Building competency in infant, toddler, and preschool assessment requires time and energy. Investing such time and energy demonstrates a respect for the young children and families who will benefit greatly from improved services in this area. Improvements in training will lead to the development of more competent practitioners and will provide us with a workforce that is made up of the kind of professionals whom we would all want to assess our own children.

References

Bayley, N. (1993). *Bayley Scales of Infant Development—Second Edition (BSID-II).* San Antonio: Psychological Corporation.

Bayley, N. (2005). *Bayley Scales of Infant Development—Third Edition (BSID-III).* San Antonio: Psychological Corporation.

Bracken, B. A. (1998). *Bracken Basic Concept Scale-Revised (BBCS-R).* San Antonio: Psychological Corporation.

Bracken, B. A. (2002). *Bracken School Readiness Assessment (BSRA).* San Antonio: Psychological Corporation.

Gould, S. A. (2001). *Family reactions to transitions in service delivery for preschoolers.* Unpublished doctoral dissertation, California School of Professional Psychology, Los Angeles.

Kaufman, A. S., & Kaufman, N. L. (1983). *K-ABC: Kaufman Assessment Battery for Children.* Circle Pines, MN: American Guidance Service.

Knobloch, H., Stevens, F., & Malone, A. (1987). *Gesell Developmental Schedules—Revised.* Houston: Developmental Evaluation Materials.

McCarthy, D. A. (1972). *The McCarthy Scales of Children's Abilities.* San Antonio: Psychological Corporation.

Miller, L. J. (1982). *Miller Assessment for Preschoolers.* San Antonio: Psychological Corporation.

Wechsler, D. (1989). *Wechsler Preschool and Primary Scale of Intelligence—Revised (WPPSI-R).* San Antonio: Psychological Corporation.

Wechsler, D. (2002). *Wechsler Preschool and Primary Scale of Intelligence—Third Edition (WPPSI-III).* San Antonio: Psychological Corporation.

CHAPTER FOUR

Diagnosis of Mental Health in Young Children

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Mental health in young children is evidenced by their affect and by their behavior. The behaviors that children demonstrate vary along a continuum from normal variations to problems to significant disorders. The primary task of differential diagnosis, then, is to address the identified affective and behavioral concerns and to assess their significance.

The roles of diagnosis are (1) to understand the extent to which the child's affect and behavior are contributing to the child's well-being in the context of self-regulation, developmental mastery, caregiver-child relationships, peer interactions, and family functioning; (2) to identify the strengths and vulnerabilities of the child and the caregiving environment; and (3) to develop, with the parents, a plan for therapeutic intervention. The differential diagnosis process places high value on certain behavioral indicators. However, it is clear that a child's behavioral development is influenced by the interaction of biological, psychosocial, and environmental circumstance. As a result, behavior needs to be viewed within an ecological context.

Early seemingly maladaptive behaviors may reflect response patterns that are actually *adaptive* reactions to transient disturbances

within the family (Richters & Weintraub, 1992). Young children within given situations will naturally adapt to the environment. When the psychosocial environment itself is discordant or pathological, the child's adaptations may also be pathological when compared with children's behaviors within more healthy settings (Department of Health and Human Services, 1999). Conversely, nonadaptive behaviors may be due to an unaddressed constitutional regulatory problem even when the child is raised in a healthy setting (Poulsen, 2002). Understanding the roles of child robustness, the caregiving environment, and the "goodness of fit" between the two is crucial to differential diagnosis and treatment planning.

Diagnosis of mental health in young children differs in many ways from the differential diagnosis of disease that has been developed by medical disciplines. Whereas the term *diagnosis* usually is identified with pathology and an evaluation of symptoms, the pediatric community applies a similar diagnostic approach to children seen primarily for health supervision. In this approach, diagnosis determines the selection of health-promoting developmental guidance for children whose mental health is already robust, intervention strategies and supports for children and families who evidence mental health risk-producing vulnerabilities, and recommendations for child and family therapeutic interventions for children who evidence mental health disorders (Green & Palfrey, 2000).

The term *differential diagnosis* is typically applied to address the possibilities of disorder. However, a central feature of infant mental health practice has been an orientation to *potential problems* prior to the appearance of disorder (Zeanah, 2000). From a preventive intervention perspective, it is important to consider patterns of behavior that raise concerns with the same sense of gravity as those that are identified at the problem (versus disorder) level.

The value of an evidenced-based diagnostic category, formulated from an accumulation of knowledge on a particular pattern of behaviors, is considerable. It implies, in a general way, a symptom complex along with a clinical course and tells something about the expected outcome (Department of Health and Human Services, 1999).

Identifying a differential diagnosis helps the clinician organize observations and facilitates communication among professionals by allowing the use of diagnostic labels in place of a full listing of all of the features of a child's difficulties (Cantwell & Baker, 1988). It allows for the development of specialized mental health treatment programs,

which lay the groundwork for research on the development of evidence-based practice. In addition, increased awareness of particular diagnoses mobilizes specialized parent and child community supports and services, increases public awareness, and in many cases defines eligibility for services.

DIFFERENTIAL DIAGNOSIS: WHAT ARE THE ISSUES?

There are critics of the use of differential diagnoses for young children. Several issues may need to be considered when infant mental health and developmental psychopathology are addressed with parents and primary service providers.

- There may be reluctance on the part of both parents and primary service providers to refer for diagnosis due to a felt stigma of a mental health disorder. Many individuals only think of mental health services in terms of "irrevocable psychopathology." The fear is that children will be inappropriately labeled and more harm will be done than good (Yoshikawa & Knitzer, 1997).
- There may be a fear that the label will contribute to a self-fulfilling prophecy based on the developmental adage that "children grow up to be that which we expect them to be." Many fear that once assigned, labels are difficult to remove. Zeanah (1993) notes the danger that although children grow and change, too often their "outgrown" labels remain.
- There may be reluctance to use categorical diagnoses due to the feeling that psychiatric disorders are not clearly differentiated for infancy and early childhood (Zeanah, 1997; Greenspan & Wieder, 2001) and that there is still much to learn about the meaning and interpretability of childhood maladjustment—particularly within the domains of social and emotional functioning (Richters & Weintraub, 1992). Clinicians, giving a closer look at the criteria for such diagnoses as attention deficit hyperactivity disorder, oppositional defiant disorder, and separation anxiety disorder, indicate that many behaviors that define these disorders may be age-appropriate or typical ways of reacting to stress in young children (Campbell, 1990).
- There may be concern that with a diagnosis the focus will remain on the child and will not extend to the context of the parenting process or family circumstance. There are situations where the nature

of the circumstances within the family is the most salient aspect of the case (Rapoport & Ismond, 1996). The behavior may not reflect disorder in the child, but rather a disturbance in the parent-child relationship or family stability. Campbell (1990) notes that it is difficult to discriminate between child attention deficit hyperactivity disorder and parent-child interaction problems. Expectations of behavior may be developmentally inappropriate, or there may be a poor psychological fit between mother and child. The child may be labeled as the patient when significant changes have occurred in the family structure, such as illness, separation, divorce, or out-of-home placement of the child. If family situations are ignored, there can be an artificial labeling of the child as disordered.

- There is concern that differential diagnoses that are used to meet different service system eligibility criteria may lead to narrow, rather than *comprehensive,* program planning (Zeanah, 1993). For example, a child with a developmental disability and a mental health disorder may be caught between the intervention models of two systems and may receive fragmented service delivery. In most states, there is a lack of sufficient funding for interdisciplinary and intersystem care planning.
- There may be a concern for *diagnostic overshadowing,* whereby the mental health differential diagnostic label becomes the sole focus, and the reality of the child's life situation is ignored. With diagnostic overshadowing, minimal significance is paid to health and nutrition and to neurodevelopmental, societal, and environmental factors.

DIAGNOSTIC FORMULATION

Behavioral problems can be viewed from both dimensional and categorical perspectives (Rutter & Tuma, 1988; Zeanah, 2000). From a dimensional point of view, most common emotional and behavioral disturbances throughout childhood may be conceptualized on a continuum ranging from normality to disorder. It frequently is difficult to differentiate degrees of worrisome behavior. The symptom may be a sign of transitory stress, a sign of adaptation, or a signal that some underlying developmental process such as relationships is not being suitably negotiated (Greenspan & Wieder, 2001).

The question clinically is how to determine whether child behavior is within normal expectations, is at risk for disturbance, or indicates the actual presence of a categorical disorder. The role of the diagnostic process is to differentiate between the broad variations

found in typical behavior and the presence of disturbed behavior. In the final analysis, the actual diagnosis depends on careful and thorough assessment and integration of all the available data. Beyond the differential categorical diagnosis, there is a need to explain the extent, scope, and nature of an infant's or young child's difficulties.

The value of diagnostic formulation is that it helps the clinician understand the child in the context of family and community (Department of Health and Human Services, 1999). The role of diagnostic formulation is to review and integrate findings, identify predisposing and precipitating factors, establish a multiaxial differential diagnosis, and provide current knowledge of the prognosis and consequence of symptoms ("Practice Parameters," 1997).

Diagnostic formulation synthesizes biological, psychosocial, and cultural influences that influence the child's way of adapting to the world. The diagnostic process thus expands the formal categorical diagnosis. In collaboration with the family, child temperament, developmental competency, neurobehavioral regulatory mechanisms, and health issues are explored, along with the quality of dyadic relationships and family psychosocial strengths and stressors. Behavior that is considered normal is that which conforms to prevailing cultural and societal expectations. Acceptable child behavioral responses in any given situation are based on the expectation of the majority of the group at that given point in time. Behavioral expectations are a function of the prevalent societal norms within the family's cultural group.

Families in the United States have pluralistic cultural beliefs and values that influence diverse caregiving practices, different family styles of communication, and various expectations of behavior. *Mental Health: A Report of the Surgeon General* (Department of Health and Human Services, 1999) noted that the same behavior in one setting or culture might be acceptable and even "normative," whereas it may be seen as pathological in another. For example, in a study of parental expectations in Anglo and Filipino families, there was a twenty-month difference in weaning expectations, a twenty-five-month difference in independent sleeping, and a thirteen-month difference in expectations of a child playing alone (Carlson & Harwood, 2000).

Interpretation of child behavior and the development of differential diagnoses and treatment plans must be attuned to the unique worldviews of the families served (American Psychological Association, 2003). The *Diagnostic and Statistical Manual of Mental Disorders: DSM IV* (American Psychiatric Association, 1995) notes that if the referred

behavioral pattern is a culturally sanctioned response to a particular event, it cannot be considered as a mental health disorder. Diagnostic considerations must incorporate an understanding of family ethnic, linguistic, racial, religious, and cultural background and how such factors influence diverse parenting styles, child-rearing practices, behavioral expectations, and child and family service and support needs.

PREDISPOSING CONSIDERATIONS IN DIAGNOSTIC FORMULATION

The repertoire of infant and early childhood behavior is narrow. For example, behaviors such as temper tantrums may have several underlying causes. It is more important to understand the mechanisms of tantrums for a particular child than to describe the symptom itself (Rolf, Masten, Cicchetti, Nuechterlein, & Weintraub, 1992). The interpretation of behavior must be understood within an ecological framework, focusing on the interrelationships between the robustness of the child and the caregiving received, the environment, and family psychosocial circumstances.

Child behavior, differential diagnosis, and intervention plans must be viewed in the context of the child's temperament, neurobehavioral regulatory mechanisms, developmental competency, and health. In addition, the caregiving environment, the cultural expectations, and the family's stability, stressors, and resources must be considered.

Temperamentally Based Perspectives on Child Emotions and Behavior

Temperament refers to a constellation of inborn traits that influence how children react to the world around them. Although temperament is a biologically based mode of emotional response that relates to such neurobehavioral aspects as reactivity and self-regulation, the caregiving environment can modify it. Easy, slow-to-warm, and difficult temperaments in children, as defined by Chess and Thomas (1996), focused on the importance of goodness of fit between child and caregiver as the mediating variable in child outcome.

The goodness of fit between mother and the child with a mellow or slow-to-warm temperament typically comes easily when both mother and child are healthy, stable, and secure. However, the child with the temperament that includes extreme activity, vehement reactivity, and

delayed compliance typically is the child who is easily disturbed and tearful and prone to more negative social interactions than his more easygoing peers.

Temperament alone is not a major risk factor for serious behavior problems, but in a troubled, discordant, or overwhelmed household, the child with the challenging temperament is at increased risk for becoming a target of negative interactions. It is not "always clear whether extremes of temperament should be considered within the spectrum of mental disorder, or whether certain forms of temperament might predispose a child to the development of certain mental disorders" (Department of Health and Human Services, 1999, Chapter Three, p. 9).

Difficult temperament in combination with other risk factors, particularly maternal perception of difficulty and perinatal stress, can be very predictive of behavioral maladjustment (Sanson, Prior, & Kyrios, 1990). Temperament is constitutionally based, but caregiver supports override biology. Diagnostic formulations and treatment planning must include temperament within the context of the goodness of fit between caregiver and child.

Neurobehavioral Self-Regulatory Perspectives on Child Emotions and Behavior

Infants are born with a wide range of regulatory mechanisms that have a neurological basis. These biologically rooted characteristics influence how the growing infant perceives, initiates, and responds to the persons, objects, and events in his or her world. They are not only the foundation for the development of cognition but are the basis for the development of self-regulation of behavior. Regulatory mechanisms are the wellspring from which arises a wide range of neurobehavioral competencies that account for individual differences in how infants establish feeding and sleeping patterns, learn to control states of alertness, maintain a balanced sensory threshold, recover from stress, organize behaviors, and—most important—develop reciprocal social interactions with the significant persons in their lives.

Neurobehavioral markers refer to the presence of a biological vulnerability affecting self-regulation that is of developmental concern. Young children who are dysregulated become distress prone and are more susceptible to environmental and emotional turmoil. Self-regulation in early childhood is developed through dyadic regulation

provided by caregiver support. Caregivers offer support by providing the template from which the child learns how to experience, interpret, and respond to distressing events. The continuing presence of atypical neurobehaviors, despite caregiver intervention, offers suspicion for significant neurological compromise (Neisworth, Bagnato, & Salvia, 1995).

Developmentally Based Perspectives on Child Emotions and Behavior

Child behavior must be understood and addressed within the context of maturational, cognitive, language, and emotional development. For example, the extent of prematurity should always be considered during infancy when regulatory problems are assessed. Dysregulated sleeping, crying, and feeding patterns of an infant may require specialized caregiving strategies and supports but may not represent long-term neurobehavioral significance if the baby was born prematurely. A matter of months during infancy may distinguish between a transient problem and one of major clinical significance.

Behavioral difficulties rise in early childhood as part of the transient normative developmental process. It is during early childhood that preschoolers learn how to comply with rules, how to wait their turn, how to control anger, and how to tolerate frustration. Gesell (1940) in his seminal work describes a typical four-year-old as being of "an age of going out of bounds" (p. 261) and as a child who can be "very bossy in directing others" (p. 50), refusing to comply to adult expectations, and frequently showing "poles of aggression and withdrawal" (p. 239). Disturbances must be evaluated in the context of such normative behavior patterns. The critical issue is the need to make the distinction between clinically significant, troubling behaviors and those worrisome behaviors that are normative and transient in nature (Zeanah, 2000).

There is a lack of consensus about the conceptualization and measurement of disruptive behavior in preschool children. Critics such as Keenan and Wakschlag (2002) assert that it is arguable whether behavioral problems in young children should even be considered within a diagnostic framework, because normative behavioral disruptions so frequently occur during the preschool years. Campbell underscores the difficulty in clearly differentiating degrees of troublesome behavior and emphasizes the necessity to keep the *patterns* of troubling

behavior in focus. "The frequency, intensity, and constellation of symptomatic behavior are relevant to a determination of whether a clinically significant problem exists, as is its wider family and social context" (Campbell, 1990, p. 60).

A child's level of cognitive development is also a critical consideration. As an example, the significance of reported concerns about "lying" and "stealing" in three- and four-year-olds needs to be understood within the context of distinguishing fantasy and reality, of the child's understanding of the social rules of truth telling and ownership, and of a young child's propensity to avoid discipline if questioned directly. For the most part, these behaviors are transient behaviors of early childhood. Caregivers may need developmental guidance in not placing a child in the position to tell untruths, or in understanding that young children are still in the process of learning to respect the property of others. However, chronic, persistent child actions and denials of negative behaviors, or chronic food or toy hiding and hoarding behaviors, may well be red flags for preventive intervention focused on caregiving strategies and early childhood mental health treatment.

Children with language delays frequently lack the *verbal mediators* that assist typical children in the development of behavioral regulation. Rules are more easily understood, retained, and internalized when the child has the language to map on a particular caregiver's expectations of child behavior. This is most pertinent when the young child with language or cognitive delay has several caregivers with differing expectations of behavior or differing verbalizations for behavioral expectations.

Children with developmental disabilities are also at increased risk for social and emotional difficulties. This is due to the fact that they are facing not only the typical demands of growing up but also the added challenges that frequently accompany delay or disability, including the development of a sense of self-mastery, competence, confidence, and a sense of belonging.

It is essential to understand a child's development when ascertaining the significance of dysregulated behaviors such as chronic noncompliance and tantrums. There is a difference in interpretation of tantrums and noncompliant behaviors between when a healthy, robust five-year-old does not get his way and when the same behavior is observed in a five-year-old child whose overall cognitive and emotional development is at the two-year-old level. Both children will need

assistance in developing self-regulation. However, the diagnostic formulations, differential diagnosis, and intervention-treatment plans will differ in approach and implementation.

Health and Physiologically Based Perspectives on Child Emotions and Behavior

Prenatal and postnatal health circumstance can play a significant role in the self-regulatory, emotional, and behavioral development of infants and young children. Low birth weight, inadequate nutritional status, substance exposure, lead exposure, and iron deficiency anemia can result in biological vulnerabilities that affect child well-being and the parenting process, as well as social, emotional, and behavioral outcomes.

A biological vulnerability may be mild enough to require extraordinary psychosocial circumstances for behavioral dysfunction to become evident. In contrast, the biological deficit may be grave enough to lead to behavioral disorders even in the absence of negative environmental circumstance. In fact, children with neurological damage evidence a two to three times higher incidence of behavioral disorders than do other children. The question remains as to how much of the behavioral disorder is due to actual biological deficit and how much is due to biological vulnerability that has been compounded by negative environmental influences that perhaps could have been ameliorated!

Biological vulnerabilities do not directly *cause* behavioral disturbance. However, they contribute to a physiological state that makes the child more sensitive to environmental circumstances and increases the likelihood of negative outcome if left unaddressed in the caregiving process. Biological vulnerabilities frequently go unidentified because it is both the degree of child vulnerability and caregiver capacity to serve as a buffer that determine significance.

- *Low birth weight.* Babies born prematurely or born small for gestational age may need special caregiving to address hypersensitive nervous system functioning. Low-birth-weight babies may evidence neurobehavioral markers that include poor organization of behavior, poor consolability, and less focused alertness (Ochler, Thompson, Goldstein, Gustafson, & Brazy, 1996; Field, 1998).
- *Inadequate nutrition.* Research findings show that insufficient nutrition, even on a relatively mild basis, can have significant effects on child development and behavioral regulation (Center on Hunger,

Poverty and Nutrition Policy, 1995). Undernutrition can influence the biochemical functioning of the brain, affecting the intactness of the child's neurobehavioral development. Symptoms may include increased lethargy, reduced focused attention, and a lower tolerance to frustration, leading to increased susceptibility to stress. The child who is malnourished may show a lack of persistence in task completion and interpersonal engagement, resulting in *functional isolation.* Thus the physiological sequelae from undernutrition are compounded by experiential loss.

• *Drug and lead exposure.* The toxic effects of cigarette, alcohol, and other drug exposure are well documented. Pre- and postnatal substance exposure may result in central nervous system vulnerability, including compromised neurobehavioral regulatory mechanisms. Exposure does not *cause* maladaptive behaviors, but it may result in serious behavioral difficulties when neurobehavioral vulnerabilities go unaddressed. Needleman's study (Needleman, Reiss, Tobin, Bisecker, & Greenhouse, 1996) on the consequences of early lead exposure found that there might be enduring problems relating to somatic complaints, anxious and depressed behavior, social problems, and aggression.

• *Iron deficiency anemia.* Iron deficiency is the most common single-nutrient deficiency. It is estimated that 25 percent of low-income children are iron deficient (Center on Hunger, Poverty and Nutrition Policy, 1995). Lozoff (1986) reports that 36 percent of her anemic infant group showed affective abnormalities during developmental testing. She hypothesized that iron deficiency alters activity levels and the metabolism of several central nervous system neurotransmitters that influence affect and arousal. In a later study (Lozoff et al., 1998), she described toddlers with iron deficiency anemia as being more wary, being less attentive, needing closer proximity to caregivers, and evidencing less pleasure in their play. In a ten-year follow-up study, parents and teachers rated child behavior as more problematic in areas related to anxiety and depression, social problems, and attention difficulties (Lozoff et al., 1998; Lozoff, Jimenez, Hagen, Mollen, & Wolf, 2000).

Experiential Perspectives on Child Emotions and Behavior

Recent infant brain research has underscored how negative experiences can actually undermine brain development and central nervous system functioning. Extreme experiences of emotional and physical trauma, neglect, separation, and loss can result in prolonged elevated

stress hormones that affect the structures of the brain that are involved with vigilance and arousal. This leaves the child with a more sensitive nervous system, distress prone, and with a predisposition to overinterpret and overreact to emotional and physical experiences.

Parenting Perspectives on Child Emotions and Behavior

Runyon, in his seminal article (Runyon, Hunter, & Socolar, 1998), pointed out the maternal benefits to the parenting process that are derived from personal-social relationships. Parenting is not innate, but rather an acquired process that comes more easily when there is a two-parent household and when there is a community of moms and neighborhood and family supports to aid the inexperienced or overwhelmed mother. Societal changes have led to the demise of many traditional supports. The majority of mothers are now in the workforce, and single parenthood is at an all-time high. In areas of high mobility and high immigration, there are thousands of women who are isolated from their families of origin. With these changing demographics, parents more than ever are expressing concerns and requesting guidance relating to their child's development and behavior.

Caregiving Relationship Perspectives on Child Emotions and Behavior

The focal point of infant and early childhood mental health is the relationship between the primary mothering figure and the child. Infant brain research has demonstrated that close, intimate contact between parent and infant actually affects the circuitry of the brain (Dawson, 1994) and that nurturing care enhances the child's stress management system and the capacity to cope with and recover from stressful events. Critical keys to quality parent-child relationships and infant attachment include dyadic emotional availability, interaction reciprocity, clarity of infant-child cues, and parental understanding of child needs. Because the relationship is the mechanism that helps the child develop adaptive capacities, any circumstance that interferes with the relationship and the parenting process must be assessed and addressed in the treatment plan. It has been suggested that clinical disturbances in infants are best described as relationship disorders rather than individual disorders (Zeanah, 1993).

Several circumstances influence parental emotional availability, the capacity to form intimate relationships, and the capacity to parent. Parents differ in how they perceive, interpret, and respond to their infant's cues or their child's affect and behaviors based on their own temperament, knowledge, culture, and experience in having been parented. These all shape adult expectations regarding child development and shape their beliefs of how children learn to meet adult expectations.

It is critical that we understand a parent's belief system before we try to interpret parental behavior. A multitude of psychosocial circumstances influence the dyadic relationship and are predictors of parenting difficulty. These circumstances include maternal depression, family substance abuse, domestic violence, poverty, unsupported single parenthood, and the mother who has a history of trauma and broken relationships.

Cumulative Risks

Most single child or family stressors do not lead to negative child outcome. The impact of significant health or psychosocial risks depends on the age of occurrence and whether they occur alone or with other risk factors (Department of Health and Human Services, 1999). Although risk is not destiny, the accumulation of risks is of serious consequence. Significant family risk factors rarely occur in isolation. Poverty, low levels of education, and single parenthood are highly correlated (Illig, 1998), as are perinatal biological risks, concurrent harsh parenting, and parental stress (Wakschlag & Keenan, 2001). Understanding the extent and gravity of risk is imperative to the diagnostic formulation process.

DIAGNOSIS OF INDIVIDUAL DIFFERENCE IN YOUNG CHILDREN FOR THE PROMOTION OF CHILD WELL-BEING

All inexperienced parents need support in guiding their infants and toddlers to develop self-regulation, social reciprocity, intimate relationships, developmental competency, and social-emotional well-being. Infants and young children may display behaviors that concern parents but are actually within the expected range for a very young child. Crying, sleeping, and feeding difficulties are common areas of concern during infancy (Jellinek, Patel, & Froehle, 2002).

Preschool children typically have higher energy levels and are more active and rambunctious than school-age children. Overactivity, poor regulation of impulses, noncompliance, and aggression are common concerns of parents of preschool children (Keenan & Wakschlag, 2002). These are typical, transient, developmental perturbations seen in young children. However, there is a need to distinguish between a rambunctious child who is exasperating to caregivers and the one who truly has a clinical deficit in compliance with adult expectations.

Transient difficult behaviors may become symptoms of emerging problems or disorders if the caregiving environment does not help young children develop self-regulation and more adaptive ways of dealing with their environment. Behaviors become of significant concern when they continue unabated past the time that they are seen as age-appropriate expressions of frustration or autonomy seeking or when they interfere with more age-appropriate social and communication skills, such as negotiating, sharing, and playing cooperatively (Campbell, 1990).

At times, service providers are faced with inappropriate referrals. When children are cared for in group situations, active and rambunctious behavior can be experienced as disruptive. Limited tolerance for normative but transient disruptive behavior can lead to overreferral to mental health professionals. Despite professional concerns about overreferral, caregiver concerns should always be addressed.

The mental health service delivery tasks are to support parents by disseminating information and promoting positive parent-child relationships. Support and promotion may be provided through anticipatory, developmental, and interaction guidance that encourages responsive caregiving aimed at matching child temperamental and developmental needs. All intervention plans should provide caregiver support, influence caregiver-child relationships, offer strategies for behavioral guidance, and provide recommendations for program or environmental modifications that match the developmental and temperamental needs of the child.

DIAGNOSIS OF MENTAL HEALTH PROBLEMS FOR PREVENTIVE INTERVENTION

Early childhood behavioral problems are typically categorized as either internalizing or externalizing. Internalizing behaviors are often seen in children who do not use caregiving adults to get their needs met.

These children may be disconnected, depressed, excessively passive, and withdrawn. Externalizing behaviors include those that indicate poor self-regulation, such as aggression, tantrums, and noncompliance. Externalizing behaviors, when left unaddressed, tend to continue over time (Department of Health and Human Services, 2000).

However, not all early affective and behavioral difficulties are the hallmark of a mental health disturbance. Young children may demonstrate affective or behavioral difficulties that interfere with functioning at home, child care, or preschool and may require clinical attention but are of insufficient intensity and duration to be considered a mental health disorder (President's New Freedom Commission on Mental Health, 2002). The V codes in DSM IV are for situations that are a focus of concern but are not attributable to a psychiatric disorder.

Left unaddressed, early social and emotional difficulties can be antecedents for later behavioral and emotional disorders. Ineffective or discordant parent-child interactions may result in negative behavioral chain reactions and ultimately a mental health disorder. The focus of early childhood mental health preventive intervention is to thwart disorder at a later age by reducing child and family predisposing risks and by promoting protective factors.

DIAGNOSIS OF MENTAL HEALTH DISORDERS FOR THERAPEUTIC INTERVENTION

Clinicians agree that a mental health disorder in young children consists of a pattern and level of impairment that has been troublesome for some time. The symptom pattern can include abnormalities of emotions, thinking, behavior, or relationships. It is only after a certain degree of intensity, frequency, duration, and level of impairment in more than one situation that symptom patterns become significant enough to be considered a disorder (National Institute of Mental Health, 1999). Determination of disorder rests on establishing that the behavior is causing clinically significant distress or impairment in the child's emotional, social, developmental, or other important areas of functioning.

Formal diagnostic classification systems focus on the more severe and extensive mental health conditions. The classification systems provide mental health criteria for the medical necessity that is required for third-party payment from private insurance or public funding. Commonly used classification systems include the *Diagnostic and*

Statistical Manual of Mental Disorders: DSM IV of the American Psychiatric Association (1995) and the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (1994).

The DSM IV is the classification system most commonly used to define mental health disorders and medical necessity for service eligibility. Criteria for differential diagnosis are specified by symptoms, duration, and situations in which the behaviors occur. The DSM IV includes a multiaxial diagnostic system that provides a framework for organizing and communicating clinically important information.

The DSM IV is composed of five axes:

- *Axis I* is for assessment of clinical syndromes and patterns of behavior that may require clinical attention. Disorders usually diagnosed in early childhood include the following:
  - Pervasive developmental disorders
  - Attention deficit and disruptive behavior disorders
  - Feeding and eating disorders of infancy or early childhood
  - Tic disorders
  - Elimination disorders
  - Separation anxiety and reactive attachment disorders
  - Selective mutism
- *Axis II* is for assessment of personality disorders and mental retardation.
- *Axis III* is for assessment of general medical conditions.
- *Axis IV* is for assessment of psychosocial and environmental stressors that influence the diagnosis, treatment, or prognosis of the mental health disorder.
- *Axis V* is for a global assessment of functioning on a scale of one to a hundred.
- *V Codes* designate mental health conditions that do not qualify as mental health disorders but require attention or treatment. Parent-child relationship problem is listed as a V Code and frequently is excluded from third-party payments.

The criteria for diagnosing DSM IV mental health disorders in children are derived from those for adults. Relatively little research

attention has been paid to the validity of these criteria for children (Department of Health and Human Services, 1999; Keenan & Wakschlag, 2002). Although the DSM IV multiaxial diagnostic system provides comprehensive, systematic evaluation of many facets of individual functioning, the early childhood mental health community believes that it does not adequately describe the mental health disorders found in infancy and early childhood (Greenspan & Wieder, 2001).

The *Diagnostic Classification 0–3* captures the importance of the parent (or caregiver) and child relationship as the process that helps the child develop adaptive capacities. It emphasizes a developmentally based, multiaxial approach that provides a structure for identifying strengths and weaknesses in infants or young children and the caregiving environment. The framework sets the stage for developing a developmentally appropriate, comprehensive intervention or treatment plan. The five axes include the following:

- *Axis I: primary classification* captures the presence of conditions that lead to the disorder:

  Traumatic stress disorder is considered with an identifiable stress.

  Disorders of affect are considered when there is no identifiable stress and no clear constitutionally based vulnerability.

  Adjustment disorder is considered with mild problems of short duration associated with a clear environmental event.

  Regulatory disorder is considered with clear-cut constitutionally based difficulties.

  Sleep behavior disorder is considered when it is the sole presenting problem.

  Eating behavior disorder is considered in absence of regulatory or interpersonal precipitants.

  Disorders of relating and communicating are considered when combined with difficulties in the regulation of physiological, sensory, attentional, motor, cognitive, somatic, and affective processes.
- *Axis II: relationship disorder classification*
- *Axis III: medical and developmental disorders and conditions*
- *Axis IV: psychosocial stress*
- *Axis V: functional emotional developmental level*

POLICY ISSUES

Child mental health public policy is limited in scope. The publicly funded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program restricts funding for screening, assessment, and treatment of mental health disorders to children in low-income families. Children who do not have publicly funded or private insurance coverage remain underserved.

Private insurance–paid and publicly funded mental health services require the child to have a differential diagnosis. This requirement leaves thousands of children with problem behaviors without services until their problems become extreme. Currently, there is no comprehensive infrastructure for preventive intervention services for social, emotional, or behavioral problems that do not meet the medical necessity criterion required for EPSDT or private insurance coverage. The early childhood mental health community needs to advocate for comprehensive preventive intervention and treatment services for all children.

TRAINING ISSUES

Diagnostic formulation is based on a comprehensive assessment, including play-based developmental and psychometric data, child and family interview, physical and nutrition evaluation, review of medical records, and preschool observations. In order to comprehend the differential diagnostic process, the professional needs to have expertise in child and family assessment and an understanding of child development, family systems, psychodynamic theory, attachment theory, and the impact of biological and psychosocial vulnerabilities on child social-emotional health.

Training should include a focus on health, nutrition, regulatory mechanisms, and temperamental considerations, as well as maternal and family factors that interfere with dyadic relationships, family stability, and child well-being. An internship experience with supervision is the most effective way for providers to develop the skills needed for diagnosis and treatment of early childhood mental health problems and disorders.

All early childhood service providers should be able to address typical developmental concerns relating to social, emotional, and behavioral development. Mental health preventive interventions should be diagnosed and designed by early childhood mental health

specialists but can be implemented by individuals coming from many disciplines with mental health supervision. Differential diagnosis and treatment of early childhood mental health disorders should only be conducted by licensed early childhood mental health specialists.

Child social, emotional, and behavioral health must be viewed within an ecological context. The mental health professional, in partnership with the child's parents, seeks to understand the biological, psychosocial, and environmental influences on the child's patterns of behavior and social-emotional well-being. The identification of strengths and vulnerabilities within the child and the caregiving environment provides the framework for differential diagnosis; anticipatory, developmental, and interaction guidance; preventive intervention strategies; and child and family mental health services and supports.

References

American Psychiatric Association. (1995). *Diagnostic and statistical manual of mental disorders: DSM IV* (4th ed.). Washington, DC: Author.

American Psychological Association. (2003). *Guidelines on multicultural education, training, research and practice, and organizational change for psychologists.* Washington, DC: Author

Campbell, S. B. (1990). *Behavior problems in preschool children.* New York: Guilford Press.

Cantwell, D., & Baker, L. (1988). Issues in classification of child and adolescent psychopathology. *Journal of the American Academy of Child and Adolescent Psychiatry, 5,* 521–533.

Carlson V. J., & Harwood, R. L. (2000). Understanding and negotiating cultural differences concerning early developmental competence. *Zero to Three, 20,* 19–24.

Center on Hunger, Poverty and Nutrition Policy. (1995). *The link between nutrition and cognitive development in children.* Medford, MA: Tufts University.

Chess, S., & Thomas, A. (1996). *Temperament: Theory and practice.* Philadelphia: Brunner/Mazel.

Dawson, G. (1994). Development of emotional expression and emotion regulation in infancy: Contributions of the frontal lobe. In G. Dawson & K. W. Fischer (Eds.), *Human behavior and the developing brain* (pp. 346–379). New York: Guilford Press.

Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Washington, DC: Author.

Department of Health and Human Services. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Author. [http//:www.ussurgeongeneral.gov].

Diagnostic classification: 0–3. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (1994). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Field, T. (1998). Touch therapies. In R. R. Hoffman, M. F. Sherrick, & J. S. Warm (Eds.), *Viewing psychology as a whole* (pp. 603–626). Washington DC: American Psychological Association.

Gesell, A. (1940). *The first five years of life.* New York: HarperCollins.

Green, M., & Palfrey, J. S. (Eds.) (2000). *Bright futures: Guidelines for health supervision of infants, children and adolescents* (2nd ed.). Arlington, VA: National Center for Education in Maternal and Child Health.

Greenspan, S. I., & Wieder, S. (2001). Developmentally based diagnostic classification of emotional disorders in infancy and early childhood. In S. I. Greenspan, G. DeGangi, & S. Wieder (Eds.), *The Functional Emotional Assessment Scale (FEAS) for infancy and early childhood* (pp. 269–307). Bethesda, MD: Interdisciplinary Council on Developmental and Learning Disorders.

Illig, D. C. (1998). *Birth to kindergarten: The importance of the early years.* Sacramento: California Research Bureau, California State Library.

Jellinek, M., Patel, B. P., & Froehle, M. C. (Eds.). (2002). *Bright futures in practice: Mental health—volume 1. Practice guide.* Arlington, VA: National Center for Education in Maternal and Child Health.

Keenan, K., & Wakschlag, L. S. (2002). Can a valid diagnosis of disruptive behavior disorder be made in preschool children? *American Journal of Psychiatry, 159,* 351–358.

Lozoff, B. (1986). Iron-deficient anemic infants at play. *Developmental and Behavioral Pediatrics, 7,* 152–158.

Lozoff, B., Klein, N. K., Nelson, E. C., McClish, D. K., Manuel, M., & Chacon, M. E. (1998). Behavior in infants with iron-deficient anemia. *Child Development, 69,* 24–36.

Lozoff, B., Jimenez, E., Hagen, J., Mollen, E., & Wolf, A. W. (2000). Poorer behavioral and developmental outcome more than 10 years after treatment for iron deficiency in infancy. *Pediatrics, 105,* 51.

National Institute of Mental Health. (1999). *Charting the mental health status and service needs of children.* Washington DC: Author.

Needleman, H. L., Reiss, J. A., Tobin, M. J., Bisecker, G. E., & Greenhouse, J. B. (1996). Bone lead levels and delinquent behavior. *Journal of the American Medical Association, 7,* 363–369.

Neisworth, J. T., Bagnato, S. J., & Salvia, J. (1995). Neurobehavioral markers for early regulatory disorders. *Infants and Young Children, 8,* 8–17.

Ochler, J. M., Thompson, R. J., Jr., Goldstein, R. F., Gustafson, K. E., & Brazy, J. E. (1996). Behavioral characteristics of very-low-birth-weight infants of varying biologic risk at 6, 15, and 24 months of age. *Journal of Obstetrical Neonatal Nursing, 25,* 233–239.

Poulsen, M. K. (2002). Defining early childhood/family mental health. *Cathie Wright Technical Assistance Center Updates, 5*(3), 1–9.

Practice parameters for the psychiatric assessment of infants and toddlers: 0–36 months. (1997). *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(10, Supplement), 21S–36S.

President's New Freedom Commission on Mental Health. (2002). *Achieving the promise: Transforming mental health care in America.* Washington DC: Author.

Rapoport, J. L., & Ismond, D. R. (1996). *DSM-IV training guide for diagnosis of childhood disorders.* New York: Brunner/Mazel.

Richters, J., & Weintraub, S. (1992). Beyond diathesis: Toward an understanding of high-risk environments. In J. Rolf, A. S. Masten, D. Cicchetti, K. H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 67–96). New York: Cambridge University Press.

Rolf, J., Masten, A. S., Cicchetti, D., Nuechterlein, K. H., & Weintraub, S. (Eds.). (1992). *Risk and protective factors in the development of psychopathology.* New York: Cambridge University Press.

Runyon, D. K., Hunter, W. M., & Socolar, R. S. (1998). Children who prosper in unfavorable environments: The relationship to social capital. *Pediatrics, 10,* 12–18.

Rutter, M., & Tuma, A. (1988). Diagnosis and classification: Some outstanding issues. In M. Rutter & A. Tuma (Eds.), *Assessment and diagnosis in child psychopathology* (pp. 437–452). New York: Guilford Press.

Sanson, A., Prior, M., & Kyrios, M. (1990). Contamination of measures in temperament research. *Merrill-Palmer Quarterly, 36,* 179–192.

Wakschlag, L. S., & Keenan, K. (2001). Clinical significance and correlates of disruptive behavior in environmentally at-risk preschoolers. *Journal of Clinical Child Psychology, 30,* 262–275.

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs.* New York: National Center

for Children in Poverty, Columbia University School of Public Health, and American Orthopsychiatric Association.

Zeanah, C. H. (1993). *Handbook of infant mental health.* New York: Guilford Press.

Zeanah, C. H. (1997). Infant development and developmental risk. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 165–178.

Zeanah, C. H. (2000). *Handbook of infant mental health* (2nd ed.). New York: Guilford Press.

CHAPTER FIVE

Dyadic Therapy with Very Young Children and Their Primary Caregivers

Joan Maltese, Ph.D.

A more comprehensive understanding of the intricacies of the developing relationship between parent and child may be the most important advancement in the field of early intervention in the last decade. Although support for the first relationship is not new, the potential for improving development that is at risk of derailment, delay, or disability is seen with new appreciation.

As forefathers of the *dyadic therapy model,* John Bowlby (1969, 1982) and Donald Winnicott (1965) emphasized that the very survival of the infant depends on adult caregiving. They suggested that both infant and parent are biologically biased to engage in a relationship that supports healthy development.

A decade later, Selma Fraiberg's work established *parent-infant psychotherapy* as a distinct therapeutic intervention that defined the task of freeing the infant-toddler from the parent's unresolved conflicts that surfaced as "ghosts in the nursery" (Fraiberg, Adelson, & Shapiro, 1975, p. 20). During the past twenty-five years, countless leaders in early childhood development have focused on supporting and guiding parents in building relationships with their children that foster

secure attachment and greater resilience to later psychological trauma (Lieberman & Pawl, 1988; Sroufe, 1997).

The latest findings from neuroscience research and clinical reports from a wide range of developmental applications implicate dyadic therapy as a crucial component of early intervention programs. New technologies in the field of neuroscience depict basic brain development as an intricate dance between heredity and environmental influence, specifically the environment of the relationship between parent and child.

Neuroimaging studies suggest that the relationship is not just supportive of unfolding biology. It is also decisive in the wiring of brain connections between affective registration in the limbic system, the modulation and organization of incoming stimuli in the cerebellum, and response patterns organized in the prefrontal cortex.

These findings have led to an explosion in developmental literature pointing to the critical influence of early relationships in both synaptic organization and behavioral expression of biological and environmental influences. Although the field is far from providing the final answers regarding human psychological development, we know more of when, where, and how the brain develops and how that development may influence later developmental trajectories.

CRITICAL INFLUENCES

The development of affect regulation is the result of attuned parental response to the child's signals and to highly charged, shared emotional states. Alan Schore's work (1994) on the developing sense of self emphasizes the critical influence of relationships. These influences include limiting the exposure to prolonged states of stress and increasing shared joyous affect, visual gaze, and reciprocal nonverbal coregulation of calm and sustained attention.

Consistent parental regulation gives way to coregulation of affective inputs. Both parent and child attempt to recapture a calm state and eventually self-regulatory processes emerge. The infant-toddler then has greater power over response to stimuli and can make adjustments in order to self-soothe and adapt to incoming stimuli. This increased capacity to regulate and modulate incoming sensory and affective information allows the infant to interact constructively with his environment. It also sets the stage for the infant's increasing

interest in the world beyond the personal sensory experience and for active participation in determining experiences with parents and other caregivers.

The developing mind of the young child is shaped by the ongoing, consistent feedback loop between biological maturational thrusts, internal sensory and affective experience, and the responsiveness of the environment to the expression of these forces. Daniel Siegel (1999, p. 70) defines "consistent, collaborative communication" between infant and parent as the cornerstone of the system that allows the child to organize the world. This communication also helps the child develop a hierarchy of mental processes that allow mindful participation in the continuous exchange of social, emotional, and cognitive information.

Understanding the powerful influences of parent-child relationship dynamics broadens the dyadic therapy model. The model now includes prevention and support to families, as well as intensive intervention when development is seriously threatened. First, considering early attachment influences, risk factors can be identified before derailment or disturbance is established. In fact, risk factors can be addressed in prenatal and perinatal programs for prevention and risk reduction.

Second, as early intervention programs are fueled by the organizing and stabilizing influence of consistent caregiver relationships, attention is paid to the ongoing dynamic exchanges between caregiver and child. These are viewed as a means of optimizing development, even when significant biological and environmental risk factors are established.

For example, Stanley Greenspan and Serena Wieder's *Floor Time approach* (Greenspan & Wieder, 1998) uses a relationship-focused model in working with young children with neurodevelopmental disorders. Greenspan and Wieder postulate that consistent responses that generate and sustain positive affect can foster children's capacities for attention, intimacy, and two-way communication. This lays the foundation for cause-and-effect reasoning and later emotional thinking (abstract reasoning) and more complex cognitive capacities.

The positive effects of early stable relationships extend well beyond early childhood. It is suggested that many problems of later childhood may have different characteristics and a more optimistic prognosis if effective early intervention is provided. In a longitudinal study, Sroufe (1997) has demonstrated increased resilience in children who face

challenges later in life when early caregiving patterns foster secure attachments and positive sense of self.

A SHIFT IN THINKING

What makes dyadic therapy different from other developmental therapies and intervention models is the absence of a "patient." Rather, the focus of treatment is the *relationship*—the dynamic interplay between a parent and child. There are unique circumstances in this relationship that present both challenges and windows of opportunity to effect change. These include the rapid growth curve of the infant-toddler and the *biological preparedness* of infants to seek care and emotional connection with caregivers.

This is accompanied by the primary caregiver's own *biological readiness* state, referred to as *primary maternal preoccupation* (Winnicott, 1965) or the *motherhood constellation* (Stern, 1995). Both infant and parent are biologically biased to seek engagement and intense interaction with each other to ensure the infant's survival. The relationship influences and is influenced by the actions and reactions of each member.

The therapist working with the dyad must hold in mind these mutual influences. Although there is often a pull to identify with either parent or child as the focus of intervention, the relationship itself is where the clinical action is. Calling this the "centerpiece of the clinical situation," Daniel Stern (1995, p. 59) suggests that it is here that a parent's most critical representations, wishes, fears, and fantasies about the infant are played out. It is also the arena in which the infant expresses emerging representations that directly influence the parent. The interaction bridges two sets of representations that mutually respond to and affect each other.

In the dyadic model, there has been a move away from pathologically oriented mental health treatment to a family-centered, strength-based model. Parents are typically encouraged to be collaborators in the process of understanding a child's signals and responding and supporting adaptive patterns of development. The diagnostic framework of the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (1994) relies on a developmental and relational approach to developmental difficulties in the first three years of life rather than on labels of pathology.

Diagnostic categories are part of the mental health system, because a diagnosis is often necessary before a child can receive services. However, thinking about the complexity of what a child and the child's family need to support development does not stop with a diagnosis. In the new format, assessment and diagnosis are fused with treatment, in an attempt to describe the child's capabilities and challenges. Attention is given to relationship support, physical conditions, psychosocial stress, and functional emotional development level.

This system, although it provides preliminary categorization of presenting symptoms and behaviors, is guided by the awareness that all infants are participants in relationships. Individuals are components, each with her own range of self-regulatory capacities. Improving the relationship often reduces the infant's regulation difficulties by increasing the mutual satisfaction that both caregiver and child receive from the interaction.

As a separate component of the interaction, each child has his own developmental profile. Parents also bring a unique history, temperament, and parenting style that must be considered. This is a lot to keep track of simultaneously, especially because the "individual differences" have limitless possibilities and pertain to multiple domains of development. Each therapist working in the family model is likely to have certain biases, favored perspectives, and personality traits that affect the interaction. It is important to know that a myriad of influences is always operating. Ignoring any domain may keep us from evaluating critical information that may affect developmental outcome.

When development is challenged by known or suspected risk factors, an intensive and comprehensive approach is required. Understanding the powerful influence of a child's primary relationships is not limited to the field of mental health. Other disciplines, such as occupational therapy, physical therapy, speech and language therapy, early childhood education, and special education, also consider the influence of relationships in their treatment approaches.

It is not unusual for a family to receive up to four or more types of therapies or support services. The impact of managing multiple relationships and inputs can leave a family feeling fragmented and spread thin. Transdisciplinary approaches allow teams to work together to support the parent's role in fostering the development that can serve as an additional layer of the *scaffolding*.

The influence of relationships goes beyond the infant and parent to the parent and professional (or teacher) and to professionals with

other professionals. As the model expands to the multiple relational influences in the child's development, attention to extended family, noncustodial caregivers, and cultural and environmental influences becomes relevant to our complete understanding of the factors that support or threaten healthy development.

DEVELOPMENTAL SCAFFOLDING

In addition to attention to the relationship between parent and child, dyadic therapy requires extensive knowledge of early developmental processes. Understanding the sequence and hierarchical nature of early development allows the therapist to provide information and guidance to parents when they have concerns about their children's development. Familiarity with developmental principles may bring relief and confidence to both parent and therapist as they work together to influence the child's development.

As parents get to know their infants or toddlers, variations or individual differences in development can cause anxiety or fear. Attempts to change these differences instead of attending to their communicative value may unwittingly confuse or distress the child in his attempt to cope with impinging stimulation or needs. Parents are often vulnerable to criticism and comments made about their infants. This may spark a parent's shame and may lead her to feel critical of her child's behavior and respond harshly to the child's very natural attempt to communicate his experience.

Conversely, a parent fearful of the implication of a child's differences in development may distort or ignore warning signals of developmental distress or disability and not respond when a response could facilitate developmental support. When a parent is helped to recognize a child's developmental needs, the parent and child are more likely to have a positive emotional experience. The child is not frustrated by the parent's need for the child to do something for which the child is not ready, and the parent is not frustrated by the child's inability to understand what the parent wants.

The progression of developmental milestones shifts the focus of the therapeutic window and changes the port of entry into the relational system. These transition points in development can be thought of as *clinical windows* or as *touchpoints* (Brazelton, 1992). Clinically relevant issues such as trust, attachment, dependence and independence, control, autonomy, mastery, individuation, and self-regulation

are ongoing issues (Stern, 1995). They build over time and are worked on all the time.

There are functional capacities and milestones that make way for the emergence of new skills and capacities, each building on the previous levels. Emde and Harmon (1984) point out that at critical points of change, almost all aspects of the infant's functioning changes: motor, affective, cognitive, and social. The timing of these changes seems to be part of the biological clock that is also influencing the progression of development. This is significant clinically because basic issues such as independence or trust are negotiated differently in terms of the infant's new capacities for communication and relatedness.

There are numerous resources for charting young children's milestones, including popular magazines, developmental Web sites, and pamphlets in pediatricians' offices. Regulation of the affective or emotional system is a core task facing the parent-infant dyad. Initially, parents serve as an external regulating system. They read signs of discomfort and pleasure and facilitate relief from distress or enhancement of positive affect.

Infants can easily become dysregulated by too much excitement or distress, and signals to communicate can become aversive and dysregulating for the parent. This is particularly so when the parent is unable to effectively return the child to a calm and regulated state. Managing their own regulatory system can be very challenging for caregivers, especially if they do not have another source of support when they are overwhelmed.

Mutual regulation develops as the child becomes more able to give more discrete cues, and parents develop an expanding repertoire of responses. Through repeated experiences that mostly bring relief, satisfaction, and joy, the young child develops the capacity for self-regulation; skills of self-control, empathy, and concern for others; and an understanding of negotiation and compromise to get needs met.

CLINICAL WINDOWS

Understanding the sequence and scaffolding of capacities and skills tells us where the clinically relevant dynamics are likely to be played out. For example, in the *first few months of life,* parent and child are mutually engaged in the processes of regulating feeding and sleeping and the modulation of multiple sensory inputs impinging on the

infant. Episodes of crying and soothing are interspersed with attention to the social world of smiles and coos.

During this period, there are frequent breakdowns in the regulatory process. Parents' attempts to respond to infant complaints and distress are opportunities to observe the early development of the nonverbal communication system as are times spent putting children to sleep, feeding, diapering, and dressing them. The tones of parents' voices, along with rocking, cradling, and holding in response to baby's cues of pleasure and dysregulation or displeasure are clinical windows into relationship dynamics.

Within a few short months, the *six-month-old* infant's preference for face-to-face interaction brings about joint emotional involvement. The infant's social and affective capacities and the parent's capacities to elicit and respond often provide the opportunity to see mutual regulation of social interactions. A baby who is difficult to soothe or a parent who may be under- or overresponsive to gazing or vocalizations may have frequent bouts of dysregulation. This may cause frustration and begin to weaken the confidence of both infant and parent.

By *six to twelve months,* maturing hand-to-hand, hand-eye, and other motor coordination, along with better-regulated sensory and affective systems, allows increased curiosity and interaction with toys and objects. Intentionality and reciprocity can be observed in the way interests are communicated, focus is shifted, and play is elaborated or disengaged. Patterns of under- or overresponsiveness on the part of the child or under- or overregulation on the part of the parent demonstrate important variables in the interaction.

Supported by maturing physical, verbal, and nonverbal communication patterns, the child's movements toward and away from the parent may reveal important dynamics in the relationship. Patterns of attachment and separation are also observed during this time.

The capacity to use mental representation, as seen in the language and play of the *eighteen-month-old,* offers yet another level of interaction. Building from early communication skills, words that represent concrete and abstract experiences between parent and child allow a more complex dialogue, which exposes underlying relationship issues. With continued physical and emotional development, the child's striving for independence and socialization requires limit setting on the part of the parent and primary caregivers. The negotiations that ensue are prime windows for understanding how the relationship is functioning.

Increased ability to elaborate on ideas through language and pretend play brings the *two-year-old* and the parent into a world that goes beyond basic needs to complex intentions, wishes, and feelings. A growing sense of self as a separate agent in the relationship invites observation of complex negotiations and tests of will and determination.

The *three-year-old* is typically involved in a myriad of relationships with preferences and knowledge of relationship rules. With increased capacities for logic and categorization, the level of negotiation reaches new heights. The clinical window for observation widens as multiple relationships are often routinely handled and preferences discussed.

Greater elaboration of symbolic representation and problem-solving capacities of the *four- and five-year-old* provides a new level of relating. A wide range of experiences beyond the dyad is present in communication and play. The relationship may serve as a vehicle to sort out and understand a child's other relationships at school, with playmates, and with other caregivers.

There is considerable overlap in windows, and although development continually builds on previously gained capacities, there are leaps forward and regression back to previous levels of development, particularly under stressful conditions. The clinical window helps direct clinical observation. It should be used as a guide, not as a strict classification system.

In addition to milestones, the process and sequencing of affect regulation leading to self-regulation and the development of a cohesive sense of self are critical aspects to be watched and supported in the infant-toddler–parent relationship. Other infant-toddler characteristics to watch include level of curiosity, level of activity, initiation of interaction, and level of pleasure and displeasure. These motives are strong influences on caregiving behavior as they pull for both action and emotional responding.

STRATEGIES FOR THERAPEUTIC ALLIANCE

One of the unique aspects of dyadic therapy is the dual role held by the therapist and the parent as both participants and observers. The therapist aligns with the parent in attending to the progress of development. The therapist also holds the needs of the child-parent pair in balance. The parent is a collaborator and a participant in the process of watching and wondering about development.

Because parents are often participating in therapy for the benefit of their children and not necessarily for insights or help for themselves, the goals of therapy should be clearly determined at the outset. Parents should be encouraged to establish the agenda and welcomed to give feedback about the therapeutic process. From the outset, the therapist should invite and support parental reflections, thoughts, and feelings related to the presence and care of their infants or toddlers.

Sensitivity to parents' feelings about therapy is crucial. Many parents feel judged and uncertain of their own capabilities when they enter into dyad therapy. Assuring them that there is no "right way to be" and that the therapist also does not have the answers may be very helpful. The explanation that your time together will be spent "watching, waiting and wondering" (Muir, Lojkasek, & Cohen, 1999, p. 12) or developing an understanding of the needs and individual differences of their child's communication efforts will also be useful.

Whether sessions are held at the family home or at a center may offer different opportunities to observe interactions and present different levels of comfort for both parent and child (McDonough, 2000). Some parents are not comfortable being seen in their homes. It may feel intrusive, or they may feel that their home life will be scrutinized. Home visits may feel more comfortable after a good relationship is established between parent and therapist. Very often, home visits offer a rich environment in which the therapist may see how the family responds to the child's attempts at communication and how the child responds to the parents or other family members. The home environment is so rich that it is often not possible to take note of all that is going on.

A video camera can be an invaluable resource in capturing communication styles and opportunities for both parent and child. Although both therapists and parents are sensitive to being recorded, this can be approached in a way that is sensitive to parents' timing and comfort level. Taping part of the session, with playback for both parent and therapist to review, offers an opportunity to see and be seen without judgment or critical feedback. When parents are critical of their own participation or of the child's behavior, that may be an opportunity for the therapist to gently reframe the behavior in terms of intention of the work and address the challenges we all face in attempting to improve our communication skills.

Empathizing with the parent's vulnerability is probably best fostered when the therapist is able to reflect on his or her own vulnerability in

the process of "not knowing." The emotional landscape is traversed without a predetermined agenda but with openness to the unique communication patterns that this child-parent dyad may discover on their own. Often therapists can be seduced into the role of "expert," giving advice and too much "help" and robbing the parent and child of the opportunity to discover that which is truly theirs to determine.

Parents sometimes express frustration between appreciating what a therapist is "doing for them" and feeling that it leaves them obligated to do what the therapist needs or wants. It is sometimes a difficult balance for the therapist—on the one hand being knowledgeable about development and the role of relationships and on the other hand not directing but supporting the parent and child in defining the terms and contours of their unique relationship.

THE EVALUATION PROCESS

Families are referred from many different sources and for a wide variety of reasons. The range of concerns that lead parents to seek or be referred for service include problems with self-regulation, separation, feeding, sleeping, and fussiness; problem behaviors that accompany developmental disabilities; and delays that affect social-emotional and communication development. In addition, parents may feel challenged in dealing with their child or children because they lack resources, support, skill, or information.

Parents may also be struggling with anxiety, depression, or other mental or physically challenging conditions. A full family history is critical to understanding the complex circumstances that each family faces. In addition to evaluating the stresses on the family, it is important to gather information about the resources the family has and the strengths each member contributes. This will begin to lay the foundation for building optimal capacity. Often the initial history taking begins with the parents, without the child present, and with other family members who share in the care of the child. History in the form of family memories and stories unfolds over the course of working together.

Step one is to determine the appropriate intervention format. This is done by evaluating the clinical issues, developmental concerns, biological and environmental risk factors, and parent motivation to seek or receive therapy. Understanding these issues will sensitize the therapist in the beginning stages of building a trusting relationship with

the parents. If the dyad is referred by the court or if parents come with developmental concerns about their child or fears about their own feelings as parents, their expectations, hopes, wishes, and resistances will affect the process and the outcome of the therapy.

The therapist's responsiveness to the parent's experience is essential to building the trust that the therapeutic relationship will build on throughout the course of intervention. This attitude of respect and interest will mirror those attributes that the therapist seeks to foster in the parent-infant relationship. Therapist, parent, and child all bring their own levels of expertise to the situation. The therapist should be aware of any inclination to take the role of expert and also the possibility of a parent's expectation that the therapist is the authority with the right answers.

Relationships develop over time. During the early evaluation phase, there may be missteps. Just as with ruptures in the parent-infant bond, repair of the breach between parent and therapist can actually strengthen the relationship. Holding fast to a stance of respect and concern and exhibiting a willingness to understand and work toward mutual satisfaction lay the groundwork for negotiating difficult feelings as they surface in the course of therapy.

The parent-infant dyad is an intimate relationship with primal affects that trigger strong feelings in both partners as well as the therapist. The therapist will be required to contain this wide range of affects. Issues such as competition, jealousy, abandonment, and loss are likely to surface.

Common errors for therapists include losing the balance between parent and child needs and acting on fantasies to rescue parent, child, and family. At times, the overwhelming circumstances of the family require the therapist to bridge a number of relationships and roles in order to stabilize the holding environment (parent capacity). At these times, the therapist may "lose the baby" while trying to contain the mother's fears and anxieties.

At other times, the therapist may empathize with the infant's situation and blame the parent for poor parenting or a lack of empathy and attunement. The therapist then "loses the parent," which ultimately leads to a loss of the baby, too. When a parent's issues, psychological or otherwise, are overtaking the sessions, it may be appropriate to refer the parent for individual therapy in conjunction with the dyadic work.

During the evaluation period, it is also important to determine the specific arrangement of sessions, including frequency, who needs to be involved, and whether the therapist should meet with parents without the child. Sometimes parents need to express hostile or fearful feelings that could be overwhelming to a child. At other times, parents may need to grieve for losses or sort out child-rearing conflicts that arise between the parents or in the extended family. Parents' input at this stage of planning is essential so that they will feel that the methods are compatible with their needs and those of their children.

UNOBTRUSIVE OBSERVATION

Unobtrusive observation is the primary vehicle for understanding relationship dynamics. Increasing a parent's capacity to observe, read, and respond to the child's social-emotional cues is the driving force of dyadic therapy. The importance of observation is not only to learn about infant experience, level of development, and relational capacities but also to develop an empathic and sensitive therapeutic stance.

A number of dyadic therapy models explicitly use observation as a tool for enhancing parent knowledge, skill, and sensitivity. In the *Floor Time approach* (Greenspan & Wieder, 1998), parents are supported and guided in helping their child to achieve functional capacities that scaffold levels of development. Parents may be coached to help them identify child strengths and develop the means to expand on those strengths.

The *Watch, Wait, and Wonder* program (Muir et al., 1999) typically offers no advice regarding development but encourages parents to use their own observations of discomfort while observing their children's activities. The mother is supported in working through unavoidable anxieties aroused by her infant-toddler's striving to get needs met. In this way, development is freed from interfering processes and proceeds on course naturally.

Interaction Guidance therapy (McDonough, 2000) is perhaps the least instructive model of all. This approach is often employed with very fragile parents and focuses on creating opportunities for parents to have repeated, positive engagement with their children.

All of the therapy models cited here instruct the parents to observe their children's spontaneous, self-initiated activity and then follow the lead from child cues. Parents frequently comment on how difficult it

is to observe without jumping in to direct the child's play or activity. This is also a common observation made by therapists in training, who may feel compelled to step in to "help things along."

The opportunity to discuss the observation with the therapist helps the parent observe and reflect on her own experience as well as that of the infant in the interaction. This is also true for the therapist, who must find the optimal distance between being drawn into a shared emotional experience with the infant and parent and being appropriately detached in order to minimize observation distortion.

Because of the importance of capturing the subtleties of the interaction and the difficulties in doing so, clinicians often use video recording to help them. Many therapies use video replay as a fixed feature of the therapy. Immediate replay has the advantage of nearly instant recall of feelings and motives that accompanied action and may augment the sensitivity to the emotionally relevant exchanges.

Many of the clinically important events are the very small, everyday, repetitive nonverbal events that happen at any moment during the parent-infant interaction. Stern (1995) suggests an ethological perspective as a first glance in order to get a feel for the "dance" or the "rhythm" of the pair. This can be achieved by watching the tape without sound or with barely audible sound, so that the focus is on the approaches and retreats and other body language before evaluating the content of what is being said. A second look is then taken to think about motivation and negotiation of underlying conflicts and issues.

General patterns of interaction are likely to be repeated often and may point to difficulties in the relationship. There are an endless string of exchanges that become more complex as the child's capacities for communication increase. It is important to identify not only the difficulties but also the exchanges that go well, that bring joy and laughter, and that bring the parent and child to a self-rewarding state of being together.

Many people are uncomfortable being videotaped. A parent may need time to warm to the idea. Some may clearly decline because they do not want to stand the discomfort. When there is agreement to tape and review the sessions with the therapist, the level of nervousness must be taken into consideration during the evaluation phase. Often, especially in the first few sessions or at the beginning of the session, the anxiety of being on tape can distract parents from fully and naturally engaging with their children as they might otherwise.

Over time, most people become accustomed to the camera (or the idea of it, if it is concealed) and seem not to be affected by it. Children,

especially those over twenty-four months, may also be affected by the presence of the camera. Although they are less often anxious about it, they often become quite interested and want to see themselves, or they may want to perform as they have done at parties or during home videotaping.

Therapists are also likely to feel uncomfortable in front of the camera. They may feel nervous about their "performance" as a therapist, which may take them away from a more natural partnership with the parent. Therapists should spend ample time outside the sessions to familiarize themselves with operating the camera and viewing themselves on-screen with others present. It may be helpful to role-play on tape with colleagues and even to use the camera playfully to achieve a level of comfort before using it in the session. Acknowledging that most people feel awkward at first being taped but eventually get used to the experience can put parent and therapist on equal footing when starting this process.

Video review in supervision is especially helpful in training the therapist to develop better observation skills and to have a better picture of his or her own impact on the observed relationship. The review also helps refocus on the pair, as attention to both partners is easier when material can be viewed multiple times.

THE MENTAL HEALTH SPECIALIST IN DYADIC THERAPY

A focus on the relationship between child and parent changes the dynamics of the therapist-client relationship as typically conceptualized in most psychotherapy models. As previously mentioned, the therapist acts as both a collaborator and the holding environment for the parent. This is true for most therapies that guide and support developmental process. A specific difference for the mental health practitioner is in understanding and navigating the issues of transference and countertransference that develop in the process of the therapeutic relationship. From a mental health perspective, the power and vulnerability of a relationship-focused therapy are seated in the development of psychic structures and internal working models that influence how we perceive and conceptualize our interactions.

In addition, specific attention to the emotional health of both parent and child is paramount. The infant-toddler mental health specialist is called on to understand and contain the multiple anxieties, risks, and challenges for parents and other caregivers involved in the

child's developmental process. Evaluating the parent's overall stress tolerance, as well as coping style and capacity, is critical before exploring the complex interplay of multiple relationships, both past and present. This exploration may evoke strong emotions and memories that may be painful or disturbing. The process also requires supervisory support that facilitates respect for appropriate timing and for the limitations of parents and therapist, as these psychological issues are examined. Without this awareness, parents may be invited into an intimate relationship that stirs up conflict and anxieties. When these conflicts are not acknowledged and processed, they may be acted out with detrimental effects to child and parent.

As mentioned earlier, dyadic therapy is likely to rekindle a variety of feelings that may be expressed in transference to the therapist. Issues of personal distress for the parent may need to be addressed outside the dyadic therapy, and a referral for individual therapy may be helpful. This may be a difficulty boundary to define because the work space (the relationship) is understood to be of psychological exploration, but the explicit therapeutic relationship is not one of individual adult psychotherapy. The therapist and parent must be aware of this limitation.

The question of whether or not the parent should be seen individually by the therapist who is providing the dyadic therapy should be carefully evaluated. Individual sessions with a parent may provide containment and a working space for the parent's anxieties and negative feelings about parenting the child. Sometimes there may also be a need for the parent to have a therapeutic relationship that can address parent psychological needs that fall outside the scope of the dyadic work. Individual or marital therapy should be suggested when the parent expresses the need for more extensive exploration of his or her own issues.

TRAINING IN DYADIC THERAPY

A training program for dyadic therapy must include information and materials related to early development of the infant, toddler, and preschooler as well as the developmental process of becoming a parent and all of the inevitable challenges that follow. Therapeutic competencies should include training that covers the following subjects:

- Attachment theory and implications for treatment
- Developmental milestones and processes
- Sensory development and regulatory function

- Language development
- Individual difference (for example, sensory profiles, temperament)
- Cultural awareness and sensitivity
- Family systems theory and inclusion of parents as full partners
- Neurobiological development
- Transdisciplinary assessment and treatment models
- Child and family assessments
- Zero-to-three diagnostic classification system
- Public policy regarding children's rights and services
- Community supports

Training in the therapeutic process should be specific to mental health practitioners. Course work in theory, critical clinical and developmental issues, and clinical applications, along with significant clinical supervision needs to be included. Training programs specializing in infant and toddler family mental health are not common, so many practitioners create specialized training through postgraduate training programs.

SUPERVISION

One of the difficulties in the supervision of infant mental health practitioners is that it is a relatively new field. Many of the elements specific to the field are being discovered as senior practitioners update their own training and new standards in early care are established. The bridging of mental health to interdisciplinary intervention offers additional new challenges. The practitioner must understand not only how mental health fits into the team but also how other disciplines may contribute to help address problems in early development.

Supervisors must be aware of developmental trajectories and processes as well as the intricacies of the child-parent relationship. Especially important is an understanding of parallel process. This requires a reflective, nonjudgmental stance to afford the greatest level of "lived emotional experience" that is supported in the child by the parent, in the parent by the therapist, and in the therapist by the supervisor.

The use of videotaped sessions is also invaluable in providing opportunities to stand back and look at the process with all involved

in a nonjudgmental way. Nuances in relationships are so natural that it is virtually impossible to grasp them in the moment of interaction. As in the therapy session, the "right answer" is not the goal. Instead the goal should be to develop respect for the development of a better understanding of the child's needs and communication. In this way, "collaborative, contingent communication" (Siegel, 1999, p. 70) can follow from the parent's optimization of the security, joy, and curiosity that fuel development. In addition to videotaping the session, it is useful to view the tape in supervision to examine the relationship between therapist and parent. The therapist's sensitivity to a parent's comfort level and sense of competence can be monitored in this way.

ETHICAL ISSUES IN PRACTICE

As in all therapeutic contracts, the limits of the therapy offered must be stated. In particular, the nature of the focus on the relationship as a means to understanding the child's developmental needs should be made clear. The possibility of a separate referral for individual, marital, or family therapy should also be discussed. As much as the therapy is intended to be supportive and empowering, it is also mandatory to inform parents of the duty to report concerns or evidence to the Department of Child Protective Services if neglect or abuse is suspected.

Because other professionals are often involved, including pediatricians, other therapists, and early educators, it is important to be aware of the confidentiality of the clinical content of the therapy sessions. It is important to clearly state how any videotaping will be used in supervision. In addition, personal information about the parent or child cannot be discussed without the parent's clear consent to the exact content of the disclosures. This is important because professionals who work with young children are often unaware of privacy issues related to their young clients and to the parents, who may not always be viewed in the traditional clinical perspective.

The ultimate goal of dyadic therapy with very young children and their primary caregivers is to improve the relationships that support a child's social and emotional well-being. A shift in thinking, in which the relationship is seen as the focus of treatment and collaboration with the caregiver is seen as a vehicle for affecting the child's development, presents both opportunities and challenges. The infant mental health specialist is

called on to attend to the emotional needs of parent and child equally, supporting the strengths and capacities of the whole family and helping to develop strategies that build on developmental knowledge.

In early infancy, the crux of the relationship lies in nonverbal cues of eye gaze and feeding. In a few short months, the energy in the relationship is seen in the baby's babbling and the mother's use of cooing and intonation with gestures, as emotional attunement is being established. Within a year, the baby is capable of more gesture, physical movement, and verbal expression, and the mother's parenting repertoire has also transformed considerably. By the time the child is two or three years old, attempts at autonomy may evoke a whole new set of reactions from the parent and may challenge the relationship in ways that previously posed no disturbance. The preschooler and beginning kindergartner have very different capacities and needs and add even more complex demands to the relationship.

Just as the parent is encouraged to observe and respond to her child's cues, the therapist supports the parent through observation and reflection. The supervisory process should hold the same level of support for the therapist, so that there are enough levels of support to meet the complex needs of young children and their families.

Infancy and early childhood are optimal times to intervene when development is impaired or at risk of derailment. It is also a prime opportunity to provide support for the strengths and capacities that parents and families bring to the care of their children. Dyadic therapy provides a framework for such intervention and support to occur.

CASE STUDY ONE

Martha, age eighteen, arrived at the Child Development Institute Community Clinic for the first appointment along with her mother and younger brother. Her two-year-old son, Danny, was being cared for by his great-aunt at her home. The infant mental health specialist invited them to share their concerns about Danny.

The family's list was long, and they were clearly distressed and unsure about what to do to help Danny. They were aware of his differences in development from a very early age. Martha was sixteen when she gave birth to her son. Danny's father, her high school boyfriend, left her and the baby a year after the birth. Martha had not had contact with him since that time.

When Martha moved back home with her parents and younger brother, her mother took early notice of Danny's distress. He was tense—always arching his back and crying. As they talked about Danny's development, the grandmother began to cry. She could see that something was wrong, and she could not make it better.

Martha had her own story to share. She did not want to quit school but did not know the best thing to do for her child. The younger brother described his attempts to help and voiced his concerns about his own mother's level of stress.

Listening to the family, the therapist could sense how overwhelmed they were feeling, yet she also listened to the strengths that were emerging. They were very supportive of one another and very committed to this little boy. They came to the clinic in an attempt to understand and get appropriate intervention for Danny. At this first meeting, the most important job of the therapist was to understand the challenges that the family was facing and the natural resources they had in getting help for Danny.

The family arranged to bring Danny in for a developmental evaluation with the interdisciplinary staff. It was the beginning of a relationship with the family and the first step toward scaffolding the support that Danny's development needed.

CASE STUDY TWO

Mr. and Mrs. Smith arrived for their first appointment with the infant mental health specialist at the Child Development Institute. They had recently been asked to remove their son, Ian, age three and a half, from preschool. (This was the third preschool he had been asked to leave.) They had been told that Ian was very bright but not "ready to be with other children." Reports from school described aggressive behavior toward other children and frequent crying bouts during which he was very difficult to soothe. The parents were very distressed because even though Ian had tantrums at home, he liked playing with his toys and got along with his parents.

The parents were also very anxious because they had little family support and both worked full-time. In the first observation session with Ian and his mother, Ian was crashing cars and running over toys of family figures. Mother indicated that she did not think that this was his typical play behavior and that this type of play disturbed her. She was encouraged to watch and respond to his gestures on his terms.

Over the ensuing weeks, sessions with both parents revealed many anxieties. The parents were worried about Ian's development and well-being and also felt ill equipped to guide his development. As both parents gained more experience playing with Ian, a general sense of comfort and confidence in their relationship with their son emerged. Mrs. Smith commented that she was beginning to understand Ian's world and that for the first time she was "actually having fun with her son."

References

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment* (2nd ed.). New York: Basic Books.

Brazelton, T. B. (1992). *Touchpoints: The essential reference to your child's emotional and behavioral development.* Reading, MA: Addison-Wesley.

Diagnostic classification: 0–3. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (1994). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Emde, R. N., & Harmon, R. J. (1984). *Continuities and discontinuities in development.* New York: Plenum.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problem of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14,* 387–422.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth.* Reading, MA: Addison-Wesley.

Lieberman, A. F., & Pawl, J. H. (1988). Clinical applications of attachment theory. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment.* Hillsdale, NJ: Erlbaum.

McDonough, S. C. (2000). Interaction guidance: An approach for difficult-to-engage families. In C. H. Zeanah Jr. (Ed.), *Handbook of infant mental health* (2nd ed., pp. 485–493). New York: Guilford Press.

Muir, E., Lojkasek, M., & Cohen, N. (1999). Observant parents: Intervening through observation. *The International Journal of Infant Observation, 3*(1), 11–23.

Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* National Research Council Institute of Medicine. Washington, DC: National Academy Press.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ: Erlbaum

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience.* New York: Guilford Press.

Sroufe, L. A. (1997). Psychopathology as an outcome of development. *Development and Psychopathology, 9,* 251–268.

Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy.* New York: Basic Books.

Winnicott, D. W. (1965). The theory of the parent-infant relationship. In D. W. Winnicott, *The maturational processes and the facilitating environment* (pp. 37–55). Madison, CT: International Universities Press.

CHAPTER SIX

Reflective Supervision in Infant, Toddler, and Preschool Work

Mary Claire Heffron, Ph.D.

Reflective supervision refers to a deceptively simple program practice in the infant family field. The purpose of this chapter is to provide a systematic description of the definitional, theoretical, programmatic, and competency components of reflective supervision. This chapter will also highlight common points of confusion and misperception related to reflective supervision, which can be used as cautionary tales for implementers and practitioners.

Throughout the chapter, I will refer to supervisors using the feminine pronoun. The terms *intervener* and *supervisee* have been used interchangeably to refer to the person that the reflective supervisor is working with in supervision. Use of the term *infant family field* also will encompass programs that serve preschool children and families.

Interest in the use of supervision in the infant family field was stimulated by a 1992 collection entitled *Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers and Their Families.* Edited by Emily Fenichel, the collection of articles was developed by a National Center for Clinical Infant Program task force of leaders in the infant family field. The articles outlined the rationale and uses of supervision and other supports in program settings

serving infants and toddlers. The book also detailed how regular meetings with staff could be useful in helping them to develop a reflective perspective in their work. This involves learning ways to think about responses to families. It also involves learning how to formulate informed questions that might lead to greater understanding instead of quick problem resolution.

The book outlined features of reflective supervision and staff support. These include regular meetings, collaborative approaches, and the opportunity to develop insight through reflection and discussions that incorporate an emphasis on examining issues from multiple perspectives. The approach was influenced by the tradition of clinical supervision from the mental health world, but the practice as described was clearly also useful for other programs in the emerging infant family field, including early intervention, child care, and preventive intervention.

Currently, reflective supervision is used in a variety of programs in the infant family field that define relationships with families as a tool to accomplish a program mission. It is also used in programs that see relationships between parents or caregivers and their children as an important focus of intervention.

THE FOCUS OF REFLECTIVE SUPERVISION

As a provider of direct services to infants and families, as well as a supervisor of service providers from mental health and from other fields, I have come to see reflective supervision as a *pause* or *marker* in the week or sometimes in the month. It is a chance for a focused and lively conversation about the work that an intervener is doing with a family and child and sometimes about the impact of the work on the intervener. This pause is essential, because the compelling nature of infant family work often leaves little time for reflection, refueling, or consideration of what to do next.

Supervisory sessions include expressions of interest, positive regard, and concern about the intervener, but mainly conversations are directed toward the purpose of the meetings, which is an in-depth and detailed discussion of the work. Sometimes reflective supervision can be a time for difficult conversations as well. These difficult conversations can be initiated by the intervener and may contain expressions of frustration, anger, or despair. Sometimes conversations can be

initiated by the supervisor, based on serious concerns about a particular family, a child's needs, or more structural issues, such as incomplete documentation or incomplete assessments.

Although the focus of reflective supervision is the work that the intervener is carrying out, the conversations include much more than a simple recitation of activities, events, and changes. The supervisory conversation includes attention to both the content (that is, what is happening in a particular classroom, family, or program) and the process underlying the activities, including feelings evoked by both content and process.

During the supervision session, the supervisor becomes aware of not just what is said but also the body language, the emotional tone, and the cadence of speech. The supervisor does much more than listen or reflect back what has been said. At best, reflective supervision includes careful listening, observation, attunement to the supervisee's affective state, and questions and responses that indicate that the supervisor is fully present with the supervisee. The supervisor listens with empathy and attention and responds through questions and statements that are contingent on and linked to what has been presented. Such exchanges lead to a collaborative dialogue between supervisor and supervisee that promotes an increased understanding of self and the family and the cocreation of next steps in the intervention process.

The supervisor works with the intervener to understand the history of the child and the family. She uses available information about the family as well as her knowledge of the intervener as a guide to discussion. She might help the intervener to think about how the current situation might be influenced by the family's past as well as the intervener's own experiences and needs.

For example, an intervener who tends to move quickly to provide toys for a family because of her own discomfort with the infant's lack of play materials might be asked questions designed to increase her self-awareness and her notion of the impact of her actions on the family. These might include remarks such as, "What is it like for you to see Cari with so few toys?" "Do you think the family is as worried about this as you are?" "Have you had a chance to think about what it will mean for the family to bring toys to them so suddenly?" "I wonder how we could help dad understand that the kids need some things to play with."

The goal of these questions and the ensuing discussion is to limit precipitous and potentially harmful responses to situations on the part

of the supervisee and to shift to a more positive position that will help build the depth of communication between a family and an intervener. The supervisor helps the intervener identify her own needs and feelings about the situation, consider the perspective of the family, think about intervention strategies that would fit in the situation, and plan approaches and language to address these concerns.

Often this material is presented as a kind of tangled ball with multiple skeins twisted and interwoven. Over time, the supervisor helps the supervisee sort out the strands by considering both those in the foreground, or the most obvious strands, and those that are lodged at the center of the ball. At times, the supervisor links together pieces of the story that have been presented and raises possibilities with the intervener.

Sometimes the supervisor listens closely and becomes a witness to the work that the intervener is doing with a family by sharing and containing feelings, accomplishments, and frustrations. At other times, the material presented is linked by the supervisor to theoretical perspectives or programmatic activities. At all times in the framework of supervision, the work remains central.

THEORETICAL CONSIDERATIONS

The practice of reflective supervision is built on the premise that the effectiveness of early intervention depends on many factors, including these: knowledge of child and family development; careful consideration of social-emotional issues; the interpersonal skills of the intervener; the intervener's ability to think about the context of the work; and the internal and external experiences of the infants, children, and families who are being served.

The premise is that in order to be effective in infant family work the intervener must establish rapport, trust, appropriate professional boundaries, and a collaborative working alliance with families. Depending on the setting in which the work is done, the intervener also must develop effective working relationships with team members, community collaborators, and administrators. These basics require an awareness of one's beliefs and internal responses to interactions with others and an ability to imagine the impact one is having. Reflective supervision provides an arena for exploration of these issues and other issues specifically related to intervention work.

In addition, reflective supervision can assist professionals in recognizing, managing, and effectively using the strong feelings that they

may experience when working with infants and young children. The identification of these feelings is often referred to as *countertransference,* and the recognition of the feelings that the family may have about the intervener can be termed *transference.*

To distinguish these terms from other definitions used in more traditional mental health arenas, specialists have utilized the concept *use of self.* The professional use of self includes the importance of self-awareness and the willingness to explore what a particular family scenario may bring up for the intervener. For example, a home visitor working in a teen parent program may find herself disciplining her own teenager more frequently because of worry about the problems she has observed with her teen clients.

The practice of reflective supervision is a method to support the well-established premise that the quality of early relationships is central to healthy development in all domains. For those providing services to infants, young children, and their families, understanding the importance of relationships in the development of infants and young children is important, as is the understanding that the relationships that they form with others in the course of their work serves as a tool to support early development. The relationship that the supervisor forms with the supervisee is in some ways parallel to the process of relationship formation between intervener and family.

In short, interveners in many settings need to be able to approach families, team members, and children with sensitivity and a clear understanding that the preferences, worldviews, temperament, and past experiences of children, parents, and colleagues influence behavior. In order to accomplish program goals, the intervener must be able to operate with an appreciation of multiple perspectives, learn to observe and inquire, and jointly construct the goals and activities to be carried out with parents or work partners.

Sessions with a reflective supervisor provide a practice arena that can shape and strengthen the intervener's knowledge of self in regard to relationships, empathy for others, and skills in perspective taking. These sessions may help interveners who may otherwise get swept away by their own personal, disciplinary, or cultural perspectives begin to see a fuller picture of a situation. The organizational institutionalization of reflective supervision and the growing number of practitioners of this practice signify the degree to which consensus has developed that infant family work is complex and is enriched by the support provided by trained supervisors.

ANTECEDENTS, QUALITIES, AND ABILITIES OF THE REFLECTIVE SUPERVISOR

To ensure a successful relationship with a supervisee, a reflective supervisor must first lay the groundwork for that relationship. The supervisor must also have a certain set of qualities and abilities in order for their work together to flourish and have value.

Antecedents to the Supervisory Relationship

Reflective supervision practices are based on a foundation of respect, interpersonal safety, trust, and a working alliance between a supervisor and a supervisee that includes a well-defined shared sense of responsibility for work carried out by the supervisee. Supervisors should begin discussions with supervisees about the goal of providing this time as a support for their work, as well as specifics about how supervision time will be used. These discussions should also include suggestions regarding how interveners can prepare for supervision and what they should expect from the supervisor.

Early supervision meetings should include discussions of prior supervisory experiences and chances to talk about approaches that the intervener has found helpful. The way that supervision is begun and carried out is as important as what is discussed. In short, supervision is a relationship like any other, and it merits prior clarification about its intent as well as an ongoing willingness to explore similarities, differences, perceptions, misperceptions, and concerns of social, cultural, and disciplinary differences as they arise. Developing this kind of relationship with an intervener takes time, just as it takes time to develop a solid bond with a family, colleague, or child.

Essential Qualities and Abilities of the Reflective Supervisor

Self-awareness well beyond the norm that is expected in everyday social interaction in society is a necessary quality for all reflective supervisors. Such heightened self-awareness combined with the ability to use self in the supervision sessions is a useful strategy to help the supervisee understand her work more completely. It also provides a model for the supervisee's later conversations with families and colleagues.

First, the supervisor must be aware of her impact on the supervisee and the possible ramifications of differences in gender, ethnicity, and age. Supervisors must recognize that their supervisee's perceptions of power, control, and authority may need to be explored in order for supervision to be useful.

In addition, supervisors may benefit from exploring their own feelings about supervisory responsibility. Some supervisees who have learned to defer to others who supervise their work may feel uncomfortable with the more collaborative style of reflective supervision; some supervisors may feel uncomfortable with the notions of joint responsibility implicit in reflective supervision.

Second, the supervisor should be willing to be vulnerable by revealing her reactions and admitting to points of confusion. This openness increases the likelihood that the intervener will carry out similar explorations in the sessions with families.

A third aspect of this kind of self-awareness is that the supervisor should not fill up the supervisory time with anecdotes about herself that have tangential connection to the work being presented. Instead she should use her experiences or insights sparingly and carefully to help the supervisees with their work.

Finally, an important aspect of self-awareness for the supervisor is developing a thorough knowledge of her own tendencies, life experiences, disciplinary training, preferences, and style that influence her understanding of infant family work. This kind of self-awareness includes the ability to accept and acknowledge different perspectives and experiences rather than to impose personal beliefs on the supervisee.

ABILITY TO LISTEN WELL. Listening well has been termed the *gift of perfect attention.* For a reflective supervisor, providing such attention requires clearing the mind as much as possible of competing agendas, preparing to listen to a particular intervener by refreshing details of the intervener's work ahead of time, and controlling impulses to judge the content or tell the intervener exactly what to do next. Listening for themes, repetitious dilemmas, gaps in knowledge, or difficulties in managing feelings or logistics of the work is important.

Supervisors can learn to take what they hear or perceive and use what seems most relevant with the supervisee in ways that build understanding, insight, and self-awareness. This kind of skilled listening involves paying attention to nonverbal communication and omissions as well as the narrative being presented.

The supervisor must be able to listen to stories and question missing pieces of the stories, as well as empathize, acknowledge, and support the supervisee as the tales are recounted. The supervisor must ask herself, "Is what I am hearing coherent? What are the missing elements? What is my experience of listening? Will sharing this experience help the supervisee recall additional information and construct a more complete account of what has happened?"

ABILITY TO INQUIRE WITHOUT INTERROGATION. An essential skill for the supervisor is the ability to ask questions in a fashion that allows the intervener opportunities to explore her own reactions to a parent, situation, or event, as well as opportunities to see the perspective of another or to wonder about the meaning of a particular child-rearing approach to a family. The presentation of questions in a manner that allows an intervener to feel supported but not threatened, judged, or ashamed about missing a particular point or perspective is crucial. Too many questions presented too quickly can elicit defenses, shame, or a reluctance to bring up difficult feelings or content in subsequent sessions.

Careful attuned listening, genuine curiosity, and a desire to understand the supervisee's experience, as well as a desire to support the supervisee's own exploration, guide positive questioning. Use of inquiry that is not sensitive to the supervisee and contingent on what has been said previously can be experienced as an unwarranted judgment or a hostile interrogation. Supervisors should strive to feel comfortable with some silence, providing time for processing and reflection.

Another useful technique for supervisors related to questions is to observe the supervisee's response to a question and comment on discomfort or confusion about a question that has been raised. For example, a supervisor might have an exchange like the following with her supervisee:

SUPERVISOR: Jake, I noticed that when I brought up the incident with the slide, you seemed to want to change the subject. Did that question feel like I was putting you on the spot?

JAKE: Well, I did feel bad when Timmy hurt himself. I think I could have prevented that. It's kind of hard to talk about.

One common concern related to questions is a lack of response or muted, nonexploratory answers to questions. For example, a supervisee

when asked a question may habitually respond, "I don't know." At this point, a supervisor might wonder with a supervisee if he felt put on the spot by the questions and might thereby open up a conversation about concerns of doing or saying the right thing.

Another approach to this dilemma of supervisees who are reluctant to explore an idea is to provide a choice of possible approaches, with a trailer question such as, "Which of these approaches do you think would work best with this family?" This technique allows a supervisee to use her knowledge of the family while understanding that both approaches have been explored and have merit. There is no risk for the supervisee, because the supervisor has said that both would work.

ABILITY TO USE A HISTORICAL PERSPECTIVE ABOUT THE INTERVENER'S WORK. The supervisor has the opportunity to become involved with the intervener's work with particular families over time and often develops an overall sense of perspective about a family or child that may be difficult for the intervener to recall when a case is not progressing in a positive way. Reminding the intervener of her strengths, helping her to recall successful approaches from other times, and helping her to see and remember small but important successes and changes within the family can assist the supervisee in becoming more aware of subtleties. It can also help her develop a sense of confidence about her work.

In order for a supervisor to use a historical perspective effectively, it is necessary to have a systematized method to document important themes, case events, and the intervener's growing ability to handle complex situations. Documenting observations or questions that a supervisor may wish to ask in the future can also be useful. These notes should be written soon after each session so that important details are not lost.

Developing a historical perspective about the work of a supervisee also implies that the supervisor is aware of her own perspective and does not impose it on the supervisee in an overly determined manner. Instead she should use her skills to help the supervisee develop her own strengths.

ROLES OF THE REFLECTIVE SUPERVISOR

Some confusion has developed in mental health and non-mental health settings about the various roles of a reflective supervisor in the infant family field. There is also confusion about how these roles set

this model apart from other forms of supervision. The following set of four role descriptions is offered to clarify the discussion of reflective supervision in a variety of settings and to serve as an overall guide for implementation of reflective supervision.

Some programs may choose to have more than one supervisor address these roles. However, a reflective supervisor usually addresses all of these roles at least to some extent. All staff with any kind of support role (for example, monitoring, mentoring) would also use reflective approaches in programs that fully embrace a reflective supervision model.

Reflective Supervisor as Coach and Mentor

The reflective supervisor plays an essential role in training, enhancing skills, and deepening the intervener's own reflective function. This role can be seen as an opportunity for individualized coaching and discussion of important program content that has been covered through program or disciplinary training. It is often an opportunity to take a particular concept, program requirement, or theory and create opportunities in real time to discuss how these are implemented in the day-to-day world of service delivery.

The first requirement of mentoring and coaching is a sense of safety and trust that comes from the supervisor's accepting and respecting the supervisee's wishes to do the work well. A second requirement is defining the work in progress as a shared responsibility between the supervisor and the intervener. The supervisor does not take over but may suggest approaches, reframe points of view, and raise concerns. If the intervener wants to do something that is worrisome, deviates seriously from program standards, or is highly likely to be ineffective, the supervisor should take time to explore the thinking behind the approach. She should also clarify why she is concerned about this.

A third aspect of the coaching and mentoring role is allowing enough time for guided exploration that can lead to deeper comprehension rather than telling, instructing, or taking over the work. For example, in a case where an intervener is describing a parent who is disciplining harshly, a supervisor might ask questions such as, "How does this seem to you?" "What do you think the parent is hoping to accomplish by acting like this?" "How is it for you to be with this family when Serge is being punished?" "Do you think the parents worry about what you

think?" "How has what you have learned in your training affected how you are seeing this?" "Are you wondering how I see this?"

Sometimes the supervisor may request or even insist that a particular approach be followed. This way of working in supervision should be reserved only for instances where ethical or safety issues are a question. The approach, although straightforward, requires a great deal of caution on the part of the supervisor. It can be easy to take over a case or a problem and solve it by providing a rapid answer. However, this approach will not build the supervisee's sense of competence or ability to think through a similar situation in the future.

Conversely, holding back too much with suggestions or concerns can be frustrating to an inexperienced intervener. The challenge in the coaching and mentoring role of reflective supervision is to help the supervisees find their own strengths and creativity and to provide enough information and assistance without overwhelming, intimidating, or dampening curiosity or concern.

An awareness of the intervener's past experiences of supervision is important. Has the intervener experienced reflective supervision before? Explanations of expectations will help, but the supervisor should be aware of each supervisee's responses or lack of responses. If the atmosphere of the session seems uncomfortable or forced, the supervisor should continue to check in with the supervisee about the focus of the discussions or any confusion about the intent of the questions that are asked. The following dialogue illustrates how a supervisor might seek to clarify how reflective supervision works with a reluctant supervisee.

SUPERVISOR: I know that this is the first time you have worked with this kind of supervision, and I am wondering how this is working for you.

SUPERVISEE: I am not sure, but I am not always sure what kind of answer you are wanting.

SUPERVISOR: I'm not looking for a particular answer, but the questions are to help me understand the situation with the family and the children through your eyes.

Reflective Supervisor as Provider of a Safe Holding Environment

This role consists of a three-part process. The first step of the process is that the supervisor recognizes and accepts the accomplishments, frustrations, and dilemmas that the intervener presents by listening

carefully and creating a shared sense of the intervener's experience. Supervisors speaking of this role report that they feel that they have "lived through" a particular session with a client, even though they have just listened to the account of it by the supervisee.

The supervisor's calm presence and the supervisee's experience of being heard help the supervisee feel less alone with the experiences she is recounting. This sense of shared experience, being heard and felt, assists the supervisee in regulating her emotions and feelings and sets the stage for the next steps.

Next, the supervisor encourages the intervener to reflect on what she has presented through questions that promote analysis, perspective taking, and self-examination. Finally, the supervisor helps the intervener summarize thoughts, develop insight, consider new ideas, put the experience in perspective, and if needed come up with next steps. Providing a thoughtful and unrushed environment requires patience and a genuine belief that careful listening will result in a more regulated and supported staff, leading eventually toward a higher quality of services provided to families.

Reflective Supervisor as Guarantor of Quality Assurance

This role implies that the supervisor is someone who listens to and observes the work of the intervener and helps develop best practices by bringing attention to boundary issues, conceptual drift, and ethical problems. Given this role, the supervisor must be someone who is aware of current best practices, along with requirements in the given program.

In addition, the supervisor must have the capacity to listen for responses and tendencies that an intervener might have that can impair the quality of her work. The supervisor can also use supervision time to bring up concerns about structural problems and documentation. This combination of functions has advantages, because structural problems are often linked to concerns about how the services are delivered and in some instances cannot be separated. However, supervision sessions can quickly be taken over by structural concerns, leaving little space or time for reflective exploration and discussion of the dynamics of program concerns.

Some supervisors, therefore, divide supervision time, setting aside a brief period for structural concerns and documentation issues so that adequate provision is made to use reflective supervision

approaches on a regular basis. When concerns are present in either structural issues or in service quality, the supervisor brings them up in a way that invites exploration, identification of the sources of the problem, and understanding, rather than blame or shame.

The following examples help clarify these roles of reflective supervisors. Martha is an intervener who perpetually is overwhelmed by her work and often does more than needed for the families she serves. She is usually late in completing needed documentation. Her supervisor begins with an empathetic statement:

SUPERVISOR: Martha, I know how hard you work and how much you want to help all of your families, but I have some concerns about how hard you are working. How are you managing?

MARTHA: I am tired, but I just don't know what else to do.

SUPERVISOR: Sometimes I wonder if you do things for families that they might do themselves.

MARTHA: I always wonder if I haven't been quite as helpful as I might have been, and we both know what a mess I am with paperwork.

SUPERVISOR: I'd like to talk more about some of these cases to help you figure out when to slow down and when action is truly needed. I realize the pressure you must feel with so many needs in the families.

MARTHA: Yeah, last week I ran around getting a shelter placement for this family and when I got there, they didn't even want it.

In general, reflective supervision is enhanced by patience and the willingness to let supervisees muddle to a certain extent while exploring their own internal responses, resistance, and frustration. To do this requires the supervisor to hold back to a certain extent even when another approach to the work is advisable. These kinds of dialogues can also be used to help supervisees learn how to respond to families where cultural differences and different perspectives on child rearing may be issues:

JANE: I am so frustrated. This baby is losing weight, and mom does not seem to be able to keep track of when she is fed or how much she takes in.

SUPERVISOR: There seems to be something about the mom's approach that really bothers you.

JANE: Well, it's just that she has no routine; the kids eat, sleep, and play whenever.

SUPERVISOR: I wonder if you have brought this up?

JANE: I just don't feel good about it. You know, I feel in a way like I don't even belong there. My Spanish is OK, but I don't understand how things work in that home.

SUPERVISOR: I wonder if you feel this way because mom is from Nicaragua and you are confused about the culture, but I see the kids are kind of at loose ends. Let's think together about how you could address this. It needs to be talked about, and I can understand that you might feel worried about how to do this.

Here is another example of how the supervisor helped her supervisee, Jane, to explore her own feelings and get back to more positive intervention methods:

JANE: I found myself feeling really angry with this family because they had not followed through on the baby's medical needs. I really didn't know how to handle this. I think I started preaching to the family about what might happen to the baby.

SUPERVISOR: Were you aware that you were mad when you were there or after?

JANE: Only after. They kind of hustled me through the visit, and when I left, I realized I was really upset.

SUPERVISOR: What do you think was going on?

JANE: I think I am worried about this baby so much. The parents just don't seem to care.

SUPERVISOR: It sounds like you wanted to protect the baby, and you were mad because the parents hadn't done what you would have done.

JANE: Yeah, I just don't get it.

SUPERVISOR: Do you have any idea what's keeping them from taking care of the medical needs?

JANE: Hmmm. Well, dad just lost his job, and I don't know if that had anything to do with it. I should have asked them.

SUPERVISOR: Do you think you could do that now?

JANE: I would be embarrassed, but I guess I could. I feel bad that I was so preachy.

SUPERVISOR: Do you think you could bring that up with the family?

JANE: I guess I could mention that I got worried and forgot that it might just be impossible to get him there because of the changes around dad's work.

SUPERVISOR: I think it would be good to talk about this with them. It sounds like this might help you feel more comfortable working with them again.

Reflective Supervisor as Model of Open Communication

Regardless of the particular service model, all professionals serving infants, young children, and families are called upon to work with others because of the complexity of the work. The work involves taking on roles as co-teachers, as community partners, or as colleagues. The reflective supervisor's role includes modeling open inclusive communication about difficult topics and helping interveners to solve problems in this area.

For example, listen to this dialogue between a supervisor and a supervisee about a case manager in a program for homeless families:

SUZY: I have really had it with the case manager at the housing authority. They had promised to get the Smiths into their unit by September, and now they haven't. The older kids will have to switch schools again when their apartment is assigned. They are so irresponsible.

SUPERVISOR: It is frustrating. Were you able to understand what the difficulty is? How did you approach them? I wonder if the authority knows that these children have been in four different shelters this past year?

SUZY: You know, I was so furious, I just hung up.

SUPERVISOR: I wonder what the best way to get them that information now might be?

PROGRAM VARIATIONS IN THE USE OF REFLECTIVE SUPERVISION

There is no specific staffing formula for the implementation of reflective supervision. Programs must look at staff needs, population issues, internal resources, and preexisting methods of providing staff support.

In some programs, reflective supervision roles are shared by several people (for example, programs may have one staff person primarily responsible for monitoring documentation requirements and another person who provides the more supportive and teaching roles).

Such a division of labor may depend on skills, availability, and needs of staff for specific types of supervision. Newer staff with no prior experience will need more supervision overall, but the need for reflective supervision, support, and professional growth continues for all staff.

CLIMATE AND SUPPORT ESSENTIAL FOR IMPLEMENTATION OF REFLECTIVE SUPERVISION

The implementation of reflective supervision requires organizational understanding, sanction, and fiscal support so that the supervision activities are defined as a valued part of the scope of work and not as an add-on to an already taxing work schedule. Program leaders set the tone for providing a supportive work environment that can be seen to parallel the work that interveners do with families.

Program governors and administrators benefit from an understanding of the full implications of the support of the development of early relationships as central to all aspects of development. If they lack this information, they may shy away from reflective supervision or view it as a fuzzy, feel-good add-on rather than as an activity central to the most crucial aspect of infant family work.

Time must be planned for supervision, along with an expectation by program administration that reflective supervision is essential for program quality, enhancement of staff skills, and staff retention. Some supervisors may also have other program administrative duties, so care must be taken in planning to protect the supervision time. This helps ensure that regularly scheduled supervision times can occur without interruption from other pressing priorities.

Planning to adopt a reflective supervision system takes careful planning and involvement of staff so that the new supports are understood and accepted. Supervisors' needs must also be considered, and consultation or peer discussions among supervisors can provide a support network for them to examine their practices and improve their skills. Organizations that fully value reflective practice also incorporate time for reflection into administrative meetings and other staff support activities.

POINTS OF CONFUSION IN THE PRACTICE OF REFLECTIVE SUPERVISION

There are several areas related to reflective supervision implementation and practice that frequently cause confusion. These include the ways in which reflective supervision factors into employee performance evaluation, the use of power and authority, how confidentiality is interpreted vis-à-vis reflective supervision, the meaning of ghosts of supervision past or past supervisory experiences and their impact on the use of this new model, and misinterpretations of reflective supervision as a form of therapy for the supervisee.

Employee Evaluation

Programs that implement reflective supervision models usually have organizational requirements for employee performance evaluation. Some programs may separate the more supportive functions of supervision from staff evaluation; however, skilled reflective supervisors can combine these two functions successfully with careful planning and foresight.

Supervisors can set the stage for later evaluative functions by fully explaining the program's formal evaluation process. Supervisors should clarify who will be involved in the program evaluation and talk about each person's role in the process. Areas that should be made explicit include whether or not the supervisor is present at the evaluation, how material from reflective supervision sessions is included, and how other performance areas will be evaluated.

Here is a sample of a conversation between a supervisor and an intervener about this activity:

SUPERVISOR: Jane, do you have any questions so far about how we will do the reflective supervision sessions?

JANE: I am a little confused because you have said you want me to bring my concerns and things I am not sure about, but I wonder how that will affect my evaluation at the end of the year?

SUPERVISOR: That's a great question. Other staff have wondered that as well. Will it be held against me if I am honest about things I don't know?

JANE: I did wonder, because I want people to think I am doing my job.

SUPERVISOR: Let's look at that evaluation form. As you see here, one of the evaluation points is use of supervision. What we look at here is

your willingness to bring up things you are unsure about and figure out next steps. This will be seen as a plus for you if you do raise questions and concerns.

JANE: And you know I have a lot of them.

SUPERVISOR: Also, if I ever have any concerns about how your work is going, I will bring those concerns to your attention right away, and we can figure out the kinds of support you need to address them. There will be no surprises at your evaluation, as we will talk about the same kinds of things we have been talking about all year, but in a slightly different way.

As this dialogue indicates, programs that implement reflective supervision should review their employee evaluation procedures and think about ways that reflective supervision might influence these processes.

Power and Authority

Reflective supervision relies less on authority derived from power than it does on authority derived from the supervisor's influence that emerges out of a trusting collaborative relationship and a dialogue about work-related issues. The reflective supervisor, in order to be effective, must have the respect of the supervisees. This respect is often gained through a demonstration of her ability to do the kind of work that those she supervises are doing.

Although the practice of reflective supervision recognizes the need for mentoring, support, and reflective dialogue that helps each intervener do her work better and grow in her abilities, monitoring and quality assurance are often a part of the supervisory role. The supervisor must be comfortable enough with power and authority so that when issues of quality assurance are in play, she can balance reflection, support, and empathy with clarity, exploration, and movement toward quality.

Ghosts of Supervisors Past

Despite the best efforts of a supervisor to practice reflective supervision, expectations of supervisory time and behavior in supervision is to an extent shaped by what might be called ghosts from the intervener's and the supervisor's past. These ghosts can be former supervisors who

approached supervision in a critical, haphazard, or overly controlling manner.

Ghosts from the past can also be seen when there are disciplinary, cultural, racial, gender, or age differences. Supervisees may have been trained to see children's needs above all. In supervision, they may think that the supervisor's questions about the parents are missing the point of the program. Some supervisees may be wary of stating an objection because it seems impolite in the face of the supervisor's status or because of a belief that the supervisor, because of her race or culture, would not approve or accept their views.

Supervisors themselves are not immune from these ghosts and may be wary of raising a concern for fear of offending a person of a different race, gender, or background. Despite the presence of these shadowy figures from the past, reflective supervisors can tame these specters through self-awareness, observation, and a willingness to address the relationship emerging between the supervisor and the intervener. This sample dialogue illustrates this approach:

SUPERVISOR: Jackie, I have noticed that when I ask you questions, you often will respond to me by saying, "What do *you* think?" I am wondering if you are uncomfortable letting me know your own responses.

JACKIE: Well, you have been doing this a long time.

SUPERVISOR: That's for sure, but I was worried that you might think I was expecting you to see things exactly the way I do. I was wondering if you thought I would get upset or something if you didn't.

JACKIE: I just don't want to do anything wrong.

SUPERVISOR: As you grow in this job, you are going to find ways of doing things that are unique to you. I want to help you do that and learn some new things from you as well. However, I do promise that if you are ever way off in what you are doing and I think it won't work, I will discuss that with you.

Confidentiality

Because reflective supervision is enhanced by a trusting and supportive relationship, it is imperative that the confidential nature of the supervisory relationship be defined in each setting. In general, this

includes guarding information that a supervisee might share about her personal life, the feelings elicited by her work, and the difficulties that she might be experiencing with a situation.

Typically, reflective supervision content is not shared with other staff members or administrators. However, if an intervener does something that might become public knowledge or is necessary to share because of safety, ethical, or program concerns, the supervisor should talk with the supervisee beforehand about what would need to be shared, with whom it will be shared, and why this is necessary.

Here is an example of material shared in supervision that should be discussed before it is shared with others:

SUPERVISOR: I am glad we talked about Jason and his family situation today. I am a little worried that the day-center staff doesn't know about the fighting between the parents. I wonder if this should be shared with them so they can be a little more supportive to Jason.

INTERVENER: Well, I told mom it was confidential. It wouldn't feel right.

SUPERVISOR: Do you think you could talk about this with mom and ask her if some of this could be shared in order to help Jason?

INTERVENER: I just wouldn't know what to say.

SUPERVISOR: How have you addressed difficult things with her in the past?

INTERVENER: Well, I have always told her that I want to let her know how I feel. I guess I could tell her that I know she cares about Jason, and I wonder if we could talk about some things that he might need in school. Also, right now I am concerned that if I don't talk to her, one of those teachers might put her on the spot. Jason is pretty wild since that incident affected him.

Notice in this situation that the supervisor does not tell the supervisee what she must do but guides her to think more fully about the situation in a way that helps the supervisee figure out what she will do. If this had been a clear question of child, intervener, or parent safety, the supervisor might have become more direct about confidentiality issues, particularly if she felt that the supervisee was unclear about the concern.

In addition to issues about the confidentiality of supervision, issues related to the intervener's understanding of how to explain confidentiality to families is crucial. It is important for families to understand that the activities and conversations that occur with program staff are discussed and monitored by a supervisor who shares responsibility for the quality of the services.

Confusion About the Therapeutic Nature of Reflective Supervision

Reflective supervision is not a form of program-sponsored therapy. Reflective supervision methods encourage an exploration of responses to work with infants, young children, and families. Sometimes, in the course of supervision, supervisees reveal personal concerns, crises, or ongoing dilemmas. Discussion of these personal issues can be stimulated by problems that a family is having that may remind the supervisee of her own troubles. The discussion may be started because the supervisee knows and trusts the supervisor and desperately needs to discuss a problem.

It is part of the supervisor's role to try to understand any difficulties that a supervisee may have, in order to help her manage her work. However, if reflective supervision time begins to be used mainly for exploration of a supervisee's personal concerns, the reflective supervisor has an obligation to help the supervisee examine what other personal or professional resources might be available for this purpose.

WHO CAN PROVIDE REFLECTIVE SUPERVISION?

In some settings in which interveners are licensed mental health clinicians or social workers, supervision issues are clear. The reflective supervisor must hold a similar license, particularly if workers are interns. However, in many work situations in the infant family field, staff members from other disciplines take on supervisory roles because of their experience and knowledge of the work, knowledge of populations served, and particular skills needed.

It is not enough to have done the work to become an effective supervisor. Supervisors must have an understanding of the skills of reflective supervision and relationship-based approaches. Questions

that are often asked include these: "Is it necessary to have mental health training to provide reflective supervision? What must a supervisor be able to do?"

To a certain degree, these questions reflect confusion between reflective supervision and mental health approaches. To answer these questions, program planners must consider the program mission, the population needs, and the program resources. The program examples listed previously offer some examples of how reflective supervision provided by individuals who are not trained specifically in mental health can be supported by mental health consultants and staff.

EVALUATING THE EFFECTIVENESS OF SUPERVISION

Like interveners, supervisors often wonder about the quality of their work and the effectiveness of their interventions. Does the supervision time seem worthwhile, and is it supporting the intervener's work sufficiently? There are several approaches to looking at evaluation of reflective supervision.

From a program perspective, administrators can look at quality markers such as staff turnover, retention of families in the program, number of home visits or other services completed, and client evaluation of services to see if staff are receiving the kinds of support and guidance that lead to effective services. If things are not going well, administrators should think about the structure of the supervision services, the frequency of meetings, the skills of the supervisors, and the perceptions of the staff about the supervision.

For supervisors, it is valuable to check in with interveners formally and informally to ask about the use of the supervision time. What do they find valuable? How does the supervision help them with their work? How can we work together more effectively? Supervisors can also be helped to enhance their skill level by videotaping sections of reflective supervision sessions and later discussing the video clips with a trusted mentor or manager skilled in reflective supervision. This kind of videotaping must be done with the permission of the supervisee, with the clear understanding that it is meant as a help to the supervisor in her skill development. It should not become an intrusion on the supervision process. The development of competencies for interveners and supervisors in the infant family field will be of some assistance to both in their skill development in the years to come.

CHALLENGES

The practice of reflective supervision has grown exponentially in the ten years since the publication of Fenichel's edited collection. In addition, many important publications have appeared that highlight aspects of reflective supervision work. The practice of reflective supervision is well accepted in the infant family field, and the link between the skilled use of reflective supervision and program quality is often described, yet three major challenges face those who desire full implementation of this practice.

The first challenge is the need for evaluation and research on the uses and implementation practices of reflective supervision in the infant family field. Paradoxically, the majority of publications about the infant family field refer frequently to the importance of reflective supervision, yet there has been little research or systematic program evaluation of different approaches to reflective supervision, models of implementation, or specific impacts on program quality.

These research and evaluation studies are needed to fully address the second challenge: the development of better administrative understanding and support for the role of reflective supervision. With well-crafted research or evaluation studies related to the implementation of reflective supervision and other supportive practices, the field would have not only anecdotal reports and best practice recommendations about the usefulness of this practice but empirical data as well.

The last challenge to the practice of reflective supervision is appropriate financial and programmatic resources to allow for sufficient training and ongoing support for those who wish to learn the skills of reflective supervision. Currently, training for reflective supervision is done in many different ways, and sometimes not at all. Practitioners in many fields who are skilled in their work may simply be promoted to the role of supervisor with little attention to the support needed to transition to their new role and develop competencies that allow for the skillful delivery of reflective supervision to others.

The time is right to seek a constructive resolution of these challenges. The rapid growth of services to very young children and their families brings with it an opportunity to provide higher-quality services. The promise of the infant family field to improve the future of young children and their families will depend in large measure on inspired program leadership. First and foremost, we need to have more supervisors using reflective processes so that we can maintain and build on the improvements we have made in service delivery to infants, toddlers, preschoolers, and their families.

CHAPTER SEVEN

A Seminar to Support the Supporter

Promotion of Provider Self-Awareness and Sociocultural Perspective

Graciela "Chela" Rios Munoz, L.C.S.W.

Cheryl, an African American nurse, was working with a Mexican immigrant family and felt "stuck" in her work. She could not understand why the mother, Luisa, would jeopardize her daughter's education for a family vacation to Mexico. Luisa told Cheryl that her daughter's education was important to her, and Cheryl had worked hard to secure the school placement for the child. However, Luisa had decided to take a trip to Mexico that might result in the loss of the school placement. Although she cared about this family, Cheryl felt that Luisa was only "thinking of herself." Cheryl was feeling very frustrated, worried, and angry. Cheryl knew that unless she received consultation and support, she was at risk of losing this family.

Cheryl presented this case to the NOSOTRAS Seminar. (The Spanish translation of *nosotras* is the feminine form of *we.*) The NOSOTRAS seminar is a multidisciplinary group of practitioners who meet monthly to discuss their work with Latino immigrant families who have medically fragile infants.

Thanks to Margie Gutierrez-Padilla, L.C.S.W., for her support and help in putting this chapter together.

WHY A LATINO-FOCUSED SEMINAR?

In the past decade in the county where I live, the Latino population has increased by 50 percent. This is a trend that is well established in California. This trend is also unfolding in other parts of the country. The U.S. Census indicates that the overall national growth of the Latino population has increased by 58 percent during the last decade (U.S. Census 2000).

These statistics forcefully demonstrate that the face of America is changing. The cultural and linguistic profile of the country is shifting. Despite this dramatic trend, our society has not engaged in dialogue about the impact of multiculturalism. This silence has implications on multiple levels in our society, including in the delivery of services to young children and their families.

In an effort to provide culturally and linguistically relevant services, our program has worked hard to diversify the staff. However, in large part due to a historical trend of unequal opportunity that has resulted in Latino educational disparities, there is a dearth of bilingual and bicultural staff to serve the Latino immigrant community. Many Spanish-speaking families in our area are served by non-Latino practitioners who are bilingual, or by practitioners who speak only English and work through interpreters. Practitioners who provide services cross-culturally face the challenge of working with language barriers while trying to understand cultural factors.

I am one of the few bilingual and bicultural practitioners in our area. I am a Mexican American and I am the child of Mexican immigrant parents. My siblings and I were raised by my widowed mother. As a child, I regularly witnessed the challenges that my Spanish-speaking mother faced in negotiating our family needs in an English-speaking world. There were many things about being an immigrant that made my mother vulnerable and affected her as a parent. Her undocumented status kept her in constant fear of deportation and made her cautious in seeking services, preferring the safety of anonymity.

Generations of family remedies and practices were protectively withheld from the doctor for fear of chastisement. My mother sensed that her traditional cultural practices would not have been understood or accepted as valid and feared that they would be criticized and dismissed as folklore. Her difficulty with learning English put her children into the role of interpreters in adult matters. She faced child-rearing challenges as she struggled to negotiate differences in parenting and norms of behavior between children in the United States and

in her small town in Mexico. Language barriers also limited her capacity to help us with our schoolwork.

As a child, in addition to witnessing my mother's challenges, I also witnessed the tremendous benefit that emotional and practical support provided her. The support that my mother received, particularly from other immigrant women, greatly contributed to my mother's capacity for resiliency in facing the overwhelming daily stressors of the immigrant experience. This resiliency provided a protective shield for my siblings and me.

In my professional role, I work with immigrant families and see that the process of adaptation to life in a new country can be inherently overwhelming. I see that the difficulty with the adaptation process can create isolation, worry, self-doubt, and depression. Chronic stressors can lead to the parent feeling overwhelmed. This may compromise the sensitivity that parents are able to show to their children and may negatively affect the child's social and emotional development.

My childhood experiences and professional work have given me an understanding and appreciation for the importance of support for families with young children. These experiences have also taught me that meaningful support must be predicated on socially, culturally, and linguistically sensitive interactions.

PROGRAM SERVICES

I work in a hospital developmental follow-up program that serves medically fragile infants through home visiting. Our program has a collaborative grant with a unit in the local county public health department that also serves medically fragile infants. Both programs serve a multicultural population, including the Latino immigrant community.

Although there is a commitment from individual practitioners and their respective agencies to serve Latino families, I became aware of the fact that many staff felt a need for more in-depth support and guidance in their work. They were particularly concerned about issues such as the impact of cultural and social influences.

Working with multicultural and multilingual populations requires focused attention and consideration of the specific issues and influences facing particular populations in order for interventions to be meaningful to the unique needs of individual families and

communities. In the challenge of working with a multicultural population, this focused attention can be difficult to maintain. Unless specific and deliberate attention is placed on sociocultural issues, the complexity of the work can be overwhelming and can unconsciously result in a universal or color-blind approach to the work.

This realization led me to develop a focused seminar that would provide practitioners with a regular opportunity to have ongoing thought, dialogue, and attention around these issues. I obtained support from hospital management to create a seminar that would specifically focus on work with the Latino immigrant community. The Latino-focused seminar was intended to enhance the existing support for staff, which included individual supervision, team meetings, and staff trainings.

To initiate the seminar, I sent out a universal e-mail to all staff with an open invitation to participate in a seminar that would focus on work with the Latino immigrant community. Thirteen women responded from a staff of approximately forty. Respondents included social workers, nurses, a physical therapist, an infant development specialist, and family advocates.

The group is multicultural and multiracial. It includes U.S.-born and immigrant Latina, African American, Jewish, and European American participants. There is variance among the seminar members with respect to the number of years in the field and the types of professional work experiences that they have had in the Latino immigrant community. Yet what joins us is a desire and willingness to better serve this community.

All of the participants work with Latino immigrant families. The monthly seminar is voluntary, and the stated purpose is to further the work with Latino immigrants. The seminar has two co-facilitators, both Mexican American social workers, who meet together regularly to plan for the seminar.

USING A MODEL OF PARALLEL PROCESS IN THE SEMINAR

As practitioners who support infant well-being, we understand that the infant's development is influenced and shaped by the parent-child relationship. If the parent is available to the child in a sensitive manner, the parent-child relationship will promote the child's well-being.

It follows that parental well-being optimizes the type of sensitivity available to the child.

Practitioners working with young children must prioritize support for the parent in order to strengthen the parent's capacity to support the child. It is important that practitioners also receive support in this vital role when working with parents.

The NOSOTRAS seminar is an effective model to support practitioners in their work with Latino immigrant families while engaging in a parallel process. The parallel process in the seminar is realized through support for the practitioner so that the practitioner will be better able to support the parent. This parallel process ultimately enhances the child's well-being. Although the seminar focuses on work with the Latino community, the model has useful applicability in work with other groups. It is important to note that such application should attend to the nuances specific to the client population being served as well as that of the provider.

A DUAL APPROACH: SOCIOCULTURAL PERSPECTIVE AND PRACTITIONER SELF-AWARENESS

The seminar is guided by two working principles. One is the use of a sociocultural perspective. The other is the use of self-awareness or the "I" in intervention (that is, what the practitioner brings to the relationship). I define these principles in the following terms.

In order to be truly supportive of the parent, the practitioner must explore and understand who the parent is, namely, what the parent's life experiences have been with regard to childhood experiences, current family relationships, and the overall developmental process of adulthood. Understanding the parent and the family is informed and influenced by many factors, including class, culture, education, race, gender, and historical legacies.

For Latino immigrants, further influencing factors include immigration status, English-language capacity, the impact of migration, and adaptation to life in the United States. Consideration of these factors will allow the practitioner to understand and decode the meaning of the client's behavior, values, and very dreams for the child in a way that is meaningful to the client. It is this understanding that will facilitate a collaborative approach with the client and will ground the

practitioner's interventions in a manner that is meaningful to the unique reality of the family.

The quality of the intervention is dependent on the quality of the relationship between client and provider (Seligman, 1993). Because relationships are based on mutual interactions, it follows that part of the mutuality is what the provider brings to the interaction. The mutuality and quality of the relationship between client and provider are critical aspects of our work and are often written about. However, in everyday practice, the provider's contribution is given too little attention. Instead attention is given to the skill base of the practitioner, which is typically education based.

Although the practitioner's education and training are an important part of the intervention, so, too, are the practitioner's worldview and level of self-awareness. These can drive the practitioner's emotional response to the interaction with the client. Without self-awareness, the nature of the emotional response can remain at an unconscious level and unknowingly and unintentionally hamper the intervention and the relationship. It is, therefore, imperative to support practitioner sociocultural self-awareness and to understand how it relates to emotional responses in clinical work with young children and their families.

No one would argue these points. In fact, these aspects of the work seem obvious. But the reality is that consistently practicing these points is easier said than done, especially as we work in an increasingly multicultural society and with clients with backgrounds different from our own. Our professional commitment to a multicultural population must include the institutionalization of a process and protocol that integrates these principles of practitioner self-awareness and the use of sociocultural perspective in the structure of the delivery of services.

NOSOTRAS SEMINAR: APPLYING THEORY TO PRACTICE

"As a rule, we become so comfortable with our own worldview, that we tend to confuse it with reality" (Lieberman, 1990, p. 103).

This sentence defined the mission of the seminar, as it implies two vital tasks of practitioners. The first is self-awareness: to think about and understand our values and beliefs in order to differentiate our worldview from that of the client. This process will help the provider avoid unconscious imposition of his or her own worldview. The

second task is understanding the sociocultural context: to conceptualize the client's behavior in the context of the client's social reality. This approach makes our interventions meaningful and makes them fit the framework of the client's sociocultural context.

The following sections will describe actual events that illustrate how these two tasks were approached in the seminar. The events were a clinical dilemma as discussed in a case presentation in the seminar and an interpersonal crisis among the seminar participants that was a result of stereotyping.

How the Seminar Supported the Supporter by Means of Case Presentation

In Cheryl's presentation to the NOSOTRAS seminar, she began by explaining that her work had to be done via an interpreter because she does not speak Spanish, and Luisa, the mother, does not speak English. Cheryl shared her frustration with having a language barrier and in working with an interpreter.

Cheryl felt excluded because of the dynamics between Luisa and the interpreter, which were characterized by long conversations in Spanish that she perceived were poorly interpreted. This exclusion exacerbated her difficulty in creating rapport. The group validated Cheryl's frustration in her experience in working with the program's system of providing services to non-English-speaking clients and encouraged her and other staff to discuss this frustration with management so that interpreter services could be improved.

Cheryl used the case presentation format (see Appendix) to guide her in gathering pertinent information about the family. Cheryl explained that Luisa's migration from Mexico to the United States was precipitated by economic difficulties. The business that she and her husband, Fernando, had started in Mexico was losing money, making it difficult for them to make a living. It was also difficult for Luisa to help support her widowed mother economically.

The couple felt that the best chance they had for economic opportunity was to go north and work in the United States for a while until they could save enough money to return home. Fernando came to the United States first and got a job as a gardener. He sent for Luisa within a year, and Luisa found a job cleaning houses. At this point in the presentation, Cheryl shared with the group that Luisa became teary eyed as she recalled having employed two housekeepers in Mexico: "Que

vida . . . ahora *yo* soy la criada" (translation: "What a life . . . now *I* am the housekeeper"). Luisa and Fernando have two children, nine-month-old Nora and six-year-old Rosita.

Luisa had recently received a letter from her sister, asking Luisa to return to Mexico for her niece's baptism. Luisa told Cheryl that she was planning to take her two children to Mexico for the baptism. Because Fernando had hopes of gaining legal residency in this country, he would remain at home and await notification from the U.S. Citizenship and Immigration Services.

After presenting this family history, Cheryl incredulously described to the group that Luisa and the girls may not return to the United States until after school has resumed at Rosita's new school. Cheryl worried that if Rosita was late to restart school after Christmas vacation, she might lose her enrollment. Cheryl had worked diligently to help enroll Rosita in kindergarten. She described to the group with enthusiasm how bright and precocious Rosita was.

In her case presentation, it was apparent that Cheryl was bothered by Luisa's decision to remain in Mexico beyond the commencement of classes. Although Cheryl was very caring about the family, her unspoken judgment and frustration were on the surface.

As I listened to Cheryl's presentation of this case, I wondered if Cheryl had unconscious dreams and hopes for this family that she was not stating. I felt that it was important for her to identify these. As the facilitator, I drew a line down a sheet of easel paper on the wall. On one side of the line, I put "Cheryl's goals and dreams for family." On the other side of the line, I put "Family's goals and dreams." I then asked Cheryl to complete the lists. For her section, Cheryl listed supporting Rosita's education and getting dental care for the family. For the family's section, Cheryl listed that Luisa wanted to see her family in Mexico and to "make it" in this country.

Through this juxtaposition, the exercise provided an opportunity to establish two important points. First, as practitioners, we are not blank slates. We have our own hopes and dreams for our clients, and we bring these to our work. Second, the unconscious tension in the relationship between Cheryl and Luisa was rooted in the difference between Luisa's dreams and priorities for her family and Cheryl's dreams and hopes for the family.

With this juxtaposition in view, Cheryl was ready to consider the complexity of Luisa's circumstances in their sociocultural context. In addition, Cheryl was able to delve further and to recognize that her

unconscious hopes and dreams for the family were tied to her own personal experiences and that these created tension in the client-provider relationship.

Sociocultural Perspective: The Mother's Worldview

With input from the group, Cheryl broadened her understanding of Luisa's sociocultural context. Although Luisa and Fernando's migration to the United States was voluntary, they had experienced losses, complications, and sacrifices. The couple's change in economic status had many implications: a reduction in lifestyle, downgrade in social status, and distress at not being able to send money to Luisa's mother. The group helped Cheryl to wonder about the impact of these changes on Luisa's self-esteem and the strain that these issues placed on the couple.

We also considered the effect of Luisa's struggle to learn English on her sense of competency. The Latina group participants talked about the cultural context of Mexican family relationships and helped Cheryl to consider Luisa's sense of responsibility and worry for her aging mother. We wondered about the cumulative impact on Luisa of birthing and raising her two children in a foreign land without the support of her mother and female network of family and friends, particularly because Nora, her younger child, had been born prematurely.

Cheryl and others in the seminar were surprised to learn about the complexities related to Luisa's immigration status. Cheryl knew Fernando and Luisa as a working couple but had not realized that their undocumented status kept them in constant fear of deportation. The children's citizenship guaranteed them reentry into the United States. However, because of her undocumented immigration status, Luisa could not legally reenter the United States despite having lived and worked here for years.

In order to return to the United States, she would have to pay a smuggler a large sum of money to cross her over the United States–Mexico border. This arrangement made it difficult to guarantee when she could be back in the United States, despite knowing when school would begin for Rosita. The group shared anecdotal experiences about other undocumented clients who had been detained at the border and the tremendous anxiety this created for the children and parents. Cheryl wondered if Luisa and Fernando were apprehensive about these potential problems. The group helped

Cheryl think about how to approach a conversation with Luisa about these issues in a supportive way. The seminar discussion helped Cheryl to increase her understanding of the family's issues.

Self-Awareness: Helping Cheryl See How Her Personal Experiences Affect Her Work

Through discussion, Cheryl also thought about how her own identity as an African American and her upbringing, which valued education, had shaped and influenced her decision to become a nurse and help people. Although these influences were very positive in her life and work, the group discussion helped Cheryl to see that in her work with this family education was an unconscious priority for her that created an unconscious agenda in her work.

In addition, as an African American woman, she understood the historical legacy of racism and its continuing impact on opportunities for people of color in this society. She therefore saw education as a necessary means for survival and success in this country, especially for minorities.

Cheryl saw that she had been responding to Luisa based on her own dreams for the family. She also saw that she had unconsciously aligned herself with Rosita, another minority female. These strong but unconscious pulls made her approach the subject of education with such vigor that she was unable to see, understand, or appreciate Luisa's circumstances. This created tension in the relationship between Cheryl and Luisa and left Cheryl feeling frustrated and judgmental of Luisa.

Approaches Change with Self-Awareness and Understanding of Sociocultural Context

Cheryl's increased awareness provided her with a clearer vision of the family and the influence of her own emotional responses on her work with the family. With this new perspective, her judgment and defenses also diminished. Cheryl was ready to approach the family with a fuller understanding. Although she still planned to broach the topic of education, it would be free of the judgment that she had held.

She understood that in order to support Rosita's education, she had to consider the family's circumstances and understand Luisa's decisions. Cheryl could then be a support to Luisa. She planned to offer support to Luisa regarding her immigration problems by referring her to a community agency that worked with immigrants' legal issues.

Cheryl also hoped to connect Luisa to a support group for Spanish-speaking women to break Luisa's isolation and help her connect to a female support network. Cheryl planned to help Luisa advocate for Rosita with the school if the school placement was lost. By bringing the case to the seminar, Cheryl activated the parallel process. The safety of the group allowed Cheryl to acknowledge and express her feelings of frustration.

Seminar participants were then able to support Cheryl as a practitioner by helping her sort out critical issues in her work. This process would now be paralleled in Cheryl's work with the mother, as her new perspective would facilitate a supportive approach. Eliminating the judgment and increasing understanding would create safety in the relationship between Cheryl and Luisa so that Luisa would feel supported.

NOSOTRAS SEMINAR: CULTURAL CONFLICT AMONG COLLEAGUES

The NOSOTRAS seminar is a microcosm of society. As seminar participants, we experienced a crisis among ourselves based on clashes stemming from cultural differences and stereotypes. I will describe the internal process of the seminar as a crisis unfolded and how the principles of sociocultural perspective and self-awareness were applied to work through the crisis. I will describe the issues that developed, how we dealt with them, and the lessons learned. The stages will reflect a deepening level of the work in the seminar.

Crisis: The Surfacing of Stereotypes

During a seminar meeting, Jennifer, a white member of the group, made a remark about her strained relationship with her Latina coworker, Alicia, who is also a seminar participant. Alicia was absent that day. The remark made some participants very uncomfortable. A Mexican American participant explained that in her culture, there was high regard for other people's feelings. Jennifer's comment felt disrespectful and negative and indicated disregard for Alicia, particularly because she was not present.

It was clear that Jennifer, a self-described "white" person, was surprised by the reaction to her words. Jennifer defended her remark by saying that she was merely being honest and expressing her true feelings, which she did not feel were a secret. In the course of defending her honest statement, Jennifer made another comment that elicited

further reaction. She surmised that the honesty of her statement was difficult because Latina women "are raised to be nicey-nicey, quiet, and passive."

The room was immediately filled with tension and emotion. Recognizing the tension, I decided that it was important to address it. So I initiated a check-in and encouraged people to express what they felt in response to the comment. The four Latina practitioners responded emotionally and were vocal about how they felt offended at the blatancy and inaccuracy of the stereotyping of Latinas. Others also expressed disagreement, and some remained silent.

Unfortunately, due to time constraints, we had to end the session that day. I explained to the group that because the issue was unfinished, the co-facilitator and I would meet and plan a strategy to follow up at our next meeting in a month. The meeting ended with feelings of tension, strong emotions, and uneasiness.

As the primary facilitator, I struggled with my role during this crisis—how could I negotiate the visceral, physical, and emotional responses that I was experiencing yet remain calm enough to continue the facilitation of the group? I negotiated this dilemma by paying attention to my complex feelings—my strong and personal feelings of horror, revulsion, and anger, while also feeling the responsibility of my facilitator's role to hold and guide the group.

I was personally aware that Jennifer's remark characterized the complexities and tensions of our society's racial problems. The tenor of the remark embodied my whole life's experience as a Mexican American—being subjected once again to the majority culture's entitlement and privilege and the imposition of that entitlement without regard to its negative impact on me and my people.

Debriefing and Planning Process

After the meeting, I spoke individually with many of the seminar participants. I wanted to give them an opportunity for venting and validation of individual experiences, while gathering information to guide me on how to proceed. I also felt that it was important to give the message that the participants should not allow the pain and emotion of the incident to split the group.

The responses of the Latinas were particularly emotional, ranging from shock and anger to disgust and tears. We discussed why the comments felt so inflammatory and why we were so immediately flooded

with emotion. We discovered that the comments brought up the pain of racism that we have experienced in our own lives. For the Latinas, the experience of being subjected to stereotyped comments in a professional setting was shocking. Even though we had "made it" into the professional world, we were not protected from the racism that we continue to confront as Latinas in spite of our educational and professional credentials.

The person who made the inflammatory remarks called me to apologize. She also called and left voice mail messages to others who she knew were upset by her remarks. It was apparent to me that she did not have an understanding of why the response was so strong, or of what she had done wrong, but she clearly saw that some group members were angry.

She felt attacked by people's responses and wondered if she should drop out, because she felt that others might not want her to return to the group. I encouraged her to stay with the seminar and not drop out because of the conflict. We needed to engage in a process of working through the crisis to gain growth, and this required the participation of all members.

Parallel Process

As a mental health specialist, I know that a principle of intervention is facilitating parents' observations and understanding of their child's behavior and the parents' understanding of their own responses to the behavior. With this crisis, I understood that I needed to initiate a parallel process in our seminar. If the group was going to stay with the goal of improving the work with Latino immigrant families, it was going to be important to facilitate a process so that members could understand the responses of the other participants, while also understanding their own responses.

I felt that this was a critical yet formidable task. I desperately needed support for myself and knew that I first needed help in coming to terms with my own feelings. In addition to conferring with the seminar co-facilitator, I sought support from friends and colleagues outside the group. This allowed me not to be overwhelmed by my own feelings and to be able to attend to the group's needs. The process of doing this helped me to prepare both the structure and the process for the seminar follow-up meeting.

While acknowledging and sorting through my feelings and emotional response, I remained focused on the group. I was aware that

without effective intervention, the emotion could cause a disruption and disbanding of the group. My immediate goal became to keep the group together and to help all of us understand this experience as a microcosm of what occurs in society and in our work with children and families. I had to use this crisis as an opportunity for members of the group to grow. I wanted to avoid getting stuck and did not want to ignore the crisis. I also worried that it could divide us.

It was clear that each seminar member had a personal response to the incident, yet the impact was different for each person. I had to find a way to implement the principle that we need to be honest with our own feelings and to be willing to support the other person's honesty about her thoughts and feelings even if the honesty creates discomfort, fear, anger, and disagreement. In addition, it was important for the facilitators to connect this crisis with the overall goals of the NOSOTRAS Seminar.

From Crisis to Action

We began our postcrisis meeting by stating that our seminar goal was to encourage honest assessment and discussion of individual feelings and to use the discussion to grow personally and in our work. We reestablished the group identity by drawing the parallel with healthy families who experience discord. The goal is to deal with conflict constructively rather than remaining silent and ignoring the trouble or expelling the offender. We established safety by declaring that each person has a right to her respectful opinion.

To facilitate the goal, we engaged in a two-part exercise. The first part of the exercise was designed to give the group members an opportunity to process the impact of the comment at an individual level, thereby validating each person's experience. The second part of the exercise was to facilitate the sharing of individual experiences with the group at large to learn from one another.

Each person was given paper and pen and asked to respond anonymously in writing to two questions that were prewritten on easel paper. The questions were in reference to the "comments" from last month's meeting. The questions were these: (1) How did you react? (2) What did you really want to do in the moment but didn't do?

When everyone was finished, the papers were folded and placed in a box. In order to promote containment and safety, we structured the exercise so that each participant read out loud someone else's response. The following were among the responses:

Question Number One

- "Shock and disbelief—did she really say what I just heard? Does she really feel that way about Latina women?"
- "I felt very angry initially and became defensive. I felt as though I needed to clarify for the group my definition of the Latino culture and Latinas specifically. I also felt like crying, as a result of my anger, my *pain* that this type of comment is what I truly hate to see and hear. It is what I fear for my family, my children, my parents."
- "I internalized *many* emotions arising at once. I held back tears and angry words."
- "I felt that nervous response one gets in the stomach when something 'unpleasant' needs to be dealt with."

Question Number Two

- "I just wanted to stomp around or leave the room or rant and rave."
- "I became inclined to want to assess my own feelings and comments more closely."
- "Take her home and have her spend a few days with the women in my family."
- "Express that it is unfair and inaccurate to make broad generalizations of how all Latinas (or all Asians, or all blacks, or all whites) are, or feel, or behave."
- "I wanted to do the whole thing over, to go back in time to rebuild the beginnings of trust and relationship that I feel I have really damaged. I wanted to leave or have someone stick up for me."

We listened to one another's responses attentively. In retrospect, I think that in addition to providing a forum for airing individual responses to the incident, the exercise allowed us to open a conversation about an issue that is always simmering at the surface of our society. This is the issue of race and stereotyping and how it affects us at the individual and group level. We do not have social permission or a protocol to discuss these delicate issues that we have historically avoided.

During the follow-up discussion, many participants elaborated on their written comments. There was emotion as space was provided to

air feelings and experiences, questions and curiosities. It seemed that this incident quickly tapped into feelings and experiences that many people hold deeply but perhaps do not discuss, particularly in mixed racial and cultural groups.

Despite the emotion, there was a sense of guarded safety, as participants began to speak about what is usually unspoken and avoided. As time drew to a close, there was consensus that we should continue the discussion. The co-facilitator and I met and decided to build on the experience.

At the following meeting, we discussed the fact that what Latino identity means solicits responses that are varied and sometimes emotional. The responses may differ, in part, depending on whether the person is Latina or non-Latina. In an effort to relate the process back to the goal of the seminar, which is to support work with Latino immigrant families, we decided to focus on ideas, experiences, and sentiments that participants have toward Latinos. We wanted to have people think about where their ideas about Latinos come from and what those ideas are.

At our next meeting, we asked each participant to think about and share their responses to the following questions:

1. Where were you born and raised and were there Latinos in your neighborhood?
2. What were the images of Latinos that you gathered while growing up?
3. When was your first contact with Latinos, and what do you remember about it? Was your contact through a personal relationship or from the media?
4. How does being a non-Latina affect your work with Latino immigrants?
5. How does being a Latina affect your work with Latino immigrants?
6. What have been the strengths and challenges of your personal experiences in your work with Latino immigrant families?

By now, the emotions of the initial crisis were better contained, and all of the seminar members remained willing to continue in the process of getting through the crisis with the faith that in so doing, there would be growth. The sharing of experiences was informative and fascinating.

For example, we heard similarities in the experiences of the Mexican Americans, but also great differences. Interestingly, the similarities included the sacrifices of our working-class parents to provide educational opportunities to their children. The influences of seeing the struggles of our parents and family experiences of discrimination resulted in our motivation to give back and to use our positions to fight injustices and help others.

There were differences about how, when, and why each of our families came to the United States. There were differences in how we identified ourselves—Mexican, Mexican American, Hispanic, Chicana, and Latina. The non-Latinas reported wide differences in their experiences with Latinos, ranging from growing up with Latinos to never seeing Latinos until adulthood.

Interestingly, there was a difference in the range of disclosure between the Latinas and the non-Latinas. Although everyone participated, the Latinas were noticeably able to access and express their feelings and experiences about Latino culture and identity. I suspect that there was unspoken reservation on the part of the non-Latina participants perhaps because of the aforementioned fears of appearing judgmental, insensitive, or lacking in knowledge about the Latino culture.

From Crisis to Growth

In sharing, everyone had an opportunity to tell her story. In so doing, we learned from one another, got to know one another at a deeper level, and formed bridges. The proverbial ice was broken. In telling about our individual experiences, we took the time to reflect on the factors that conditioned our thoughts, beliefs, and values about Latinos, thereby engaging in a process of self-awareness. With this brought to the surface, we were better able to think about how our stories and our personal legacies affected our work with Latino immigrant families.

In our subsequent meetings, the benefits of this process have become visible. Participants have been thoughtful and have shown a greater willingness to present their complexities to the group. The Latinas are thinking about clinical issues in a manner that raises questions about how we are connecting to clients and how our personal histories and experiences are reflected in our relationships with clients.

The process has made it acceptable, especially for the non-Latinas, to wonder and ask questions about Latino culture and experiences in a

manner that seeks understanding. Assumptions and stereotypes are being raised and confronted. Questions are asked and clarifications are made. Questions asked by participants reflect deeper thought about uncertainties and dilemmas instead of a more superficial seeking of facts or referrals. The act of pausing to ask questions has replaced the need to take quick action that is often fueled by habit and uncertainty.

The following are examples of questions asked by participants that reflect a desire to gain a deeper understanding of the work.

- "*Why am I visiting this family so much?*" As a Latina explored this question with the group, she realized that in her helping relationship with the client, she had unconsciously been reliving her painful childhood experiences of watching her mother face difficulties, intensified by the mother's immigrant status. But now in her role with the client, the Latina participant was not an impotent child. As an educated adult, she fought and advocated fiercely for the client in honor of her mother, while recognizing her own emotional triggers from the past.
- "*How much is culture, and how much is the dynamic with and idiosyncrasies of the client, or is it me?*" These were the questions of a white nurse as she presented her case. She admitted that she doubted herself in her work and was feeling confused and frustrated. Through group discussion, she was able to see that these feelings were leading her to go into a "fix-it" mode. The nurse was supported to consider a range of possibilities to understand the client behaviors.
- "*What is machismo?*" This is a unanimous choice for discussion for a future meeting as participants struggle to understand male-female relationships and to respond to issues related to gender roles. To help the discussion, we will bring poetry, Latino music, readings, and the benefit of our personal and professional experiences.

A part of the sociocultural perspective includes careful thought about how the practitioner will interact with the client based on new understanding gained from the group discussion. What words will the practitioner use? The seminar combines the practitioner's knowledge of the family with consideration of factors to be weighed in effective communication. For example, class, regional origin, and level of education are some factors measured to help the practitioner compose questions or statements. This step progresses the benefits of the discussion from a conceptual understanding to concrete application to be used in the home visit.

The seminar is flexible in content and format in order to be responsive to the needs of the group at large and the individual participants. We devote meetings to case presentations and discussions of themes and topics related to the work. We share concrete resources and bring in speakers.

This chapter offers a descriptive narrative of a model for practitioners to use in everyday practice to promote provider self-awareness and a sociocultural perspective in clinical work. Although the seminar focuses on work with Latino immigrant families, the principles of self-awareness and sociocultural perspective are universally important. The model also has applicability for use with other population groups.

In the United States, multiculturalism is an undeniable reality. The concept *diversity* in our society is widely accepted. Yet we are reluctant to engage in discussion about differences, particularly differences in race, class, and culture. Perhaps this reluctance is driven by a fear that attention to differences will result in divisiveness, or perhaps it is because discussion of differences can trigger painful feelings such as anger, guilt, or confusion. It is nonetheless important to consider the influence of race, class, and culture in our own lives and in the lives of our clients, as well as its impact on our clinical work.

Many practitioners participate in informative and thought-provoking trainings on cultural sensitivity and diversity. Increasingly, agencies include *cultural competence* as a standard of practice. Although these efforts are important, they are not enough to support the practitioner in the daily challenges of multicultural work. As illustrated in this chapter, the work deepens and is enhanced when opportunity for continuous dialogue is created. Without this purposeful dialogue, it is easy to remain in the safety realm of avoidance of discussion of issues related to race, class, and culture. This avoidance prevents the exploration of the complexities of working in a diverse society.

The NOSOTRAS seminar is an example of a model that provides continuity, structure, and guidance for discussion of these delicate topics and their impact on the delivery of services. The seminar leadership must set the tone for the work of the seminar. Leadership must ensure an atmosphere of safety, trust, and respect while maintaining a willingness to allow an exploration of the complexities of provocative feelings, opinions, and unspoken stereotypes. If the leadership

engages in the reflective process of self-awareness, this modeling will establish self-awareness as a principle of the seminar and encourage others to be reflective.

The racial and cultural conflict among seminar participants that is described in this chapter was provoked by an inflammatory statement. Although this type of bluntness is not necessarily typical, the underlying sentiment may be common. The use of guided discussion will help break the code of silence about stereotypes and differences.

This chapter does not provide solutions to the complex issues of working with a multicultural and multilingual population. Rather, it is an invitation to practitioners, supervisors, and administrators to embrace complexity. The development and implementation of an infrastructure that promotes and realizes a process of practitioner self-awareness and sociocultural perspective can lead to the provision of more meaningful and effective services for young children and their families.

Appendix: Sociocultural Factors and Provider Self-Awareness—Case Presentation Format

Sociocultural Factors

- Pregnancy, Labor, Birth

  Was this a planned or unplanned pregnancy?

  How did the mother and father respond when pregnancy was discovered?

  What was the quality of the relationship between mother and father prior to the pregnancy, and did this pregnancy bring mother and father closer together or did it stress the relationship? Did the mother have support during the pregnancy?

  What were mother's and father's ages at time of delivery?

  Did the mother receive prenatal care, and if not, why not?

  Were there any concerns during the pregnancy regarding maternal history?

  Who was with the mother when she delivered the baby, and did she have support?

  How does mother describe labor, birth, and when she found out that there was a problem with the baby?

- Birth History

  Birthweight

  Gestational age

  Nursery course

  Diagnosis

- Baby's Present Status

  Present age

  What is the baby's medical and developmental status?

  What are the baby's care needs, including medication, specialty follow-up, and so forth?

  How do the parents' cultural views on health and disability influence how they regard their baby's condition? Do the parents have any concerns about the baby?

  Do you have any concerns about the baby?

- Baby's Relationship to Family

  How do parents understand what caused the baby's difficulty? Have the parents received input from family or acquaintances about the cause of the baby's medical problems? Has the mother been blamed, or does the mother blame herself for baby's condition?

  How do mother, father, family feel about the baby?

  Does the baby hold a specific meaning to the family?

  Are the parents aware of the baby's cues? Do they have strategies to soothe the baby?

- Household Composition, Family Structure, and Relationship

  Who lives in the household and what is their relationship to the baby?

  What is the quality of the relationship between mother and father, and with extended family?

  What is the quality of relationships between household members? What is the quality of relationships within the family?

  What is the decision-making process and who participates?

  Who is the family spokesperson?

- Migration Issues

  What is the country of origin? Is it a city, a small town, or rural?

  What is the class status in country of origin? Has class status been affected by migration?

  Which family members came to the United States?

In what order did they come?

Which family members were left behind and why?

Are there other children in country of origin?

What was the reason for the migration to the United States, and whose decision was it?

How did other family members feel about the migration?

Were all family members able to say good-bye to those they left behind?

Do family members feel the migration was worth it?

Is there responsibility for family left behind in country of origin (for example, children, parents)?

- Adaptation to Life in the United States

  How long has the family lived in the United States?

  How would you describe the individual family members' levels of acculturation, including proficiency in English and understanding and capacity to function in various service delivery systems and institutions, such as health care and schools?

  How has the family system been able to negotiate the differences in cultural values, such as gender role expectations, generational issues, and the like?

  Has the family been able to secure opportunities to achieve adequate social functioning, such as housing, employment, and so forth?

  Have the family and its individual members been able to realize their dreams in their new context? Had they in their previous home?

- Family Coping Strategies

  What strengths have you observed in this family (for example, spirituality and use of religious rituals)?

  Has the family been able to create a network of community and support for its members to help provide support for concrete social and emotional needs?

  How have cultural practices and rituals served the family?

  Does the family use culturally based healing practices?

Has the family been able to preserve, adapt, or develop successful coping strategies to use with present crises and stressors?

Are there other service providers supporting the family?

- Stressors

  Have you observed or do you suspect that the family is facing stressors such as the following: health concerns, unresolved losses, legal worries about immigration issues, unemployment-underemployment and financial problems?

  Have you observed or do you suspect that the family has difficulty understanding or accessing entitlement benefits such as Medi-Cal, SSI, and the like?

  What about difficulties getting help for the following problems: domestic violence, inadequate housing, substance abuse, isolation, racism-discrimination, relationship problems, incarceration, limited literacy skills, other.

Provider Self-Awareness: The "I" in Intervention

- What are your dreams/expectations for this family? How do these fit with those of the family?
- What feelings do you have about working with this family? Has any part of the work been difficult, confusing, uncomfortable, frustrating, irritating, and so on?
- Is there a specific area of your work with this family where you feel "stuck" and that you would like to discuss?
- Has your work with this family evoked any thoughts, memories, or feelings from your own personal or professional experiences?
- How has the family's racial and cultural identity affected your work?
- What is the impact on the work if you share identity with the family?
- What is the impact if your racial or cultural identities differ?
- What are your concerns for baby, mom, or dad? What are the behaviors and interactions that you have seen that make you concerned?

- What is your hypothesis about this case?
- What interventions have you tried and how have they worked?

References

Lieberman, A. F. (1990). Culturally sensitive intervention with children and families. *Child and Adolescent Social Work Journal, 7*(2), 101–119.

Seligman, S. (1993). Why how you feel matters: Countertransference reactions in intervention relationships. *World Association for Infant Mental Health News, 1*(2), 1–6.

U.S. Census 2000. Population by race and Hispanic or Latino origin for the United States: 1990 and 2000. (PHC-T-1). [www.census.gov/population/cen2000/phc-tl/tab04.pdf]

CHAPTER EIGHT

Retraining Clinicians to Work with Birth to Five-Year-Olds

A Perspective from the Field

Mona Maarse Delahooke, Ph.D.

Retraining to work with the infant-toddler-preschool population involves significant shifts from adult mental health models. Few specialty programs existed ten years ago when I decided to specialize in infant mental health as a licensed psychologist in California. The following is a description of my journey toward specialization as an infant-toddler-preschool specialist.

A JOURNEY TOWARD SPECIALIZATION

Several years after becoming licensed as a clinical psychologist, I decided to specialize in infant and toddler mental health. Driven by an interest in early development, I networked with clinicians who had received advanced training in the field and discovered a dearth of infant-toddler specialists in our large metropolitan location (Southern California). Although graduate school training and postdoctoral internships had included classes and supervision with families and children, the focus was on children over the age of five. I had received little training in the area of infant and toddler development in the course of earning a doctorate and a license in clinical psychology. So

my first course of action was to find a training program and recommence my education in order to specialize in this young population.

To my surprise, no training programs were available in Southern California, although an excellent two-year postdoctoral program existed in Northern California. Applying to this program would have required a move, which was impossible for my family. Fortunately, with the help of a developmental expert and researcher, and advice from individuals at organizations such as the Zero to Three Foundation and WestEd/California Early Intervention and Training Network, I assembled a training program for specialization in infant, toddler, and preschool mental health.

My plan was to implement a three-tiered approach to training, including a thorough education in typical development, exposure to a wide range of atypically developing young children, and supervised clinical experience in a variety of early childhood settings. In order to obtain a firm foundation in early development, I audited a graduate course in infant and toddler assessment and intervention. The course covered physical and social-emotional development month by month, prenatally to age five. Theories of child development were surveyed as well as strategies and various approaches to assessment and treatment. Hands-on experience was provided through an observational lab and team practice in assessment of children between six months and five years of age.

Gaining Clinical Experience

Following the course, I was offered a position as a team member of the Behavior in Babies Clinic at the University Affiliated Program at the University of Southern California, Keck School of Medicine. The yearlong rotation on a multidisciplinary team served several functions. It offered the opportunity to observe typically developing infants at length in the hospital's day-care and early development center as well as affording team members the opportunity to observe and interact with young children with a variety of developmental and medical issues.

The clinic also provided weekly lectures and presentations by faculty members, including evaluation and treatment practices and clinical interfacing of occupational therapy, speech and language, education, developmental pediatrics, social work, and clinical-developmental psychology. As a part of the clinic, both play-based observational practices and an array of traditional infant and toddler assessment and

screening instruments were introduced, as well as extensive practice and administration experiences with the Bayley Scales of Infant Development—Second Edition (BSID-II) (Bayley, 1993).

The following year, I was offered a position at an early intervention (birth-to-three) program, serving children with special needs in a community-based setting. Members of the team included two psychologists, an occupational therapist, a physical therapist, home visitors, early education specialists, and a speech pathologist. During the assessment process at the early intervention site, each child and family were videotaped in play over time, under conditions of safety (in their home or a comfortable playroom). Developmental milestones, as well as infant and caregiver contributions to each milestone, were tracked in a team setting using an interdisciplinary approach. In doing so, the director of the program initiated a best practices approach to assessment and intervention, which was ongoing and collaborative and yielded a rich and complex view of each child's social-emotional functioning.

The Benefits of Interdisciplinary Team Membership

The benefits of membership on the interdisciplinary teams included the opportunity to experience how other disciplines view development and the time to formulate an understanding of the complex picture of each young child and his or her caregiver across developmental domains. For example, working with occupational therapists illustrated the impact of sensory processing and motor development on children's social-emotional milestones and behaviors.

Early on, it became clear that the ability to process and integrate multiple underpinnings of development involves understanding how different developmental domains affect and overlap one another. I realized that the contributions of the discipline of psychology were only one part of the complex picture that constitutes the range of work with infants, toddlers, and preschoolers. The big picture involves understanding how early behavior is influenced by multiple factors, including genetic and constitutional contributions, speech and language development, sensory processing, gross and fine motor acquisition, cognition, affective development, cultural interpretations, and the overall environmental context. In other words, because a child's social-emotional development does not occur in isolation from other

developing systems, both the assessment and the intervention necessarily need to be informed by all of these systems.

Selecting Workshops and Trainings

In order to gain exposure to domains not covered in a graduate program in clinical psychology, I was faced with what seemed like an overwhelming task: to learn enough about allied disciplines to understand the confluence of contributions to infant, toddler, and preschool development; to develop appropriate interdisciplinary skills; to learn how to ask the right questions and when to make appropriate referrals. To achieve these goals, I selected trainings from hundreds of continuing education programs in early development, in order to form a better understanding of how experts view developmental integration in assessment and intervention practices. During a three-year period, I attended over two hundred hours of continuing education workshops and conferences in the areas of attachment theory and research, relationship-based approaches, occupational and physical therapy, sensory processing and integration, speech and language, brain development, pre- and perinatal risk factors, genetics, trauma, cross-cultural implications of developmental expectations, and infant-toddler assessment and treatment.

The Retraining Journey as a Continuing Process

At the end of my "official" training years, I was offered a position as a supervisor and community liaison consultant to an interdisciplinary infant mental health training pilot program. As a supervisor and program liaison to two community-based agencies, I had the opportunity to interact with individuals from a variety of disciplines and to understand firsthand the challenges that staff face in meeting the needs of very young children. The framework of reflective supervision allowed me to obtain a frontline view of the complexities that both therapists and agencies face in serving this population.

Along the retraining journey, I met many mentors who enhanced my original notion of a basic training framework and broadened the scope of what it meant to be an infant, toddler, and preschool mental health specialist. The final training framework included exposure to and study across a variety of disciplines and developmental domains that were not included in my original training plans. Such trainings

provided a rich multi- and interdisciplinary experience that continues today, over a decade later.

RETRAINING: NOT AN ADDITIVE MODEL

One of the critical differences between adult and infant-toddler-preschool work is that the trajectory of growth and changes in adaptation between the young child and caregivers is constant and requires an openness to shifts on an ongoing basis. According to Emde and Robinson (2000), "Infancy . . . is a time of rapid change, and the interventionist is occupied at all times with facilitating favorable developmental change. Thus, the task of predicting continuities in disorder across time is difficult, if not paradoxical" (p. 169). These rapid and ongoing changes affect how assessment and intervention are conducted. The journey of retraining therefore must involve learning about the critical differences between treating adults and very young children, including best practice models of assessment, intervention, supervision, and consultation.

Selecting Theoretical Models

Infancy and early childhood involve an interaction of multiple systems that change and grow. According to Greenspan and Meisels (1996), the best practice treatment of infants and toddlers requires that the assessment-intervention be based on an integrated developmental model consisting of various developmental domains. Another retraining challenge was therefore to discover ways to organize the multiple components involved in treating young children and their families and to determine how to receive training about this complexity. I became a frontline observer of the interplay of different domains relating to early development in the infant-toddler, including the cognitive, affective, language, motor, and sensory systems, as well as the "dyadic dance" between infant and caregiver.

The word *retraining* is especially applicable to the infant-toddler-preschool mental health specialization process. Retraining in this field involves learning new ways of conceptualizing basic frameworks, not just acquiring new information and adding it to adult mental health paradigms. Work with infants, toddlers, and preschoolers involves many relational and caregiving contexts. One of the challenges of training was to find an assessment-intervention model that encompassed

multiple domains and included both the caregiver's *and* the very young child's contributions to adaptive functioning. The focus on complex and interacting affective relational systems, with variations in both the very young child and the caregiving environment affecting development, became a central part of my own clinical practice.

The developmental framework known as the Developmental, Individual-Difference, Relationship-Based (DIR) model served to organize my training. This model, developed by Stanley Greenspan and Serena Wieder (2000), provided a structure and a common language for interdisciplinary communication as well as a framework for understanding how young children's developmental milestones are cross-influenced by constitutional factors *as well as* the child's relational environment. Other theorists, including Sameroff and Fiese (2000), have described developmental interaction using a transactional model, postulating that infant mental states are a transaction between constitutional (child) factors (including phenotype and genotype) and the environment (external experience).

The DIR™ model (Interdisciplinary Council on Developmental and Learning Disorders, 2000) tied together the information that I had learned during my first two years of training about the role of other disciplines into a comprehensive framework. A contribution of the DIR model is that it tracks basic functional emotional developmental capacities of parents or caregivers with their infants. The Functional Emotional Assessment Scale (FEAS) was developed to track young children's emotional milestones in combination with the caregiver's capacities along the same milestones (Greenspan, DeGangi, & Wieder, 2001). These components include how young children function in an adaptive capacity along six major milestones: regulation and interest in the world; forming relationships or attachments; intentional two-way communication; complex problem-solving gestures and preverbal sense of self; emotional ideas, including representational capacity and elaboration; and emotional thinking, including building bridges between ideas (Greenspan, 1997).

Using the functional emotional developmental levels as an overlay to developmental processes enables clinicians to provide families with new ways of thinking about their children's strengths and constrictions, with specific affect-based intervention strategies targeting the child's capacities where growth is needed. This is especially necessary when a diagnosis is pending and when the assessment-intervention process is attempting to generate goals and strategies for caregivers

and support personnel (such as teachers) eager to begin the process of intervention. Because families often spend precious time attempting to uncover a "correct" diagnosis for their child's atypical development, a diagnosis may not be as useful a road map for intervention as the functional aspects of development. An example of a real case can help illustrate this point (all identifying information has been changed).

Max and His Family's Journey

Max's parents sought a consultation for their three-year-old due to concerns about his peer play skills, language, and overactivity. As a result of recommendations from the head of his preschool, developmental evaluations were conducted by a speech and language specialist and an occupational therapist. The family came to see me to help them interpret the results of the evaluations comprehensively and to develop an intervention plan. In Max's case, the results of the assessments were confusing. No specific diagnoses were given; however, constrictions were noted in speech-language (pragmatic usage); in the occupational therapy and sensory-processing evaluation (fine motor coordination, vestibular and auditory processing); and in peer play (below age level).

My first course of action after interviewing the parents was to arrange observations at the preschool, at home, and in my office. What appeared to be missing was an intervention plan that tied together the results of the prior testing. I administered the FEAS (Greenspan et al., 2001) in order to help the treatment team track his progress along developmental milestones. After carefully considering the results of the prior assessments, the FEAS results, and multiple observations, we developed a comprehensive treatment plan.

The formulation included the fact that Max had great difficulty regulating his activity level and was unable to be calm and focused for more than a few minutes at a time. He had a warm and caring relationship with his family and teachers but lacked basic skills to engage and communicate with peers. He therefore lacked the skills necessary for the important work of intentional two-way communication. As a result, his problem-solving skills, representational thinking, and symbolic play were constricted as well.

We then looked at underlying causes for the constrictions. At this point, many of the results of the assessments from the other professionals made more sense. Max had the need to seek physical

movement in order to feel regulated. (The occupational therapy report stated that he was a "sensory seeker," one who seeks input to the muscles and joints, as well as seeking vestibular input through movement.) He therefore could not focus for very long before these needs arose. He also was very sensitive to sounds. (The occupational therapy report stated that he had significant auditory sensitivity to sound volume.) This also made sense because Max had more difficulty when he was inside where the noise level was great and less difficulty concentrating when outdoors.

The major recommendations included support along each of the six major milestones described by the Interdisciplinary Council on Developmental and Learning Disorders (2000). Regulation and sustaining interest and attention (with a relational focus) were encouraged with occupational therapy (parent included in the sessions), speech therapy, and direct parent-child floor time work. This work helped his parents understand how to engage Max in reciprocal communication and joyful play, while paying attention to his state of arousal. The occupational therapist recommended a "sensory diet" to the parents and teachers, recommending certain activities at different times of the day to help Max focus and attend to the task at hand.

By focusing on the functional capacities in Max's development, specific support was targeted in a developmental framework through interdisciplinary communication. Valuable intervention time was not lost by waiting for a "definitive" diagnosis. Supporting Max's ability to be calm and focused took time, but it eventually enabled him to engage more with peers. His teachers appreciated knowing that Max was not simply being oppositional and that what they may have interpreted as intentional behaviors had multiple underlying causes. It is important to note that the fact that a diagnosis was pending did not deter us from focusing support on Max's functional capacities, which greatly improved over the course of treatment.

ASSESSMENT AS THE FIRST PHASE OF INTERVENTION

Assessment practices are a clear illustration of the difference between traditional adult mental health models and infant-toddler-preschool models. Characteristics of the evaluation of infants, toddlers, and preschoolers include the caregiver's involvement in the assessment process, the bi-directionality of assessment and treatment, the shift

from reliance on standardized assessment tools in favor of naturalistic and play-based observations, a focus on competencies and strengths, and a view of assessment as a collaborative, ongoing process.

These components and others are described in *New Visions for the Developmental Assessment of Infants and Young Children* (Meisels & Fenichel), published by Zero to Three in 1996. This book elegantly describes the shift in developmental assessment that is supported by critical differences in the ways that infants and young children respond to the assessment process. The notion that qualitative differences between older and younger populations require approaches that are uniquely suited to their developmental needs was a guiding principle for retraining.

Another training principle that has guided my work with families of very young children is a focus on strengths and competencies. The strength and competency focus of early childhood services is another example of divergence from adult psychotherapy models that focus on symptoms and symptom reduction. Even though behaviors and symptoms may initially create the need for families to seek services, the assessment process must necessarily focus on strengths due to the prioritization of the parent-child relationship. As such, the identification of strengths is a precursor to helping parents understand their infant's overall development.

As a clinician in training, I attended several seminars presented by Victor Bernstein. Bernstein, a father of a child with special needs, has developed a training model for clinicians, known as a *strength-based model* (Bernstein, Harns, & Percansky, 1991). Through creative visual and experiential presentations, Bernstein demonstrates how even in the most dire (or what appears to be dire) circumstances, clinicians can find strengths in caregivers and capitalize on those strengths as a basis for the intervention process. By shifting clinicians' foci to strengths, this training model emphasizes the basic principles of building positive relationships with families, as well as the nurturance of supportive relationships at every level of program operation. This includes the necessity of supporting front-line interventionists.

Differences in the Assessment of Adults and Young Children

Understanding the requisite changes in assessment practices for infants and toddlers involved a learning process over time. Participation in a traditional assessment clinic afforded the opportunity to

witness the limitations of a "one-shot" assessment of infants based on a single standardized test and history-taking session. I learned firsthand that the rapid changes in infancy and toddlerhood do not lend themselves to stable predictions over time or to the assessment as a separate process from the intervention.

Due to the rapid developmental changes of early childhood, assessment and intervention actually occur in a bi-directional fashion. This means that information from the assessment informs the intervention, and vice versa. Even more important, however, is that the relationship with the family, which is the foundation of the intervention, begins with the assessment process. In this way, the assessment is linked to intervention through the relationship with the parents (Kalmanson & Seligman, 1992; Weston & Ivins, 2001). So even though assessment-treatment is an ongoing process, the working relationship with each family begins with the very first contact. The observation of the infant with his or her most trusted caregiver forms the foundation of the assessment process and sets the framework of collaboration and trust with the child's family.

I have learned more about the parent-child bond from parents themselves than from any formal training. Parents have many stories to tell of their assessment-intervention journeys and how professionals have both added to and lessened the stress of the intervention process. Many of the parents that I have spoken with over the years report times of great distress when their children's weaknesses were objectified in reports or meetings, and they felt as if the assessment and intervention process left the "whole" child behind. As Jennifer, a mother of a child with special needs states regarding assessments, "They have the power to damage a parent-child relationship by pointing out all of the child's deficits" (Cooper, 2003, p. 3).

With the relationship as the backdrop for the assessment process, major qualitative differences exist in the overall context of the assessment-intervention continuum. Considering these differences, making a shift in thinking about assessment with families of young children became easier after integrating the change in context and settings from adult models to infant models. In working with adults, major clues about emotional functioning were obtained through the observation of how the adult appeared emotionally (affective presentation), presented on standardized tests, and interacted with me (the therapist) in a quiet office setting.

In contrast, in early childhood, the way the child interacts *with the primary caregivers* forms the cornerstone of the assessment

(Meisels & Fenichel, 1996). This interaction with the most trusted caregiver reveals the child's highest level of adaptive functioning. (Exceptions to this would be caregivers with maladaptive patterns such as abuse, neglect, or other forms of parent-child derivations. See Chapters Nine and Eleven.)

Learning to expand notions about assessment context is an important aspect of retraining. Whereas with adults the typical setting is an office or clinic, initial observations of infants and young children often include the home, day-care center, preschool, or other naturalistic settings. Prior to my work with infants, I had rarely, if ever, conducted an interview or collected a history from an adult patient at a home or workplace. In contrast, working in different settings in the retraining process necessitated flexible adaptation. It required becoming aware of and "reading" the environment in order to cause the least amount of changes in the observation.

Reading the environment also involved learning how to respect the setting by not being intrusive, as well as handling ethical and legal issues such as confidentiality (for example, what to do if a staff person who is not on the release of information asks what I am doing there or asks which child is being observed). Such circumstances are not typical of work in office-clinic settings, nor were they a part of the traditional adult-child training that I received in graduate school. Becoming comfortable with blending in to these various settings was an important part of the retraining process.

Diagnostic Procedures in the Assessment Process

Classically trained mental health professionals are taught to be diagnostically driven, as diagnoses are seen as a road map to the choice of treatment modalities, with good reason. (For example, excellent treatment protocols exist for the treatment of depression and anxiety in adults.) A commonality between infant and adult mental health models is the practical necessity of diagnostic labels in order to obtain services.

Because the assessment of infants should involve an integrated developmental model, traditional diagnostic tools may not provide the infant-toddler-preschool specialist with the same armamentarium as they do with adults. In addition, it necessitates a shift in thinking from a diagnostic and categorical model (DSM-based, diagnostically driven mental health model) to a developmental model.

Fortunately, a diagnostic manual was created for this special population, which categorizes symptomatology for the birth-to-three population and is a useful tool for clinicians as an alternative to the DSM IV manual. The *Diagnostic Classification (DC): 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (1994) system organizes infant-toddler behavior patterns and provides a triage system, with the consideration that similar behaviors observed in an infant can have multiple etiologies (for example, what looks like a mood disorder may actually be an infant reacting to trauma).

Comparing and contrasting the developmental diagnoses in the DC 0–3 handbook and the DSM IV was a useful part of retraining, as the DC: 0–3 handbook is more theoretically linked to infant mental health principles. It includes a wider range of behavioral patterns observed in the early years and provides an in-depth classification system tailored to this age range. The DC: 0–3 handbook also provides a road map to target and track functional capacities in the assessment-intervention process. Most third-party agencies, including insurance companies, however, do not recognize the diagnostic codes of the DC: 0–3 handbook. This is a practical reason why becoming knowledgeable about the differences between the DC: 0–3 and the DSM IV is useful in the retraining process.

INTERVENTION ISSUES: LAYERS OF RELATIONSHIPS

Relationships are at the heart of the work with infants, toddlers, and their families. Protecting and nurturing the caregiver's relationship with his or her baby forms the backdrop for all interventions. As Rebecca Shahmoon-Shanok (2000) aptly states, "The action is in the interaction" (p. 368). Although each family is unique and will have varying responses to the prospect of early intervention, the knowledge that the information the clinician provides to the family can profoundly influence the growing relationship between parent-caregiver and child is a certainty. This may be one of the greatest responsibilities of the clinician who works with this population: to preserve the magical bond between parents-caregivers and child while exploring potential developmental derivation.

This places a large responsibility on the clinician to have an awareness of his or her personal impact on dyads and families. In my own

clinical development, exploring this process through continuing education, personal reflection, and supervision has provided the opportunity to learn from each new family how to better support and protect the growing relationship between parent and child.

Providing information to parents about their children's social-emotional development can have a range of impact, depending on the caregiver's constitutional and emotional capacities. For parents (especially those with predisposing psychiatric conditions), the idea that their young child may be exhibiting developmental derivation can activate and increase levels of anxiety, depression, or other disorders. Under these circumstances, each intervention must be carefully constructed, so as to support and contain the stress inherent in the intervention process.

I found that the mental health training prior to specialization was extremely helpful in structuring strategies to diagnose, support, contain, and otherwise personalize interventions for those parents or caregivers who exhibit psychiatric symptoms. Understanding the repercussions of the parent-caregiver's emotional reactions to the relationship with the infant has been a natural outgrowth of my development as a psychologist. Helping parents to explore their feelings and reactions to their children in an atmosphere of trust and safety has become an important part of my clinical work. If necessary, referrals for more intensive personal support (such as psychotherapy, psychiatry, or respite services) can help parents who experience more severe emotional activation.

SUPERVISION ISSUES

Along this journey, reflective supervision has been a useful component in integrating the complexities of early development. My supervisors have provided a listening ear, empathic reflection, reassurance when I doubted myself, and a place where I could stretch my ways of thinking about young children's behaviors. Supervision is an ongoing necessity as well as an opportunity to network with colleagues who share similar caseloads. I have found unique benefits from both individual and group supervision. The former provides more opportunity for personal reflective exploration, whereas the latter provides additional exposure to more cases and multiple points of view.

Providing supervision to clinicians in the process of retraining has also enhanced my understanding of the differences between infant-toddler work and work with older populations and has illustrated the

diversity of training experiences available to clinicians. Fortunately, many fine articles have been written about the provision and characteristics of reflective supervision, perhaps none as memorable as the article containing Pawl's "Platinum Rule of Supervision": "Do unto others as you would have others do unto others" (Pawl, 1994, p. 21). Pawl succinctly describes the multiple parallel processes involved in supervision, all of which can be distilled into a single concept: *relationships.* This was a helpful road map for retraining and was powerfully necessary for the development of trust between me, the families with whom I consult, and the clinicians whom I now supervise.

I have found that supervisees who were trained to work with older children and adults often have useful ideas about behavioral change and how to help parents manage children's behaviors. Although this can be a beneficial paradigm, it does not always fit with younger populations because behavior problems with infants and toddlers cannot always be resolved by focusing on behavior management in isolation. Such a model can be quite successful with older children with behavioral problems. However, the focus with infants, toddlers, and preschoolers should be on viewing the various contributions to current concerns, including issues of parent-child fit, constitutional issues (both parent and child), and parent-caregiver interpretations of behavior.

Another benefit of reflective supervision is to process over time that the agent of change is the parent-caregiver, not the therapist, as in traditional adult models. Reflective supervision allows for the understanding that caregivers need to see their own strengths, not witness the therapist "expertly" handling their baby and potentially making comparisons. Providing reflective supervision has given me the opportunity to help clinicians understand and experience the process of being understood and tolerate the absence of a speedy diagnosis while focusing reflectively on this qualitative shift. In this way, supervision focuses on the relational components between the supervisor, therapist, and parent and puts into context the relational foundation that bears the underpinnings of the reciprocal dance between parent and child.

LESSONS LEARNED FROM THE FIELD

These are a few of the meaningful lessons I've learned along the way:

- *Infant mental health is an emerging and changing field.* When I embarked on this training journey, I was under the impression that

tried-and-true infant mental health models existed to guide clinicians on their journey of retraining. I discovered that this was a simplification. In practice, much of what I do from day to day is intuitive and is informed by all of the training that I have received over time. The contributions of neurobiology, attachment, educational paradigms, and behavioral and relational approaches all capture pieces of the complexity of the human relationship in all its variations.

As research and interest increase, the field of infant, toddler, and preschool mental health is growing and shifting year by year. I found it essential to find and experience a "goodness of fit" between my own therapeutic style and the valuable information I learned from my training. Finding and experiencing this fit has taken many years of exposure and practice. I believe that in the future, training models for infant mental health will increasingly embrace this complexity and through continued research will connect the pieces of the puzzle more comprehensively. This will make it easier to train as an infant, toddler, and preschool specialist.

• *Training is an ongoing process.* After a decade of working in this field, I have come to realize that training is a lifelong, ongoing process. Due to the miraculous complexity and uniqueness of each child, we need to be willing to learn new things and discover new parts of ourselves with each new baby and family we see. Because no two infants are alike, and parents are the only real experts about their own children, our ability to have a positive impact as clinicians hinges on flexibility and an open mind for learning with each new family we see.

• *Infant, toddler, and preschool mental health practice is a collaborative effort.* Whether in its most basic form with an infant and caregiver or in the numerous settings in which infant-toddler-preschool specialists practice, the field involves collaboration and interdisciplinary communication. Whether one is collaborating with a colleague, parent, caregiver, teacher, administrator, or caseworker, an openness and willingness to collaborate is a necessity.

PERSONALIZING INFANT MENTAL HEALTH SPECIALIZATION: PLANNING A TRAINING COURSE

Currently, many fine training programs are developing across the country. However, whether one chooses to take a dedicated infant-toddler training program or to set up an individualized training

program, it is important to tailor the program to one's own circumstances. Clinicians can choose from the various frameworks in the field that fit with their goals and the myriad occupational settings in the early intervention field. Training models that include interdisciplinary concepts, exposure to constitutional as well as environmental influences, and a focus on building relationships will enable the specialist to adapt infant-toddler-preschool concepts to a variety of early childhood settings.

In the end, one of the greatest rewards in infant, toddler, and preschool mental health is being a witness to the strength and resiliency of the parent-child bond. Recently, a mother of an autistic child was sitting in my office. She looked with such pride at her daughter playing across the room and said with a smile, "I can't believe how lucky we are." Such are the rewards of this profession.

References

Bayley, N. (1993). *Bayley Scales of Infant Development—Second Edition (BSID-II).* San Antonio: Psychological Corporation.

Bernstein, V. J., Harns, S. L., & Percansky, C. (1991). Advocating for the young child in need through strengthening the parent-child relationship. *Journal of Clinical Child Psychology, 20,* 28–41.

Cooper, J. (2003, Summer-Fall). Parent's perspectives of assessment. *IDA News, 30*(2), 3–8.

Diagnostic classification: 0–3. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (1994). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Emde, R., & Robinson, J. (2000). Guiding principles for a theory of early intervention. In J. Shonkoff & S. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 160–178). New York: Cambridge University Press.

Greenspan, S. I. (1997). *The growth of the mind.* Reading, MA: Perseus Books.

Greenspan, S. I., DeGangi, G. A., & Wieder, S. (2001). *The Functional Emotional Assessment Scale (FEAS) for infancy and early childhood: Clinical & research applications.* Bethesda, MD: Interdisciplinary Council on Developmental and Learning Disorders.

Greenspan, S. I., & Meisels, S. (1996). Toward a new vision for the developmental assessment of infants and young children. In S. Meisels &

E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 11–26). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Greenspan, S. I., & Wieder, S. (2000). Developmentally appropriate interactions and practices. In Interdisciplinary Council on Developmental and Learning Disorders (Eds.), *Clinical practice guidelines.* Bethesda, MD: Author.

Interdisciplinary Council on Developmental and Learning Disorders. (2000). *Clinical practice guidelines.* Bethesda, MD: Author.

Kalmanson, B., & Seligman, S. (1992). Family–provider relationships: The basis of all interventions. *Infants and Young Children, 4*(4), 46–52.

Meisels, S., & Fenichel, E. (1996). *New visions for the developmental assessment of infants and young children.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Pawl, J. H. (1994). On supervision. *Zero to Three, 15*(3), 21–29.

Sameroff, A., & Fiese, B. (2000). Transactional regulation: The developmental ecology of early intervention. In J. Shonkoff & S. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 135–159). New York: Cambridge University Press.

Shahmoon-Shanok, R. (2000). The action is in the interaction: Clinical practice guidelines with parents of children with developmental disorders. In Interdisciplinary Council on Developmental and Learning Disorders (Eds.), *Clinical practice guidelines* (pp. 333–370). Bethesda, MD: Interdisciplinary Council on Developmental and Learning Disorders.

Weston, D. R., & Ivins, B. (2001). From testing to talking: Linking assessment and intervention through relationships with parents. *Zero to Three, 21*(4), 47–50.

PART TWO

Specialty Areas of Practice

CHAPTER NINE

Developing Reunification and Adoption Recommendations for Substance-Exposed Infants and Toddlers in Foster Care

Valata Jenkins-Monroe, Ph.D.

As the number of women abusing drugs and becoming pregnant increases, there are growing numbers of children with mothers unavailable to care for them. Since crack cocaine hit the streets of socioeconomically depressed communities in the early 1980s, an estimated one million children have been born exposed to cocaine in utero (U.S. General Accounting Office, 1990; McCalla, Minkoff, Feldman, Glass, & Valencia, 1992).

Not surprisingly, mothers who are addicted and in need of treatment encounter multiple challenges in caring for their young children. Their addiction demands greatly influence the basic preparation, planning, and decision-making skills required to care for children. These mothers are generally distracted by their own compelling realities of economic dependence, psychological deprivations, and unfilled needs.

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The pull of satisfying the mother's physiological and psychological dependency on drugs is interfaced with the pull and demands of the basic dependency needs of a young child.

According to a Drug and Alcohol Services Information System Report (DASIS) (Substance Abuse and Mental Heath Services Administration [SAMSHA], 2001), some 439,000 admissions were registered from substance-abusing women into publicly funded programs in 1998. The report further pointed out that the women in treatment were outnumbered by men (a ratio of ten to twenty-three) and represented only 30 percent of the admissions into treatment programs. A more recent DASIS report indicated that more than 400,000 women of childbearing age (from fifteen to forty-four) were in publicly funded programs. Of these, approximately 16,000 (4 percent) were pregnant, with close to 84 percent of the pregnant women under the age of thirty-five (SAMSHA, 2002). Although some reports indicate that women are less likely than men to abuse drugs and alcohol (SAMHSA, 2000), it has been documented that other precipitating factors (for example, child care and accessibility) may prevent women from entering and completing a treatment program.

Finkelstein (1994) presents four factors that may prevent substance-abusing women from seeking drug treatment and prenatal care. First, substance use among women remains a moral issue, which makes them susceptible to societal judgment. It is not uncommon for substance-abusing women to be labeled as sexually promiscuous, negligent of their children, and irresponsible in their decision to bear children.

Second, pregnant substance-abusing women are often in denial about how their drug use affects their babies (Mondanano, 1977). This denial is often reinforced by the woman's support group (consisting of other substance-abusing women), who may be in opposition to her going outside the group for professional treatment.

The third factor is that treatment may not be accessible or welcoming to women, because substance abuse programs have been traditionally designed for, and by, men. When programs are not cognizant of the multiple responsibilities of women, such as child care or being a single parent, the programs become underutilized.

Last, and perhaps the most significant factor for mothers, is the fear that they will lose custody of their children or that their children will be placed in foster care. A component of this factor is also the possibility of facing criminal charges. Socioeconomic status influences the threat of women losing custody of their children. Unfortunately,

low-income mothers are more likely to utilize public or subsidized programs, bringing them more to the attention of social service agencies (for example, public housing, clinics, public health) than women with additional resources. They face stereotypes, prejudice, and discrimination that place them at risk for hot-line referrals to police and child welfare agencies.

The majority of substance-abusing women state that difficult life events were precipitating factors for drug use (Ettorre, 1992). Many substance-abusing women were themselves victims of child abuse and neglect (Bollerud, 1990). A study by Rohsenow, Corbett, and Devine (1988) indicated that 77 percent of female substance abusers reported having been molested as children. Davis (1990) also noted that many chemically dependent women were raised in emotionally deprived and neglectful families and often became victims of society as adults (for example, were sexually assaulted). They used drugs in an effort to reduce stress and suppress their agonized feelings (Ettorre, 1992).

For some mothers, the cycle of addiction has alienated family members and drained the resources that may have been previously available to them. For example, family members may already be caring for one of the mother's older children or may have lost contact with the mother or may have chosen to distance themselves from her. For other mothers who are addicted, the escape to drugs may have been related to traumatizing events and personal experiences in their own families that make the notion of seeking assistance from family a nonnegotiable option. The result is that we have witnessed a rapid increase in the number of infants, toddlers, and preschool children of drug-addicted women in foster care during the past decade (Everett, 1995; Dubowitz, Feigelman, & Swayer, 1994; Berrick, Barth, & Needell, 1994).

IMPLICATIONS FOR CHILD WELFARE AGENCIES

Due to the drug abuse epidemic, infants and young children are the fastest-growing segment of the foster care population. Of special note, African American children stay longer in foster care than any other racial or ethnic group. The implications of the drug addiction epidemic crisis, and the particular impact it has for mothers and children, raise questions as to how traditional human service systems can best intervene.

Saddled with an overriding responsibility to protect children and overburdened by diminishing allocations, traditional foster care systems are mandated to reunite families whenever possible. Ultimately, a permanent home must be found for young children. Gone are the years when infants were allowed to grow up in foster home after foster home before eventually being abandoned by their birth families or while waiting for parents to meet requirements for reunification.

On the one hand, what remains are fewer and fewer resources available for families and a shorter time frame to stabilize a lifetime of economic inadequacies, longtime addiction, or life-threatening conditions. On the other hand, what is also left is the potential that infants will have the opportunity either to be raised in a permanent home with parents who have met the odds of successful reunification and have prioritized the infant's needs or to secure permanent homes with other caregivers.

ISSUES IN THE EVALUATION OF INFANTS AND TODDLERS IN FOSTER CARE

Evaluating the permanent needs and best interest of the infant has routinely taken the approach of traditional assessments. Although such assessments have been useful in creating developmental profiles, they have been limited in providing detailed experiences and explicit information on the social and cultural needs of the infant in foster care. In addition, an understanding of the court proceedings and vital time lines for this population is often absent from assessments. This limits their practical use and may result in the reports having only minimal utility in influencing permanent decisions made by the courts.

The vast majority of young children who are in foster care are African American, and they stay longer in foster care than any other racial or ethnic group. This raises particular issues regarding the development of culturally informed assessment practices and training (for example, American Psychological Association Office of Ethnic Minority Affairs, 1993). The most acknowledged sources of bias have been intelligence tests that reflect cultural and ethnic group differences and personality tests that reflect differences in worldview (for example, Arvery, Strickland, Drauden, & Martin, 1990).

A testing environment that primarily relies on tests and procedures that are not a reflection of a young child's cultural and ethnic group continues to perpetuate the notion of assessment bias at one end of

the spectrum and racism at the other. It is essential that the clinician remain objective and neutral in order to achieve balance in an assessment report.

Evaluations must not only present a realistic picture of functioning but also fully capture the strength and potential of family members. The clinician evaluating young children in foster care therefore must be able to integrate knowledge of (1) the parent's substance abuse, (2) legislation and primary terminology of foster care agencies, (3) normal developmental tasks of early childhood, (4) effects of prenatal substance exposure on development, (5) impact of age, number, and quality of placements, and (6) specific issues for African American children affected by the disparity of discrimination and economics and by political and other environmental conditions. All of these factors become training and practice challenges for mental health practitioners working in this arena.

TERMINOLOGY AND DEFINITIONS

Dependency proceedings occur when minors are taken into the custody of the juvenile court. According to federal Child Welfare and Institutions Code, section 300 et seq. (2003), minors come within the jurisdiction of the juvenile court under five conditions, described under subdivisions of the law. Three of the five subdivisions (a, b, and d) pertain to mothers with drug addiction or medical conditions that contribute to their inability to provide basic and appropriate care for their infants. This may include an inability to provide such essentials as food and shelter for the infant but also includes living environments where the infant is unsafe, neglected, or abused.

Adoptions and Safe Families Act

The federal Adoptions and Safe Families Act of 1997 (ASFA) (Children's Defense Fund, 1997) was created in response to growing dissatisfaction with the record of state child welfare systems in achieving the goals of safety, permanency, and well-being for children in foster care. ASFA clarifies that the health and safety of children must be of paramount concern to child welfare agencies. As a result, the goals of ASFA are to (1) promote the safety of children first and foremost, (2) decrease the time it takes to achieve permanency for children, (3) promote adoption and other permanency options, and (4) enhance state capacity and accountability for both safety and permanency.

Carefully woven into the law is the enactment of a legal framework requiring shorter time frames for permanency decisions. Concurrent permanency planning is the method of working toward reunification while at the same time establishing a contingency plan for unsuccessful reunifications.

Permanency Planning

Today child welfare agencies are unyielding in their mission that foster care is not a legally permanent relationship and that a plan is needed to ensure that children have permanent homes and families (Katz, 1990). The ultimate goal continues to be family reunification or if that is not possible, placement with the extended family. Extended family may include relatives by kin or affinity. Affinity is defined as a relationship by marriage (even if the marriage was terminated by death or dissolution) within the fifth degree of kinship, including stepparents, stepsiblings, and stepgrandparents and their spouses (Child Welfare and Institutions Code, 2003).

Concurrent Planning

Concurrent planning is the process of immediate, simultaneous, and continuous assessment of the options to achieve early, family-based permanency for every child removed from his or her family (Child Welfare and Institutions Code, 2003). Viewed as a collaboration between the court, agency, and family, concurrent planning includes the probability of reunification, availability of extended family resources, and identification of a family who will commit to legal permanency for the child. The desired outcome is to minimize placements and social worker changes and provide permanency for the child as soon as possible.

Regrettably, agencies are all too familiar with the history of children growing up without a permanent home. Concurrent planning provides a concrete alternative plan for legal permanency of the child should reunification with the family fail.

Reunification Time Limits

Although family reunification is the preferred goal of the court and child welfare agencies, new legislative changes have outlined time limits on reunification. Parents with a child under the age of three are

provided court-ordered services, not exceeding a period of six months. Parents with a child over the age of three are provided with court-ordered services not exceeding a period of twelve months. However, services may be extended up to a maximum period of eighteen months if it can be shown that the objectives of the service plan can be met within the extended time period.

No Reunification Services

Consistent with ASFA, there are several scenarios when the court finds clear and convincing evidence that reunification is not in the best interest of the child and no reunification services are provided to a parent or guardian. These special conditions are referred to as *aggravated circumstances* and include situations in which a child's health or safety may be in jeopardy. California also includes circumstances where the parent has had a history of extensive, abusive, and chronic use of drugs or alcohol and has failed or refused to comply with a program of drug or alcohol treatment described in the case plan on at least two prior occasions (U.S. General Accounting Office, 1997).

Termination of Parents' Rights

Termination of Parental Rights proceedings must be initiated for children who have been in foster care for fifteen of the most recent twenty-two months. Additional situations that trigger termination of parental rights include but are not limited to children who have been abandoned as infants and parents who have murdered another of their children.

Permanency Review Hearings

The juvenile court reviews every dependent child no less frequently than once every six months following disposition. *In-home dependents* refer to children who remain in the care of a parent at disposition. *Out-of-home dependents* refer to children who are removed from the custody of their parents at disposition.

The six-month review hearing is scheduled six months from disposition, unless the child was under the age of three at the time of removal. For children who were under the age of three at the time of removal, the six-month review hearing is set six months from the date the child entered foster care. This is the earlier of two dates: either

the date the court took jurisdiction over the child or the date the child was removed from the custodial parent.

The twelve-month review hearing in all cases is set no later than twelve months from the date the child entered foster care. The eighteen-month review hearing occurs within eighteen months from detention in all cases (Child Welfare and Institutions Code, 2003).

Relative Placement

Relative placements are preferred when a child's safety is at risk if the child continues to live with the parents. The Child Welfare and Institutions Code (2003) identifies a relative as an adult who is related to the child by blood, adoption, or affinity. Preferential treatment for placement of the child is given to an adult who is a grandparent, aunt, uncle, or sibling.

Kinship Adoption

The Kinship Adoption Agreement allows parents and relative caregivers the opportunity to formalize by written but *voluntary* agreement continued contact between parents and child postadoption. The agreement includes but is not limited to visitation and future contact between the child's birth parents and relatives, adoptive parents, and siblings. The agreement also includes the sharing of information about the child.

Legal Guardianship

A legal guardian is a person whom the court appoints for the child and may be either a relative or a nonrelative. The guardian assumes all the rights and responsibilities that any parent has in taking care of a child. The rights of the parent are not terminated but are on hold during the time that guardianship is in place. In most situations, court dependency will be dismissed, and parents usually have certain visitation rights with the child.

Long-Term Foster Care

Long-term placement (LTP) is the final phase of placement services available for families and is one of three permanency placement options for children in foster care. LTP is the least-preferred

permanency plan option in comparison with reunification, legal guardianship, or adoption.

Multiethnic Placement Act

The Multiethnic Placement Act (MEPA) of 1994 prohibits the delay or denial of a foster or adoptive placement based on the race, color, or national origin of the adoptive or foster parents or child involved. The intent of the act was to help children become a part of a stable family when a same-race family is not available.

There are several professional associations, advocates, and families who firmly believe that racial and ethnic heritage are important and related to the best interest of the child. Even though they believe that efforts should be made to ensure that adoptive parents are of the same race as the child, they also agree that placement with parents of a different race is preferable when the alternative means that a child will be deprived of a permanent family (Hollingsworth, 1998).

Although the goals of the ASFA were intended to ultimately stabilize families, there has been less discussion of possible cultural and family values that may be in conflict or inconsistent with the law. For example, traditionally, African American families have utilized informal adoption instead of formal adoption. Legal guardianship may be more preferable for kin-related families who believe they are permanent families and do not require legal validation. Sometimes the conflict and tension that is created between the biological parent and the family member may not ultimately provide the safety and security that is hoped for the child.

In addition, there is a concern that with pressure and incentives to increase the number of adoptions, states may seek more cross-racial and cross-cultural adoptions. For example, the Institute for Black Parenting, an agency focused on recruitment of African American families for African American children, was denied expansion of services due to California's interpretation of the MEPA (McRoy, Oglesby, & Grape, 1997). Questions continue to be raised about whether or not there is less attention given to recruitment for foster and adoptive parents that are of the same race as the child in foster care.

Families and advocates of the community rally around the need for all children to have "forever families." However, some conflict and tension remains around the Multiethnic Placement Act and the preferable plan for adoption rather than legal guardianship with blood relatives for ethnic minority children.

CRITICAL CHILD ISSUES IN EVALUATIONS

Behavioral health providers who work with parents receiving mental health and substance abuse services are often asked to assess several areas as part of the concurrent permanency plan for a child. Four essential areas for evaluation are these: (1) When is it safe for a child to live with a parent who is receiving substance abuse treatment services? (2) What outcomes are expected for a child to be able to remain with or return to parents? (3) What parental behaviors are anticipated and what is the most appropriate way to respond? and (4) What supports are needed to prevent and to deal with crises? These questions are useful in providing discussions related to the readiness of a parent; however, what are generally absent are questions and discussions that integrate the child's developmental needs, physiological and socioemotional growth, and ultimate readiness for reunification or adoption.

There are three age periods that parallel significant growth areas for children in foster care: (1) prenatal to birth, (2) birth to eighteen months, and (3) eighteen months to thirty-six months. Although there are several critical areas of growth within each stage, this chapter will limit discussion to two of them: physiological growth and social-emotional development of children under the age of three. These two areas are selected to illustrate important issues that are essential to evaluation and formulation of appropriate recommendations for reunification and adoption, particularly for young children of substance-abusing women.

Physiological Growth and Drug Exposure

It has been difficult for researchers to isolate the effects of specific drugs on the development of infants because poly-drug use and environmental factors play a significant role in outcomes. However, four specific drugs have been shown to have specific effects on prenatal development. An understanding of the impact of prenatal exposure to cocaine, alcohol, marijuana, and opiates on physiological growth and socioemotional development is crucial to the evaluation process.

COCAINE EFFECTS. Prenatal exposure to cocaine has been one of the most widely researched areas. The findings have indicated consequences ranging from mild or subtle changes to substantial and negative changes (Singer et al., 2002; Chasnoff, Griffith, Freier, & Murray, 1992). However, most researchers agree that the main physical consequences of cocaine

prenatal drug exposure are low birth weight, premature birth, and a smaller head circumference (Daley et al., 2001; Kaltenbach & Finnegan, 1992).

Prenatal exposure to cocaine has been associated with substantial reductions in intrauterine growth and a variety of neurobehavioral and circulatory complications (Bateman, Phibbs, & Schwartz, 1991). Cocaine is also thought to increase the mother's blood pressure, respiration, and heart rate while decreasing her appetite, which produces contractions of the uterus (Gustavsson, 1992). There is also an increased risk of premature separation of the placenta caused by restriction of blood flow (Doering, Davidson, LaFauce, & Williams, 1989; Chasnoff, Burns, Schnoll, & Burns, 1984).

In addition, cocaine-exposed infants have been found to be less socially interactive than unexposed infants or infants exposed to other drugs (Chasnoff, Burns, Schnoll, & Burns, 1986). As these infants grow, they have been found to have limited ability to initiate creative play, interact with other children, or play by themselves (Howard, 1989).

Struthers and Hansen (1992) compared babies with prenatal exposure to cocaine and amphetamines with non-drug-exposed babies using the Fagan Test of Infant Intelligence. They found that the infants in the drug-exposed group scored significantly lower on visual recognition memory and were at a higher risk for cognitive deficits in the future.

Chasnoff et al. (1998), however, found no direct effect of cocaine exposure on children's cognitive ability. Instead Chasnoff and his colleagues found that exposure to cocaine and other drugs appeared to affect the child's behavioral characteristics at the ages of four and six.

ALCOHOL EFFECTS. Fetal alcohol syndrome (FAS) is one of the most serious results of prenatal exposure to alcohol. Infants with FAS suffer from growth deficiency and central nervous system impairment. Reported characteristics of the syndrome include mild mental retardation, pre- and postnatal growth deficiency, craniofacial anomalies, joint anomalies, and heart murmurs. Impairments also include developmental delays, memory impairment, learning problems, and hyperactivity (Gustavsson, 1992).

Fetal alcohol effect (FAE) is related to lower levels of prenatal exposure to alcohol; however, infants still suffer from the same brain abnormalities associated with FAS. Infants suffering from FAE do not have the distinctive facial characteristics of FAS infants (Hanson, Streissguth, & Smith, 1978).

MARIJUANA EFFECTS. Low birth rate, decreased fetal growth, and decreased body fat mass have been associated with marijuana use during pregnancy (Frank et al., 1990). Other indicators may include increased tremors, decreased responsiveness during sleep, a higher-pitched cry, and altered visual responsiveness (Fried & Makin, 1987).

OPIATE EFFECTS. Increased incidences of sudden infant death syndrome (SIDS), neonatal abstinence syndrome (NAS), premature birth, small head circumference, and low birth weight have all been associated with opioid use during pregnancy. NAS is characterized by central nervous system symptoms such as irritability, jitteriness, seizures, hyperactivity, exaggerated reflexes, high-pitched crying tremors, sweating, and restless sleep (Chasnoff, Burns, & Burns, 1987). Additional gastrointestinal symptoms such as vomiting, extreme appetite changes, diarrhea, and inability to coordinate swallowing are common and may appear within seventy-two hours to three weeks after birth.

IMPLICATIONS FOR ASSESSMENT. In conducting the assessment, the clinician must evaluate the parent's level of responsibility versus the level of denial regarding the consequences of substance abuse and the challenges and limitations this presents to the infant's developmental needs. An essential component of the assessment is a discussion of the primary caretaker's understanding of possible alternate sequences of development for infants with fetal drug exposure. Both reunification and adoption recommendations should speak to the fit between current and anticipated developmental needs of the infant, along with the potential of the caregiver to meet these needs.

Social-Emotional Growth

For children under the age of three, suppressed socialization skills affect social-emotional development. Much of the young child's emotional growth is related to interactions with and stimulation of their environment. During the period between birth and eighteen months, often characterized by Erikson's first stage of basic trust (Erikson, 1963), infants are exclusively dependent on their caretakers to help their emotional needs develop and be met (Schaefer & DiGeronimo, 2000). Although mothers may expect infants to express love and affection during the first six months of life, infants are learning which

adults in their lives will be dependable and available to fulfill their emotional needs during this period.

From six to twelve months, babies develop affectional attachment to their primary caregivers and respond with what now can be interpreted by the caregiver as love. By eight to nine months, this attachment is characterized by strong interdependence and vital emotional ties. The bond is being developed gradually, based on months of consistent and immediate response to the baby's cries of distress, loving touch, and play.

The period between eighteen and thirty-six months parallels Erikson's well-known stage of autonomy. This growth period is defined by the child's opportunity to make choices and to move away from the primary caretaker for brief periods, with the expectation that the relationship will endure. Toddlers want to explore their environments and do things for themselves, but they do not always have the physical and cognitive competence needed to accomplish tasks (Schaefer & DiGeronimo, 2000).

Alternatively referred to as the "terrible twos" and the "terrific twos," the push and pull between wanting to be with the parent and wanting to be away from the parent may not make it easy for all parents to give unconditional love and affection. This period of development for the child requires a parent's sense of confidence in order to provide a consistent sense of love and security for the child. Parents dealing with addiction problems and histories of troubled relationships may have difficulty meeting these needs of the child.

A parent in early recovery may initially lack confidence in handling the pseudo-independent level of a toddler. It should not be a surprise that the time line of the recovery process and the limited time of the reunification process with their children are often in conflict. What is critical for the clinician conducting an assessment is a focus on both the resources that the parent has tapped into and the parent's acknowledgment of the resources and support they will continue to need.

RELATIONSHIP BETWEEN CONCURRENCY PLANNING AND CRITICAL STAGES OF INFANT-TODDLER DEVELOPMENT

During concurrency permanency planning, the first six months are critical in determining whether or not parents are engaged in reunification requirements. Assessment of the infant's sense of trust and

level of attachment at this stage is often accomplished through observations of the child and parent for a specific number of hours during the week. The parent's consistency in visiting the infant and actively interacting with the infant during visits are considered; however, the infant's experience of the parent's availability during the infant's expression of distress is critical to the evaluation.

The infant in foster care may experience distress for a number of reasons, including an unfamiliar environment, different caretakers, and changes in daily routine. Distress may be expressed by crying, as a way of communicating that they are upset with these changes. However, for some infants, the distress may not be so obvious and may be expressed through withdrawal or not outwardly responding. These infants may not fuss when they are hungry or express irritability when soiled but instead may wait for the parent to anticipate and respond to their needs.

The baby's temperament also contributes to a mother's self-confidence in parenting. Distress may be reflected in the particular temperament style of the infant. Prenatal drug exposure may also affect behavior in young children, as described previously. For example, babies exposed to cocaine are often stiff, are difficult to cuddle, and cry frequently (Kelly, 1992). A mother with a child in foster care may view the infant's behavior as a personal rejection or a reflection of her own inability to be a good parent and form healthy attachments with her child. Partially in response to this sense of rejection, a cycle of inconsistent visits and no-shows may be observed.

The parent who is actively being considered for reunification has to develop and demonstrate a consistent pattern of responding to and anticipating the infant's needs. This same pattern is necessary as we consider the basic necessities and tasks of young children as they develop autonomy. The independence and dependence phase during the toddler period is capable of challenging even the most stable parent. For parents struggling to overcome their addictions, who are just learning how to trust themselves, learning how to respond more favorably to toddler behavior may create an even greater challenge.

The very nature of this *need-reject syndrome* is caused by a struggle inside the child, rather than a struggle against the parent (Schaefer & DiGeronimo, 2000). What is most interesting is that this need-reject syndrome may be paralleling the same struggle to which the parent was exposed in his or her family of origin and is the basis of the parent's caregiving style.

OTHER INFLUENCING FACTORS

The concerns for length, number, and quality of placements for young children in foster care were catalysts for the Adoptions and Safe Families Act of 1997. Studies have found that those children with shorter lengths of stay had more frequent visits with their biological parents (Milner, 1987; Pardeck, 1984). Contact with biological parents may begin to break the cycle of abandonment and reduce the self-fulfilling prophecy of being or becoming a bad parent.

It is important to include measurement of length of stay and amount of contact with the biological parents in the assessment. In addition, other essential requirements for developing reunification and adoption recommendations include a discussion of competing environmental and cultural factors.

Placement Disruption

A review of child welfare records in California indicated that of children in non-kin foster care, 34 percent of infants, 48 percent of toddlers, and 49 percent of three- to five-year-olds had been in placement for two years (Berrick, Needell, Barth, & Jonson-Reid, 1998). Among that population, 20 percent of the infants, 24 percent of the toddlers, and 21 percent of the three- to five-year-olds were in three or more placements after two years. With each move, children may experience a sense of rejection and impermanence, which affects their ability to stabilize emotional ties (Webster, Barth, & Needell, 2000).

Related to placement disruptions is the question of whether the significant numbers of children with prenatal exposure to drugs are increasing the number of health problems in young children who are labeled as *medically fragile.* A health status review of children in foster care conducted by Dubowitz et al. (1994) indicated a high number of medical challenges in children in foster care. Specifically, Dubowitz et al. found poor growth, visual and hearing deficits, developmental disabilities, learning difficulties, and mental health issues.

Medically fragile children and drug-exposed children are thought to be difficult to care for, leading to multiple placements (Berrick et al., 1998). Potentially, these multiple placements ignite a cycle of false alarms of permanence, leading to a child in a constant state of adjusting. On a more hopeful note, Berrick and his coworkers also found that children in kinship foster care had more placement stability than those with nonrelatives. The implications of multiple and frequent

placements for young children is the challenge of developing trust and bonding with any caretaker, further alienating the parent who is attempting to reunify.

Attachment and Age at Removal

The age of removal from the home is considered critical in the outcome of the child's emotional development. There are at least two schools of thought related to the *attachment window* of opportunity and the child's resiliency and rebonding potential. It is speculated that separation during the first six months, followed by consistent, loving, and appropriate care, may not be as disturbing to a child's development. Conversely, separation between the ages of six months and three years, due to significant family disruption, may lead to noteworthy impairment, including stranger anxiety, insecure attachments, and deficits in language development.

In part, the earlier time limits for reunification have been guided by the debate around attachment-bonding. The impact of separating a child from his or her mother can be detrimental to the young child's emotional, social, and physical development. According to Zeanah, Boris, and Lieberman (2000), attachment is the aspect of social-emotional development most affected by the child welfare system in the first year of life.

A crucial and potentially conflicting component of the attachment-bonding debate relates to the new environment that the infant will enter. According to Bowlby (1982), attachment is the mechanism that maintains the balance between the infant's need for safety and the developmental need to explore and learn. During the first three months, infants interact with their attachment figures differently from strangers; however, not until eight or nine months will children show a preference for their attachment figures. The rationale for shorter time limits for permanency planning decisions for children under the age of six months is that the child will be able to adjust to a separation if there is another stable attachment figure available.

The Adoptions and Safe Families Act of 1997 has significantly decreased the time that children spend in temporary homes. Unfortunately, young children in foster care continue to experience multiple caregivers, instability of placements, and differences in quality and style of caregivers. Part of forming secure attachments and subsequent bonding is the reciprocity that exists in the interaction between child

and caretaker. Repeated alarms of false permanency may hinder the chances for the young child to develop trust in potential caregivers or in returning home. There is also the danger that the child will have difficulties developing trust in herself and in other future relationships. These are important areas for evaluation.

Role of Culture

Yet another compounding and influencing factor relates to the disproportionate and overrepresented number of African American children who are reported to child welfare and who are in foster care (Berrick et al., 1998). African American infants represent approximately 6 percent of California's total infant population, yet they represent 25 percent of the infants in California's child welfare system. Berrick et al. found that although Hispanic children were more frequently investigated, very few received services or were placed in foster care. Regrettably, African American children are more likely to be placed and less likely to be reunified with their parents.

To what degree do poverty, racism, and social class influence decisions to remove and decisions to reunify? Even though legislation such as the MEPA prohibits and imposes strong sanctions on states for discriminating against foster care and adoptive placements of children on the basis of the race of child or prospective foster or adoptive parent, there is currently no legislation that imposes similar sanctions against state agencies for racism and discrimination against parents. It is critical to give attention not only to the alarming number of African American children in foster care but also to how the disproportionate number enters the system.

DEVELOPING CULTURALLY COMPETENT ASSESSMENT REPORTS

In order to develop family-sensitive, culturally competent reports and recommendations, there are several steps necessary in conducting assessments with young children in foster care who have been affected by substance abuse. These steps are not weighted but are viewed as equally critical in providing sound recommendations for children in foster care.

First, clinicians will need to work together across several disciplines to understand the nature of the referral and the specific questions

being asked (in contrast to the questions not being asked) in order to determine what to include in the assessment procedures.

Second, time-honored procedures will need to be expanded to accommodate observations of infants across current and potential future environments. Third, a conceptual synthesis of different paths of progress, including current and anticipated relapse for parents in treatment for substance abuse, mental health treatment, and parenting interventions must be developed. Finally, the social, economic, and political framework of the family must be considered so that practical and sensitive recommendations can be developed.

Culturally competent assessment practices with this special population of infants who have been separated from their families require sensitivity to the dynamics of mothers who abuse drugs and the consequences to infants at risk for abandonment. In addition, a heightened awareness of the cycle of being economically, psychologically, and socially depressed is necessary in order for a clinician to become more attuned to ethnocultural biases. Evaluators should be familiar with family traditions, values, ethnic identities, and worldviews. Whenever possible, clinicians should work toward recommendations that are congruent with the culture with which the family identifies. Finally, when available, culture-specific measures that have been standardized with populations of the same ethnic and cultural identity as the family being evaluated should be incorporated into the assessment.

CULTURALLY RELEVANT CLINICAL SUPERVISION AND TRAINING

The challenges identified in conducting more culturally and clinically relevant assessments for young children in foster care provide an opportunity and direction for supervisors responsible for training graduate students. This is also a challenge for mental health clinicians who are seeking continuing education training that focuses on dynamic assessments with high-risk families.

The notion of identifying the particular role that culture plays in assessment is not a new phenomenon. Lopez (2000) presents three guiding principles. First, issues of culture should be tied to key and existing conceptual tools. Second, active student participation should be promoted by exercises and illustrations. Finally, conceptual tools should be applied to actual clinical cases.

The idea is to demystify culture by naturally weaving it into common fabric. It is important for training programs to move beyond politically correct and politically appropriate discussions of class, culture, race, and ethnicity. Clinicians must be encouraged to think critically about the role of influencing factors such as culture and race in the lives of pregnant women with drug addictions in order to formulate more sensitive and appropriate evaluations.

A CASE EXAMPLE: REUNIFICATION OR ADOPTION?

Denisha, an African American infant, was born to Diane, a single mother, who was homeless and had no prenatal care. Denisha tested positive for cocaine but except for low birth weight and early withdrawal symptoms was in good health.

Diane, a twenty-one-year-old, has been on her own since the age of fifteen. Diane's mother (maternal grandmother) was caring for Diane's five-year-old daughter and four-year-old son but could not offer a home for Denisha. Denisha's father's identity and whereabouts are unknown. At the time of Denisha's discharge, Diane was unable to be reached. Reportedly, she was planning on relinquishing Denisha to her maternal grandmother. Denisha was placed in a foster home. Diane was not present during the detention hearing.

At the time of the assessment referral, Denisha had been living in the foster home for three months. Diane had made several calls to the social worker but was unsuccessful in following through with appointments. Diane reported often being sick, which prevented her from keeping her appointments. She sporadically visited her other children, often complaining about the harshness and critical judgment of her stepfather, who was also the father of her first child. After several attempts by the caseworker to reach her through the maternal grandmother, Diane agreed to meet the caseworker to review the reunification plan.

To summarize, the reunification plan included substance abuse assessment and treatment, random drug testing, parenting classes, medical screening and treatment, visitation with Denisha, cooperating with the caseworker, and establishing housing. Diane completed the drug assessment, which recommended a residential treatment program. Over a two-month period, Diane visited Denisha consistently three times a week, for two-hour visits. The visiting room staff reported her to be responsive to Denisha's needs (changing diapers, wiping her, feeding her, and playing with her). She asked several questions and during one visit indicated to staff that Denisha appeared to have a fever. Diane reportedly recognized Denisha's symptoms as similar to her own ongoing illness. She asked to accompany the foster mother to the doctor with Denisha and agreed for Denisha to be tested for HIV. Denisha tested negative for HIV.

At the time of the six-month review, Diane was making significant steps toward reunification. She had completed a ten-session parenting class, had completed the

substance abuse assessment, and had consistently visited Denisha. However, she had not entered a substance abuse treatment program, did not agree to random drug testing, did not participate in counseling, remained homeless, and no information was known about her medical condition. Diane admitted resisting the recommendation of a residential treatment program, because she did not think her problem was serious and believed that she was able to stop drinking on her own.

Interestingly, the caseworker and other professionals in contact with Diane did not observe any substance abuse behaviors or symptoms. However, she was consistently described as depressed. A recommendation was made to the court, however, for reunification services to be continued for six more months.

The assessment began with an interview with Diane, who provided some background information. Diane, the oldest of five children, was born to a single, teen mother. By age ten, she was primarily responsible for watching her siblings in the evening, while her mom worked as a dispatcher. Diane enjoyed school, but she did not consider herself a smart student. She had trouble reading but was not in special education classes. Her youngest brother's father molested Diane, resulting in a pregnancy at the age of fifteen. She stayed on and off with relatives during her pregnancy, briefly returning home to get help with her first daughter. Following an altercation with her brother's father (the baby's dad), she left home and has lived on and off the street since then.

Diane reports trying cocaine at age sixteen, but her drugs of choice were primarily marijuana and alcohol. She says that she stopped drinking after the birth of her second child, who reportedly was diagnosed with FAE. Diane reports being turned off to counseling, following a mandated report of child abuse when she was sixteen that left her ostracized by family members. She admits to doing whatever it takes to survive, although she reports no significant criminal activity.

Denisha is currently a seven-month-old, socially engaging, attractive infant. She is in her second foster home. She easily goes to adults that she meets for the first time but cries uncontrollably when they leave her. Denisha is cognitively on track and has met all of her developmental milestones.

Denisha is responsive to her mother. She is equally responsive to other adults with whom she has contact, including the transportation driver from whom she initially had trouble separating. Denisha has not had any contact with relatives other than her mother. The foster family reports being attached to Denisha. Although they are not interested in adoption, they would consider long-term placement.

QUESTIONS FOR THE CLINICIAN

The names and any identifying information have been changed, but this case example represents factual information. The recommendation for reunification or adoption is now in the hands of a multidisciplinary

team, where you are the clinician. What other information is needed or pertinent to this assessment and why? What is a likely concurrency plan for Denisha? What are the time limits and what is anticipated for the next hearing? What would you recommend: reunification, adoption, legal guardianship, or long-term placement?

How do you begin to "make predictions" about Denisha's future, and how confident are you with your role as the clinician? Equally important, to what extent are culture, race, poverty, substance abuse, and racism integrated into your report? The case example purposely does not provide answers to these questions, because set answers may lead to a "cure-all" instead of to continued critical thinking about lingering biases and assumptions that may influence recommendations for reunification and adoption.

In order for mental health clinicians to produce more appropriate and pragmatic recommendations, a shift from conventional approaches is essential. Understanding the impact of the developmental history, the circumstances leading to detention of the infant, the role of possible multiple caregivers, and the goal of securing a permanent home for the infant becomes a priority of an assessment. Comprehensive assessments should also include the involvement of child welfare agencies and the multiple providers working with the child, parent, and potential adoptive family.

A significant number of children being evaluated in foster care are from socially and economically depressed homes, and a disproportionate number of these children are African American. Although foster care children have advocates to represent them in juvenile proceedings, they are often court appointed, in contrast to the private representation available to families from higher social and economic levels. Consequently, critical steps and procedures in an evaluation may be restricted or limited in scope for the child in foster care, primarily based on county and state funding for assessments.

Perhaps the most difficult task will be for training programs to refocus on the inherent biases and assumptions that are often made about this population. Clinicians may find themselves too quickly advocating for either the child or the parent, or supporting the recommendations of the concurrency permanent plan before integrating and assessing the numerous areas.

Further, by becoming familiar with the terminology used by professionals working in juvenile courts and well known to families involved in that system, mental health clinicians begin to alter their initial approach to assessment with high-risk populations involved in legal proceedings. The preparation for assessing infants and toddlers in foster care requires clinicians to integrate and understand the essential requirements of a comprehensive evaluation and to develop the clinical skills needed to become more culturally competent.

Clinicians can acquire on-the-job training by making themselves available to the various social service county assessment panels. These panels, however, typically do not carefully screen for the clinician's level of training and make some assumptions about the expertise of the evaluator. It is therefore essential that beginning clinicians focus on opportunities to work in agencies that serve mothers with substance abuse problems. Building rapport and establishing some familiarity with this population will improve credibility, not only with the agency but also with the targeted population.

Because many doctoral programs in clinical psychology do not offer a child-family focus or developmental emphasis, it will be essential to look for continuing education classes. These should include topics such as atypical infant development, development of fragile infants, and assessments with high-risk infant populations.

This chapter has emphasized that culturally competent assessments need to be comprehensive, developmentally attuned to substance-exposed infants, and socially conscious of the conditions of unempowered women. In addition, clinicians who conduct assessment must account for the policies and practices of social service systems that affect the lives of infants and families. It is possible that through the development of comprehensive assessment practices an opportunity will be created to better understand the developmental effects of prenatal substance exposure and the ultimate placement needs of infants and toddlers.

References

American Psychological Association Office of Ethnic Minority Affairs. (1993). Guidelines for providers of psychological services to ethnic, linguistic & culturally diverse populations. *American Psychologist, 48*(1), 45–48.

Arvery, R. D., Strickland, W., Drauden, G., & Martin, C. (1990). Motivational components of test taking. *Personnel Psychology, 43,* 695–716.

Bateman, D. A., Phibbs, C. S., & Schwartz, R. M. (1991). The neonatal cost of maternal cocaine use. *Journal of the American Medical Association, 266*(11), 1521–1526.

Berrick, J. D., Barth, R., & Needell, B. (1994). A comparison of kinship, foster homes and foster family homes: Implications for kinship foster care as family preservation. *Child and Youth Services Review, 16,* 33–63.

Berrick, J. D., Needell, B., Barth, R. P., & Jonson-Reid, M. (1998). The tender years: Toward developmentally sensitive child welfare services for very young children. New York: Oxford University Press.

Bollerud, K. (1990). A model for the treatment of trauma-related syndromes among chemically dependent inpatient women. *Journal of Substance Abuse Treatment, 7,* 83–87.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment* (2nd ed.). New York: Basic Books.

Chasnoff, I. J., Anson, A., Hatcher, R., Stenson, H., Laukea, K., & Randolph, I. (1998). Prenatal exposure to cocaine and other drugs. Outcome at four to six years. *Annals of the New York Academy of Sciences, 846,* 314–328.

Chasnoff, I. J., Burns, K., & Burns, W. (1987). Cocaine use in pregnancy: Perinatal morbidity and mortality. *Neurobehavioral Toxicology and Teratology, 9*(4), 291–293.

Chasnoff, I. J., Burns, W. J., Schnoll, S. H., & Burns, K. A. (1984). Maternal nonnarcotic substance abuse during pregnancy: Effects on infant development. *Neurobehavioral Toxicology and Teratology, 6*(4), 277–280.

Chasnoff, I. J., Burns, W. J., Schnoll, S. H., & Burns, K. A. (1986). Effects of cocaine on pregnancy outcome. *National Institute of Drug Abuse Research Monograph Series, 67,* 335–341.

Chasnoff, I. J., Griffith, D. R., Freier, C., & Murray, J. (1992). Cocaine/polydrug use in pregnancy: Two-year follow-up. *Pediatrics,* 89(2), 284–289.

Children's Defense Fund. (1997). *Summary of the Adoption and Safe Families Act.* Washington, DC: Author.

Child Welfare and Institutions Code: California Juvenile Laws and Rules. (2003). Eagan, MN: West.

Daley, M., Ageriou, M., McCarty, D., Callahan, J. J., Jr., Shepard, D. S., & Williams, C. N. (2001). The impact of substance abuse treatment modality on birth weight and health care expenditures. *Journal of Psychoactive Drugs, 33*(1), 57–66.

Davis, S. K. (1990). Chemical dependency in women: A description of its effects and outcome on adequate parenting. *Journal of Substance Abuse Treatment, 7,* 225–232.

Doering, P. L., Davidson, C. L., LaFauce, L., & Williams, C. A. (1989). Effects of cocaine on the human fetus: A review of clinical studies. *Drug Intelligence Clinical Pharmacy: The Annals of Pharmacotherapy, 23*(9), 639–645.

Dubowitz, H., Feigelman, S., & Swayer, R. (1994). Children in kinship care: How do they fare? *Children and Youth Services Review. 16*(1–2), 85–106.

Erikson, E. H. (1963). *Childhood and Society* (2nd ed.). New York: Norton.

Ettorre, E. (1992). *Women and substance abuse.* New Brunswick, NJ: Rutgers University Press.

Everett, J. (1995). Relative foster care: An emerging trend in foster care placement policy and practice. *Smith College Studies in Social Work, 65*(3), 239–254.

Finkelstein, N. (1994). Treatment issues for the alcohol-and-drug-dependent pregnant and parenting women. *Health and Social Work, 19*(1), 7–15.

Frank, D. A., Bauchner, H., Parker, S., Huber, A. M., Kyei-Aboagye, K., & Cabral, H. (1990). Neonatal body composition after in utero exposure to cocaine and marijuana. *Journal of Pediatrics, 117*(4), 622–626.

Fried, P. A., & Makin, J. E. (1987). Neonatal behavioral correlates of prenatal exposure to marijuana, cigarettes and alcohol in a low risk population. *Neurotoxicology and Teratology, 9,* 79–85.

Gustavsson, N. S. (1992). Drug exposed infants and their mothers: Facts, myths, and needs. *Social Work in Health Care, 16*(4), 87–100.

Hanson, J., Streissguth, A., & Smith, D. (1978). The effects of moderate alcohol consumption during pregnancy on fetal growth and morph genesis. *Journal of Pediatrics, 92,* 457–460.

Hollingsworth, L. (1998). Promoting same-race adoptions for children of color. *Social Work, 43,* 104–116.

Howard, H. (1989). Cocaine and its effects on the newborn. *Developmental Medicine and Child Neurology, 31,* 255–257.

Kaltenbach, K. A., & Finnegan, L. P. (1992). Studies of prenatal drug exposure and environmental research issues: The benefits of integrating research within a treatment program. *National Institute of Drug Abuse Research Monograph Series, 118,* 259–270.

Katz, L. (1990). Effective permanency planning for children in foster care. *Social Work, 35,* 220–226.

Kelly, S. (1992). Parenting stress and child maltreatment in drug exposed children. *Child, Abuse and Neglect, 16,* 317–328.

Lopez, S. R. (2000). Teaching culturally informed psychological assessment. In R. Dana (Ed.), *Handbook of cross-cultural and multicultural personality assessment* (pp. 669–687). Hillsdale, NJ: Erlbaum.

McCalla, S., Minkoff, H. L., Feldman, J., Glass, L., & Valencia, G. (1992). Predictors of cocaine use in pregnancy. *Obstetrics & Gynecology, 79*(5), 641–644.

McRoy, R. G., Oglesby, Z., & Grape, H. (1997). Achieving same race adoption placements for African American children: Culturally sensitive practice approaches. Washington, DC: Child Welfare League of America Reports.

Milner, J. (1987). Ecological perspectives on duration of foster care. *Child Welfare, 66*(2), 113–121.

Mondanano, J. E. (1977). Women: Pregnancy, children and addiction. *Journal of Psychedelic Drugs, 9*(1), 59–67.

Pardeck, J. T. (1984). Multiple placement of children in foster family care: An empirical analysis. *Social Work, 29*(6), 506–509.

Rohsenow, D. J., Corbett, R., & Devine, D. (1988). Molested as children: A hidden contribution to substance abuse? *Journal of Substance Abuse Treatment, 5*(1), 13–18.

Schaefer, C. E., & DiGeronimo, T. F. (2000). *Ages and stages.* New York: Wiley.

Singer, L. T., Arendt, R., Minnes, S., Farkas, K., Salvator, A., Kirchner, H. L., & Kliegman, R. (2002). Cognitive and motor outcomes of cocaine-exposed infants. *Journal of the American Medical Association, 287*(15), 1952–1960.

Struthers, J. M., & Hansen, R. L. (1992). Visual recognition memory in drug-exposed infants. *Developmental and Behavioral Pediatrics, 13,* 108–111.

Substance Abuse and Mental Health Services Administration. (2000). *Summary of findings from the 1999 National Household Survey on Drug Abuse* (NHSDA Series: H-12, Department of Health and Human Services Publication No. SMA 00-3466). Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration. (2001). *Summary of findings from the 2000 National Household Survey on Drug Abuse* (NHSDA Series: H-13, Department of Health and Human Services Publication No. SMA 01-3549), Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration. (2002). *The National Household Survey on Drug Abuse report.* Rockville, MD: Office of Applied Studies, Author.

U.S. Department of Health and Human Services, Children's Bureau. (1997). *National study of protective, preventive and reunification services delivered to children and their families.* Washington, DC: Author.

U.S. General Accounting Office. (1990). *Drug-exposed infants: A generation at risk* (HRD 90-83). Washington, DC: Author.

U.S. General Accounting Office. (1997). *Parental substance abuse: Implications for children, the child welfare system, and foster care outcomes* (Report Number T-HEHS-98-40). Washington, DC: Author.

Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care. *Child Welfare, 79*(5), 614–632.

Zeanah, C. H., Boris, N. W., & Lieberman, A. F. (2000). Attachment disorders of infancy. In A. J. Sameroff, M. Lewis, & S. M. Miller (Eds.), *Handbook of developmental psychopathology* (2nd ed., pp. 293–307). New York: Guilford Press.

CHAPTER TEN

Play Therapy with Preschoolers Using the Ecosystemic Model

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Ecosystemic Play Therapy (EPT) is an integrated therapeutic model that incorporates neurobiological, developmental, intrapsychic, systemic, and cultural variables when addressing a child's functioning in his or her world (O'Connor, 1997, 2000; O'Connor & Ammen, 1997). EPT differs from many traditional models of play therapy, especially the client-centered approaches (for example, Axiline, 1947; Landreth, 1991) that use an exclusively *nondirective* play therapy approach in which the therapist follows the child's lead within a warm and accepting therapeutic relationship.

In EPT, a warm and accepting relationship is also critical, but the therapist is responsible for the structure and flow of the sessions and even participates in the sessions, depending on the child's developmental level and needs, focus of treatment, and ecosystemic variables. At times, the therapist may determine that the indicated intervention is a course of individual nondirective, client-centered play therapy, but this modality is part of the larger structured EPT treatment plan, rather than the overall approach to treatment.

In the vast majority of EPT cases, the treatment involves some combination of individual, parent-child relationship, family, and peer

group play therapies with consultation, collaboration, or advocacy roles with the other systems. For comparison of the different models of play therapy, including EPT, see O'Connor (2000) and O'Connor and Braverman (1997).

OVERVIEW OF ECOSYSTEMIC PLAY THERAPY

We view EPT as developmentally organized, strength based, relationship focused, and contextually grounded in the child's ecosystem. These concepts have considerable overlap with the mental health concepts recognized as critical to working with children in the first five years of life (for example, McDonough, 2000; Pawl & St. John, 1998).

Developmentally Organized

EPT is developmentally organized around an integrated view of child development from birth to adolescence. "This developmental conceptualization is the cornerstone on which the model rests; it is the template against which the child's history will be compared. Deviations or disruptions in the child's progress through it are the basis for formulating the major therapeutic goals and for designing the interventions that will be implemented within the play sessions. Finally, it is the yardstick against which the child's progress is measured" (O'Connor, 2000, p. 93).

To accomplish this, we must have an integrated understanding of development across multiple domains, including but not limited to cognitive, social emotional, communicative, physical, and play development. Within EPT, we have loosely organized these domains of development into three levels consistent with Wood, Davis, Swindle, and Quirk (1996).

LEVEL I. Level I refers to developmental processes that normally begin at birth and continue through approximately two years of age. The primary tasks during this period are to respond to the environment with interest and pleasure, to develop a primary attachment relationship, and to begin to self-regulate emotions and behavior through that attachment relationship. Cognitively, children are in the sensorimotor phase (Piaget, 1952), during which all learning is experiential, with little mediation by language.

Play therapy with children with Level I functioning requires sessions that are almost entirely experiential rather than verbal. This is true whether or not the child typically functions cognitively at Level I or only exhibits Level I thinking in emotionally loaded situations. Regardless of the client's age, play sessions geared toward remediating Level I difficulties include highly interactive and nurturing activities in which many of the child's senses are stimulated. The use of toys is limited because the focus of the activity is on the interaction between the child and parent, or on the therapist modeling with the child, with the parent observing. Content that needs to be addressed is usually introduced experientially, and the therapist entirely or mostly completes the verbal processing of that content for the child. For example, consider the following:

> A therapist working with a violently abused two-year-old who had yet to develop any language used small figures to act out the child's experiences while filling in all of the dialogue himself. The child watched these little plays with great interest and occasionally contributed to the action by moving figures. Although the child never participated in the verbal processing and problem solving done by the therapist, the child's symptoms began to abate as he seemed to develop an understanding that his parents had, indeed, not known that his baby-sitter was hurting him and had done everything they could to protect him once they found out [O'Connor & Ammen, 1997, p. 147].

LEVEL II. This level refers to developmental processes that begin around two years of age with the acquisition of functional expressive language and last until the child is about six-years-old. The primary tasks of this level are to develop a sense of self, to experience mastery and autonomy in interaction with the environment, and to fully integrate thinking and emotions such that the child can begin to plan, anticipate, problem solve, and self-regulate emotions and behavior.

Cognitively, children enter the preoperational phase (Piaget, 1952), during which learning becomes more language based and less dependent on experience. The emergence of rich representational (pretend) play begins, but only toward the end of this stage are children able to logically plan and sequentially organize their thinking and play (Westby, 2000).

Play activities geared toward remediating difficulties experienced by Level II children are designed to provide children with as much specific information about the nature of the problems they are facing

as possible. Level II children are susceptible to misunderstanding and misattributing their experiences because of their preoperational thinking and egocentric perception of the world.

Both experiential activities and verbal processing can be used to increase the child's understanding and to help the child problem solve. The parent or primary caregiver is often involved in treatment, with participation ranging from observer with an interpreting therapist to parent-child interactions to cotherapist with a role in planning activities and in reflecting the child's feelings and behaviors. Participation of other family members is common.

LEVEL III. Level III begins as children acquire increasing ability to manipulate information, which lasts roughly from the ages of six to eleven and corresponds to Piaget's (1952) concrete operations phase of cognitive development. The primary tasks are to develop peer relationships and group skills and to experience competency and success in interaction with their environments, including school. Learning is now dominated by language processing but is still dependent on experience. Children are able to logically plan, anticipate, problem solve, and self-regulate their emotions and behavior much of the time.

Children in the sensorimotor and preoperational stages were preoccupied with acquiring information, but the Level III child becomes preoccupied with organizing it. Play activities geared toward remediating difficulties experienced by Level III children include both experiential play and verbal processing and interpretations. Peer playgroup treatment is often used to focus on social skills and target specific problems such as ADHD.

With both Level II and Level III children, the therapist's first goal is to prevent regression to earlier levels of developmental functioning and subsequently to promote the child's normal developmental progress. This may mean beginning the treatment with some activities that address earlier developmental needs in order to block the regressive pull experienced by children in distress. See O'Connor and Ammen (1997) for multiple examples of session activities specifically designed to address issues at Levels I, II, and III.

Strength Based

In addition to careful consideration of the child's current developmental level, the therapist must also consider which other needs the child has that are not being adequately or appropriately met. EPT

views all behavior as a child's best attempts to get his or her needs met (O'Connor & Ammen, 1997). As such, the treatment is focused on the perspectives of child and family—their motivations and intentions, rather than on psychopathology. "Every family we serve has *vulnerabilities.* Their vulnerabilities are what bring them to our attention. While it is important to understand the babies' and families' vulnerabilities and risk factors, these are *deficits,* things that they *lack. You can't build on what isn't there.* A deficit model ultimately prevents us from identifying what the baby and family can build on, what their strengths are" (Maury & Monzon-Kong, 2002, emphasis in original).

Behavior is always adaptive in the moment relative to the child's internal organization, history, and environmental context. "Children of all ages—infants to adolescents—alter their behavior in service of preserving attachment relationships when their parenting needs are not met. Such alterations are necessary for their survival and are often wise and creative but not necessarily healthy. . . . Children's adaptive roles include being overly compliant with abusive parents, being entertainers with distracted parents, being minicaregivers with needy parents, being demanding bullies with nonresponsive parents, or being manipulators with neglectful, withholding parents" (James, 1994, p. 6).

From the perspective of an observer, a child's behavior may not appear adaptive because it compromises too many of the child's other needs. If the behavior does not appear to be functional from our perspective, then it is particularly important to try and understand what it accomplishes for the child.

Relationship Focused

Weston, Ivins, Heffron, and Sweet (1997) proposed that the *centrality of relationships* should be an organizing construct for the field of early intervention. This requires recognition that relationships are both organizers of development and the basis of all interventions with young children. EPT is consistent with this concept in that treatment is evaluated and implemented within the context of the child's primary relationships—both as a focus of the treatment and a way to facilitate the treatment.

The primary goal of EPT is to enable children to get their needs met consistently and in ways that do not interfere with the ability of others to get their needs met. A secondary goal is to facilitate the

assumption or resumption of optimal developmental functioning and growth. Two curative elements are specifically recognized in EPT.

> One is the nature of the relationship between the child [and family] and the therapist. The other is the ability of the therapist to engage the child in developing problem solving strategies that enable the child to get his or her needs met effectively and appropriately. Simply put, the role of the Ecosystemic Play Therapist is to create a context in which the therapeutic or curative elements of Ecosystemic Play Therapy take place. To accomplish this the therapist provides children [and families] with experiences and cognitive/verbal explanations that alter their understanding of their life situation. With this new understanding they are able to engage in alternative problem solving and to discover more effective and appropriate ways of getting their needs met. The alternative experiences are provided through the context of the relationship between the child [and family] and the therapist and through the play. The alternative cognitive/verbal explanations are provided through interpretation and by engaging the child in active, overt problem solving [O'Connor & Ammen, 1997, pp. 11–12].

Research on change processes in therapy (Elliott, 1984) indicates that the process of experiencing something differently or understanding different possibilities for getting their needs met can have a profound positive effect on clients. "Therapists need simply to help clients talk differently about their lives and to notice their own successes" (Eron & Lund, 1996, p. 31). In play therapy, we help children "play" differently about their lives. That is, not only do we use our verbal reflections and interpretations to help them develop new understandings, but we also help them experience themselves and their world differently through changing their interactions with their parents, siblings, and peers.

The younger the child, the more vital are the roles of the parents and the family. In therapy situations with young children, the therapist must keep the parents-caregivers in a more prominent role than that of the therapist. For this reason, the therapist's relationship with the parent figure is at least as important as his or her relationship with the young child. Often the therapeutic effect results from play-based interactions that help parents experience the relationship differently, combined with verbal reflections and interpretations that help them understand the child's experience and behaviors differently.

Contextually Grounded in the Child's Ecosystem

Children exist within the context of multiple interacting systems that change over time. Ecosystemic play therapy takes all of these systems into account when conceptualizing the presenting problem and formulating a treatment plan. We start with the child's individual functioning, which includes a developing neurobiological child engaged in interactions with others and engaged in representing those interactions through internal working models of themselves, their world, and their relationships. The child's functioning is then examined in the context of the primary parent-child relationships, family relationships, peer and other social relationships, and in the other systems in which the child may be directly involved. These systems may include schools, churches, legal systems, medical systems, and mental health systems.

The cultural context of child functioning must also be examined. "Cultural behaviors refer to the whole body of communicative interactions that give a certain continuity to the history of a group, beyond the particular histories of the participating individuals. By this definition, culture occurs in any group that has a history together. Thus, the communicative meanings that exist in a family represent that family's unique 'culture.' At the same time, the family is embedded in local cultural systems such as religious or ethnic communities, and in larger cultural contexts, such as the dominant political system" (O'Connor & Ammen, 1997, p. 7).

It is important to understand that all of these systems influence the child both directly through interactional experiences and indirectly through the meanings that the child places on these experiences. Through this process, we identify which systems are sources of support and resources, which systems add stress, and which systems should be included in or addressed as part of the treatment.

In order to understand the child's current functioning within the ecosystem, we must understand how the child experiences and perceives getting his or her needs met within that ecosystem, which may or may not coincide with the perceptions of the other members of the child's ecosystem, who are relating to one another and the child according to their own needs and perceptions. The participants in these systems (for example, parents, teachers, physicians) all have their own perspectives about why the child is behaving in a particular way, and these perspectives influence how they respond to the child's

behavior. It is not unusual for the perceptions of the child and those of the other participants in the child's ecosystem to be different. In order to work effectively with children and their ecosystems, we must try to understand the perceptions of all of the relevant participants and work to increase the understanding between them.

Last, but not least, we must remember that as therapists, we too are human beings who approach our client-families from our own perspective, which is determined in part by our own history of experiences and by our training. We must be aware of the degree to which we impose our own perceptions onto the therapeutic situation. We are not suggesting that we should not ever impose our perceptions, because that would be impossible—they are present in what we bring to the interaction. But the more we become conscious of our own perceptions and their sources, as well as the perceptions of the other participants, the more we can adjust our interactions and interventions to take these multiple perspectives into account.

MENTAL HEALTH CONCERNS WITH PRESCHOOLERS

When the idea that preschoolers might need mental health treatment was first introduced, it challenged the generally assumed view that preschool behavioral problems would be outgrown. Now, like the swing of a pendulum, the tendency is to overgeneralize and overpathologize (Campbell, 2002). Preschoolers with aggressive tendencies are seen as future delinquents and violent criminals. Preschoolers with regulatory problems are seen as having attention deficit hyperactivity disorder or bipolar disorder. The truth lies somewhere in between. Although it is true that most violent adults had very troubled childhoods that were often observable in their early behavior, it is also true that most aggressive and noncompliant preschoolers will *not* end up as seriously impaired adolescents or adults (Campbell, 2002). However, a small but significant proportion of children with preschool behavioral problems will continue to have significant difficulties later on.

Identifying which children need interventions to prevent future problems is still in its infancy, but the current thinking suggests that early experiences in the first five years of life are significant contributing factors, but not necessarily causal influences, on future functioning. Some children are inherently resilient in spite of life's

challenges and have the presence or capacity to draw supportive adult relationships into their lives (for example, Werner & Smith, 1992). The majority of children retain the capacity for change if certain key experiences occur later in life. And some children remain vulnerable in spite of supportive environments and nurturing relationships (Campbell, 2002).

Significant problems in the preschool years can best be understood as resulting from a complex interaction of child characteristics (genetic, biological, and developmental), family factors, and ecosystemic factors. Protective factors include a warm and supportive parent-child relationship, firm and consistent but flexible parenting style, and adequate environmental resources and supports. Risk factors include biological vulnerability (for example, prenatal drug exposure or current medical problems); dysregulated child behaviors; insecure or disorganized parent-child attachment; inconsistent, harsh, or rejecting parenting strategies; traumatic experiences; and ecosystemic factors such as inadequate nutrition, violent neighborhoods, and poverty. Multiple risks with fewer protective factors are most associated with chronic long-term problems (Campbell, 2002).

Specific disorders frequently manifesting in the preschool years include disruptive behavior disorders or regulatory problems such as extreme oppositional behavior or attention deficit disorders, internalizing disorders such as separation anxiety or social withdrawal, the autistic spectrum disorders, disorders of attachment, trauma-based disorders including experience of abuse, disorders of eating and sleeping and gender identity issues, and adjustment disorders (Campbell, 2002; Lyman & Hembree-Kigin, 1994; Steiner, 1997). However, "children's disorders do not emerge de novo, isolated from the childrearing environment and community supports" (Campbell, 2002, p. 81), so the impact of the child's relationships and ecosystemic context must be taken into consideration when making diagnostic decisions with preschoolers.

PLAY AND PLAY THERAPY WITH PRESCHOOLERS

Play can be seen as having developmental, interpersonal, intrapsychic, and sociocultural functions (O'Connor, 2000). Developmentally, play is the medium through which children naturally explore their environment and develop basic motor, cognitive, and language skills. Interpersonally, play that begins in the early reciprocal dialogue

between a parent and infant both facilitates the attachment relationship between them and promotes the child's neural development and sense of self. Bowlby (1982) identified mutually enjoyable social interactions within the context of a warm, intimate, and continuous relationship with a parent—that is, *play*—as one of the most critical variables in the development of a positive attachment relationship.

Intrapsychically, play allows children to explore their environments and gain mastery over situations. "Play is the language of children. While adults talk out their fears and traumatic experiences, children play theirs out. They may lack the words or the cognitive abilities to understand what has happened to them or to resolve their conflicts, but play has therapeutic qualities that allow children to play out their conflicts and to deal with them" (Frost, Wortham, & Reifel, 2001, p. 87). Socioculturally, play helps the child learn social skills, including how to share, cooperate, and negotiate. Although play is a natural developmental process for children, the expression of play content and forms are influenced by cultural expectations, family dynamics, and life experiences (Frost et al., 2001; Westby, 2000).

Representational Play Development

Imaginative or make-believe play is particularly important because it allows children to make the complex and frightening events in their lives manageable and comprehensible, and it provides a medium for playing out different outcomes and solutions. Representational play is an emerging skill for toddlers and preschoolers. As preschool play therapists, we must structure our play therapy to be developmentally attuned to the capacities of the child, which means we must have an understanding of this developmental process. The following discussion of representational play development draws heavily from Carol Westby's work (2000).

The development of representational play abilities begins at about eighteen months of age with simple symbolic play actions, such as pretending to drink from a cup or feed someone else. The critical component of symbolic play is the child's ability to transcend the immediate reality of "I am drinking" to a created reality of "I am pretending to drink." At first, the representations are based on common experiences, such as eating, cooking, or gardening, and the child is dependent on realistic, life-size (for the child) props. As children's representational play abilities develop, they are increasingly able to use

smaller object-figures and even substitute objects (a block can now be a telephone or a car); their themes become more creative and less dependent on their experience; and they begin to organize and sequence their play narratives (stories). By age two and a half to three, children still require realistic props but are beginning to use language for narrating their play. They are able to create complex, unplanned, but sequential play themes.

Between ages three and three and a half, children become less dependent on props and begin to use dolls, puppets, and small figures in their play. A significant cognitive shift occurs with the development of metalinguistic language, such as, "he said," "I think," "she wants," "they feel." This requires the ability to project into the thoughts and feelings of others and indicates recognition of internal mental states in themselves and others. This transition is associated with the ability to reflect on their behavior, to self-monitor, and to problem solve.

By age five, most children are capable of fully developed representational play with planning, sequencing, and complex narration that includes metalanguage about the participants' experiences, feelings, and desires. They no longer require props. For example, at this age, a daughter of one of the coauthors had several completely invisible "children" that frequently went in the car with the family whenever we traveled—including one named "Woof-Woof," who always refused to put on his seat belt!

Many children with attachment disturbances or trauma histories have impaired representational capacities, especially in the metalanguage areas. Some children may reenact their trauma in repetitive play sequences that do not reduce their anxiety or give them a sense of coping—this can be seen as parallel to the intrusive, repetitive thoughts that adults with posttraumatic symptoms report. Other traumatized children may respond to the play therapy setting by being resistant or avoiding representational play or expressive play techniques (Drewes, 2001).

Play Therapy with Preschoolers

Given the appropriateness of using play as a modality to communicate with young children, it is somewhat surprising that there is only limited discussion of play therapy in the major books on mental health interventions with preschoolers (for example, Campbell, 2002; Lyman & Hembree-Kigin, 1994; Nicol, Stretch, & Fundudis, 1993;

Steiner, 1997). Steiner's book *Treating Preschool Children* is the most complete, with a brief discussion of the stages of play therapy treatment with abused preschoolers. Several references on play therapy with preschoolers can be found in the more recent art therapy and play therapy literature. Willemsen and Anscombe's journal article (2001) presents an art and playgroup therapy for preschool children infected and affected by HIV/AIDS, and Proulx (2002) uses art therapy processes to promote early parent-child relationships in her book, *Strengthening Emotional Ties Through Parent-Child-Dyad Art Therapy.*

The edited book *School-Based Play Therapy* (Drewes, Carey, & Schaefer, 2001) contains four chapters that specifically address play therapy with preschoolers. Drewes (2001) presents developmental considerations in play and play therapy with traumatized children, with in-depth coverage of the impact on infants and preschoolers, as well as appropriate play therapy modalities to use with these children. Van Dyk and Wiedis (2001) discuss sand play and assessment techniques with preschool-age children. Knoblauch (2001) addresses play therapy in a special education preschool, including strategies for interfacing the play therapy with the classroom routines and personnel. Reddy, Spencer, Hall, and Rubel (2001) describe the use of a play-based group for young children with ADHD between ages four and a half and eight, including several techniques that could be adapted to parent-child or family play sessions to address regulatory problems.

The edited book *Short-Term Play Therapy for Children* (Kaduson & Schaefer, 2000) also contains several chapters specifically relevant to play therapy work with young children. Ammen (2000) presents a play-based teen-parenting program to facilitate parent-child attachment. The focus of the chapter is on teen parents and infants, but the group structure and activities are easily adaptable to any parent with young children.

Shelby (2000) describes brief therapy with traumatized children from a developmental perspective, including symptoms, coping strategies, and key intervention strategies for infants, preschoolers, school-age children, and adolescents. Gallo-Lopez (2000) presents a creative play therapy approach to the group treatment of young sexually abused children from three to ten years old. Booth and Lindaman (2000) describe the use of Theraplay® for enhancing attachment in adopted children, using a three-year-old for the case example.

In a related book edited by Munns (1999) called *Theraplay: Innovations in Attachment-Enhancing Play Therapy,* there are several

chapters presenting techniques that could be adapted to play therapy with young children. One chapter (Bernt, 1999) specifically addresses Theraplay with failure-to-thrive infants and mothers.

APPLYING THE ECOSYSTEMIC MODEL TO PLAY THERAPY WITH PRESCHOOLERS

Ecosystemic play therapy can be seen as a framework for play therapy, rather than a specific modality. As such, many modalities are integrated into the EPT framework depending on the needs of the client and the preference and training of the therapist. In the case example presented later in this chapter, components of several distinct therapeutic approaches (including Theraplay, Watch, Wait, & Wonder®, and social learning theory) are thoughtfully integrated into the EPT assessment and intervention.

Theraplay is an attachment-promoting play therapy approach that "replicates the joyful and adoring features of the parent-infant interaction" (Jernberg, 1983, p. 136). Jernberg and Booth (1999) identified four essential dimensions of parental attachment-enhancing behaviors: structuring, engaging, nurturing, and challenging. The four dimensions form the acronym SENC, in recognition that these behaviors occur in a context that includes nurturing and playful physical interactions involving the senses. *Structuring* refers to those things that caregivers do to organize their children's world so that their children feel secure and know what to expect. *Engaging* is the reciprocal dance of enjoyment that develops between parent and children. *Nurturing* refers to those things that caregivers do that let children know that they are cared for and loved (for example, feeding, holding, comforting). *Challenging* is about helping children learn new things, stimulating and encouraging their development toward feelings of mastery and competence.

Intensive Theraplay interventions should be conducted by therapists who have been trained in the Theraplay method. However, the structuring, engaging, challenging, and nurturing concepts and related activities are helpful for any play therapists to use in planning play therapy sessions, especially with young children. For example, the therapist might use an engaging activity (blowing bubbles) or a nurturing activity (putting lotion on each other) to promote positive emotional reciprocity between a young child and parent. (For information on training in Theraplay, see www.theraplay.org.)

The Marschak Interaction Method (MIM) (Lindaman, Booth, & Chambers, 2000) is a parent-child observational assessment tool developed by Theraplay, based on the four dimensions of SENC. In the MIM, the parent and child complete a set of tasks, such as (1) parent and child play together with squeaky animals, (2) parent builds a block tower and asks child to make one just like it, (3) parent leaves the room for one minute without child, and (4) parent and child put lotion on each other.

These tasks allow the clinician to assess the degree to which the adult is able to structure the situation and encourage the child to engage in the activities, while at the same time being playful, nurturing, and attuned to the child's level of frustration, emotional states, and developmental abilities. Following the observation, the MIM is reviewed with the caregiver, using SENC as a helpful way to communicate strengths and problem areas in parenting the child. Observations during the MIM also influence the treatment goals and interventions chosen.

Watch, Wait, & Wonder (WWW) (Muir, Lojkasek, & Cohen, 1999), another attachment-enhancing play therapy approach, focuses on strengthening the parent-child relationship by helping parents to understand the meaning of their child's behavior. In WWW, parents are encouraged to follow their child's lead in play and then to "wonder" about what they see. Like Theraplay, Watch, Wait, & Wonder is a distinct approach to treatment that requires training and supervision for effective use with families. However, the concepts can guide any therapist.

Social learning theory also influences how we think about a case, as we wonder if the challenges identified are caused by a lack of learned skills on the part of either the child or the caregiver. If this is the case, our approach will be to teach and practice the skills needed to be successful at a particular task. (For examples of social learning interventions with young children, see Fisher, Ellis, & Chamberlain, 1999.)

Because a traumatic event has affected the child's functioning in the case example presented in the next section, we also incorporate Janine Shelby's insights regarding developmentally sensitive trauma treatment (2000). Keeping several concepts of infant-preschool mental health practice in mind, we approach families remembering that behavior is meaningful, that everyone wants things to be better, and that relationships are key (Pawl & St. John, 1998). We also consider services outside the traditional mental health arena (for example, speech and language) to address additional developmental concerns.

A CASE EXAMPLE USING EPT

The following case example is from the Building Blocks Program, an intensive, in-home mental health intervention program for children, birth to five, and their families. Children can be referred via the county mental health department from a number of sources, including parents, pediatricians, preschool teachers, or social workers. Assessments and interventions are provided by a clinical team, consisting of a bachelor's level counselor and a master's level clinician, with additional support from clinical psychologists, child psychiatrists, and an occupational therapy consultant as needed.

Unless specified, all services—intake to discharge—are provided in the family's home. In order to protect the privacy of the children and families we serve, what follows is a case example that is actually a composite of several cases. Although this example blends the experiences and challenges of several young children, the mix of symptoms and concerns is not unusual.

Identifying Information and Presenting Problem

In EPT, we try to gather information on the presenting problem from as many perspectives as possible, including from the child. In the following case, the child's grandmother and the child were informants.

Germayne is a four-year-old African American boy referred by his grandmother, Ms. Anderson, because he has become aggressive with his younger brother and sister. His social worker is concerned that Germayne may be "too much for his grandmother to handle" and recommended to Ms. Anderson that she call us. She reports that Germayne has difficulty settling down and that he overreacts to minor frustrations. She adds that he is not aggressive at preschool; in fact, his teachers describe him as withdrawn. Germayne does not want to talk about fighting with his siblings, but he guardedly tells us that sometimes he "just gets mad."

Intake and Assessment

Our initial clinical interview is organized around strengths and challenges, development, relationships, and the greater ecosystems surrounding the child and family, including a comprehensive developmental ecosystemic history. The quality of the parent-child relationship is central when working with preschoolers, either because it is the focus of treatment or because it is a resource for the child that

can facilitate treatment. Consequently, the MIM is a standard part of our EPT intake process. Because development is so important when working with young children, our initial assessments often include a developmental screening or more formal developmental assessment, depending on the structure of our setting and available resources.

An important part of the intake is a play interview with the child to assess the child's mental status and developmental level of representational play. The Infant-Toddler Mental Status Exam (Benham, 2000) adds self-regulation, relatedness with caregivers, and play development to the traditional mental status categories. These are also important categories for preschoolers.

Because cultural and family factors affect the content and form of the child's play (Westby, 2000), a play history is gathered from the family to get a sense of what types of play and toys the child prefers and how family members view play and how they play together. If the intake-play interview occurs in the home rather than in an office setting with a playroom, the therapist can carry a travel set of play therapy supplies, such as the following list adapted from Timberlake and Cutler (2001, p. 74): small baby doll, bottle for doll, small blanket, two cans of Play-Doh, cup for water, sponge, Legos, Duplos or wooden blocks, blunted scissors, paste (nontoxic), paper, crayons, pencils, magic markers, two bendable miniature doll families (multicultural), two or three puppets, farm animals and wild animals or dinosaurs, realistic toys like pretend food and dishes, two toy telephones, and Nerf ball or other soft ball.

At our request, Ms. Anderson describes Germayne's strengths: he is a loving child who likes to help around the house. He cares deeply about his brother and sister and sticks up for them with other children in the neighborhood. And he is a good artist. Ms. Anderson adds that she loves Germayne very much and that she will always take care of him.

She tells us that she doesn't know everything about Germayne's early years, because she was only involved "now and again," but from what she knows, it appears that his birth was medically unremarkable and that he met developmental milestones when expected. She reports that he was a quiet child who "watched more than he talked," but there were no concerns. Germayne started Head Start preschool when he was three, and Ms. Anderson reports that he does well there, although she thinks he must be a bit shy, based on what his teachers tell her.

When we start to ask Ms. Anderson about Germayne's parents, his relationships with them, and how he came to live with her, Ms. Anderson asks if she can speak

privately. To accommodate this request, our counselor invites Germayne to play with her in another room. During this time, the counselor completes a brief play interview–mental status and assessment of Germayne's representational play abilities (Westby, 2000).

The counselor notes that Germayne is an attractive, engaging child of average build who is cautious initially (as would be expected on a first visit), but after warming up, he engages easily in play. He doesn't speak much and his articulation is poor when he does speak, often requiring the counselor to ask Germayne to repeat himself. Initially, he seems eager to be understood and repeats himself several times, but after a while, Germayne simply shakes his head and continues playing. As would be expected for his age, Germayne's pretend play is complex, logically connected, and sequenced.

Because Germayne's history suggests that he does not manage frustration well, and because the counselor has not yet established a strong rapport, she introduces only minor frustration into the play interview (in the form of limit setting). He accepts these limits with little resistance.

Once Germayne is out of hearing range, Ms. Anderson indicates that she has cared for Germayne and his siblings for almost two years. For most of that time, Germayne's father, her son, has lived with them. Germayne's mother is in jail for selling drugs, but although Germayne witnessed his mother's arrest over a year ago, Ms. Anderson is clear that his mother's incarceration "is not discussed in front of the children." They have been told simply, "Your mother loves you, but she is away and cannot take care of you." Germayne's father is also "away" at times (not for trouble with the law, we are assured), but he currently holds a "good job" and lives with the children and their grandmother.

Ms. Anderson reports that she loves her grandchildren and would do anything for them, but she has felt more and more isolated from her friends lately. She used to attend church services regularly, but lately Germayne's fighting has made attendance difficult. She doesn't have time to see her friends from work anymore, having cut back on her hours to look after her grandchildren. Now she feels the strain both socially and financially.

Over the next few weeks, we continue our assessment, asking follow-up questions to our initial interview, talking to and requesting records from others who are involved with Germayne (with his grandmother's permission), and completing additional assessments. Birth and medical records are unremarkable except for reference to recurrent ear infections. Germayne's teachers report that he has few problems with other children at school, but they are concerned with his apparent lack of interest in making friends. They see Germayne as unhappy and withdrawn.

A standardized developmental assessment reveals that Germayne's nonverbal skills are average relative to other children his age; however, his verbal abilities are below average. More specifically, his receptive language (his ability to understand others) is

average, but his expressive language (his ability to tell others what he needs and wants) and his articulation are more than a year delayed.

A MIM with Germayne and his grandmother suggests that they share a generally pleasant relationship. Ms. Anderson's directions are clear, but at times, Germayne just looks away, seeming not to hear her. He also appears distracted and disengaged when she tries to teach him new things or to otherwise challenge him. Ms. Anderson appears uncomfortable when Germayne ignores her, and rather than challenge him further, she appears to give up, and she too withdraws.

Treatment Planning

During assessment, we begin to develop a "shared view" with families. We begin to understand the family's story through what they tell us, through records we may get from other agencies, and through our more formal assessment tools. We make hypotheses about what is behind behavior and we test these out. By the end of our assessment, we have some ideas about what may be creating distress for the child and family, and we begin to develop a treatment plan with them.

With Germayne, we start with several hypotheses. Developmentally, we are worried about his expressive language difficulties, knowing that they can interfere with social problem solving and lead to frustration and aggression. Within his family, we wonder about Germayne's aggression toward his younger brother and sister. Is he competing with them for his grandmother's attention? Or is the aggression a by-product of his reactivity and low frustration tolerance, possibly a result of his language delays?

We also wonder how Germayne makes sense of his mother's absence. Developmentally, he is likely to have an egocentric explanation, one that is not being challenged by any adults because the issue is "not discussed in front of the children." We question how much Germayne overhears of what is "not being discussed" in front of him.

Finally, within Germayne's ecosystem, we are concerned by his teacher's description of him as "sad and withdrawn." We wonder if Germayne has developed the skills to engage and play with other children, if his language delay is interfering with his social development, or if he has the social skills but emotionally doesn't have the energy to use them. We are also concerned by Ms. Anderson's increasing isolation. Since caring for her grandchildren, she has lost several strong community supports.

Our treatment plan begins in the home, using family play therapy with Germayne, his siblings, and Ms. Anderson. Our first goal is skills oriented: to strengthen Germayne's problem-solving and play skills with his siblings. Our second goal is "fun-oriented": to address the developing emotional distance between Germayne and his grandmother.

Because Ms. Anderson identified Germayne's fighting as her primary concern, we want to reinforce her confidence in her ability to respond effectively and consistently to Germayne's aggression. Our MIM also indicated, however, that Germayne and his grandmother are beginning to disengage from each other. To prevent this, we want to reintroduce fun (enjoyment-engagement) into their relationship.

We also recommend that Ms. Anderson attend a Grandparents Raising Their Grandchildren group for additional emotional and social support, and we support her in getting back to church. Finally, we request an Individual Education Plan (IEP) through Germayne's school district and advocate for speech and language services to address his articulation and expressive language difficulties.

Treatment Process

As mentioned earlier, our choice of complementary treatment modalities is carefully considered. The "right" approach is one that fits the family and the therapist, addresses the concerns identified by both, and provides a "port of entry," an avenue through which the therapist can enter the clinical (family) system to effect change (Lieberman, Silverman, & Pawl, 2000).

Based on Ms. Anderson's assessment of the problem (that is, Germayne's fighting), we start intervention using a social-learning, skills-building approach in family play therapy with Germayne, his grandmother, and his siblings. Working from the hypothesis that Germayne has not developed the skills he needs to play cooperatively with his brother and sister, we practice "playing nicely" and reinforce the skills needed to initiate and sustain play. This includes inviting someone to play, negotiating who goes first, and choosing a game that both children enjoy. These skills are taught and practiced both before and during games, in an energetic and fun manner.

We also support Ms. Anderson as the adult who determines the rules and sets the limits. We complement this approach by using highly engaging, fun activities (many of which are drawn from Theraplay) that draw Germayne and his grandmother together in touch, eye contact, and laughter.

As family play therapy sessions progress, we notice that Germayne is more attentive to his grandmother and she to him. They seem to enjoy and seek each other out more. Germayne's relationship with his siblings, however, remains a challenge. We observe that Germayne has the skills to play nicely with his brother and sister, but he can't use them when frustrated, and he gets frustrated very easily. We also notice that almost all of his free play is about good guys and bad guys and going to jail. In fact, at times it looks as though his fighting with his siblings is actually part of his imaginative play.

With these observations, we return to Ms. Anderson to talk more about her decision not to discuss with the children the arrest and incarceration of their mother. We talk about typical development and about the need of most children to make sense of what is happening around them. We talk about how children believe that everything happens for them and because of them. We suggest that Germayne may have made up a story about his mother's absence, that his story may not be accurate, and that his story may worry him. We ask permission to talk to Germayne about his story and to correct any misunderstandings, explaining that this would mean giving Germayne more details about his mother's absence. Ms. Anderson cautiously agrees and together we decide what words we will both use when talking about Germayne's mother.

Because Germayne's family has had a rule about not discussing his mother, we believe that he will be more comfortable starting to talk about her in individual play therapy, so we shift our plan. During one of our in-home family play therapy sessions, Ms. Anderson introduces the idea of individual play therapy to Germayne, telling him that it will be a special time for him to talk about things that worry him, even things that are not normally talked about at home (like how come his mother does not live with them). We talk about the meeting at the special playroom in our office next week.

The next session is in the office. We stage the playroom with the toys that Germayne will need to "talk" about his mother because, at his age, he will need concrete prompts to remind him of why we are here. We provide toys that developmentally will allow for both role play (for example, police hat and gun, handcuffs) and symbolic play (for example, good guy–bad guy action figures, family dolls). Germayne starts with the symbolic play, acting out the good guy–bad guy play we have seen in his play with his siblings.

As individual play therapy progresses, Germayne's play becomes focused on bad people going to jail and never getting out. We carefully (and in consultation with Ms. Anderson) choose the words that we use to overlay our interpretation of Germayne's play. In response to Germayne's play activities and his occasional questions, we talk about people who break the law, what "the law" is, how "being bad" and "making mistakes" is different from breaking the law, and how children do not go to jail when they are bad or when they make mistakes.

We also talk about mommies who don't live at home, remembering what mommies look like when you don't see them for a long time, how mommies can remember what their children look like, and how mommies can love their children from far away. Finally, we talk about sad and mad (this, usually during art activities).

Initially, the "talking" belongs exclusively to the therapist, who comments on Germayne's generally silent play. Over time, however, Germayne begins to narrate his own play, allowing us greater insight into his concerns and his misconceptions.

Ending Treatment

As they do with any therapeutic process, children and families have a way of telling us that therapy is no longer necessary. EPT draws to a close when the child and family's distress has abated and when development is back on track.

We hear from Ms. Anderson that Germayne is asking her questions about his mother at home. She is recognizing the phrases that we have agreed to use in discussing Germayne's mother, as he occasionally walks up to her and says, "Sometimes mommies have to go to jail because they broke a law" or "Mommies love kids even when they're far away."

When she reports to us that she is feeling more comfortable answering these questions concretely, we invite her to participate in Germayne's individual play therapy. In session, we begin to step back in order to facilitate Germayne's confidence in his grandmother's ability to care for him in yet another way. Ms. Anderson slowly takes over the role of correcting Germayne's misperceptions about his mother and going to jail. At home, she agrees to put a picture of Germayne's mother in his room so that he can remember what she looks like.

Germayne's play in therapy shifts again, and he becomes less interested in bad guys and jail. Instead he wants to draw and paint, but no themes are readily apparent. It appears to us that he is now able to use his grandmother to make sense of his mother's absence, so we end the dyadic session and return to the home. A handful of sessions confirm that Germayne is playing well with his brother and sister. Pointing this out, we ask Ms. Anderson if she thinks Germayne will be successful at church again, and she delightedly states that she thinks he will be "just fine."

By this time, the school district has completed its speech and language assessment and determines that Germayne is eligible for services. His articulation improves almost immediately. As we end our services, Germayne still shows delays in expressive language, but he seems to be catching up. His teachers note more participation in preschool, which is helped by finding a best friend. Ms. Anderson is attending church services regularly again. She continues to participate in the grandparents group.

TRAINING IN ECOSYSTEMIC PLAY THERAPY WITH PRESCHOOLERS

There are many theoretical models of play therapy, though most can be broadly defined as psychoanalytic, humanistic, cognitive-behavioral, developmental, and integrative. Ecosystemic play therapy is a complex integrative model (O'Connor, 2000). Training for practicing mental

health clinicians in play therapy generally and EPT specifically is largely through books, workshops, and conferences.

This process has been greatly facilitated by the Association for Play Therapy (APT), founded in 1982 by Charles Schaefer and Kevin O'Connor. This organization provides a forum for theoretically diverse professionals interested in using play as an integral component of the therapeutic process with children. Through the APT and its independent branches in most states and several countries, a broad range of workshop and online training opportunities are available to mental health clinicians, including an annual international conference with presentations from leaders in the field of play therapy.

APT has a two-tiered registration process for individuals who provide documentation that they have a traditional mental health master's or higher degree issued by a regionally accredited college or university, have been licensed or certified by one or more applicable licensing or primary certifying authorities, have completed a minimum number of play therapy training and supervision clock hours, and have completed 150 clock hours of instruction in play therapy covering the following content areas: (1) history, (2) theory, (3) techniques and methods, and (4) applications to special settings or populations. The designation as a *registered play therapist* (RPT) or *registered play therapist and supervisor* (RPT-S) only confirms the education and training requirements. (See www.A4PT.org for more information about APT, the annual conference, and registration as an RPT or RPT-S.)

Training specifically in EPT is available to practicing professionals through publications (for example, O'Connor, 1997, 2000; O'Connor & Ammen, 1997) and workshops, the most prominent of which is the ten-day Play Therapy Institute held early each summer in Monterey, California. The doctoral degree in clinical psychology at the Fresno and Sacramento campuses of the California School of Professional Psychology, Alliant International University, offers graduate students the opportunity to obtain more than 150 clock hours in play therapy training from the EPT theoretical perspective.

EPT provides students and mental health clinicians with a strong theoretical basis for mental health practice with infants and preschoolers because of its emphasis on attachment theory, development, and the ecosystem. This chapter has provided an overview of key concepts

and theories used in EPT, along with a case example of EPT used with a preschool child.

EPT-trained clinicians working with preschoolers should supplement their training with a thorough grounding in early childhood development, as well as specific assessments, diagnostic systems, and mental health interventions targeting the preschool-age group. In addition to the course work, workshops, and readings necessary to develop expertise in using EPT, clinicians should obtain supervised clinical experience with preschoolers and their families under an experienced master clinician who is certified to provide such supervision.

References

Ammen, S. (2000). A play-based teen parenting program to facilitate parent-child attachment. In H. G. Kaduson & C. E. Schaefer (Eds.), *Short-term play therapy for children* (pp. 345–369). New York: Guilford Press.

Axiline, V. (1947). *Play therapy.* Boston: Houghton Mifflin.

Benham, A. L. (2000). The observation and assessment of young children including use of the Infant-Toddler Mental Status Exam. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 249–265). New York: Guilford Press.

Bernt, C. (1999). Theraplay with failure-to-thrive infants and mothers. In E. Munns (Ed.), *Theraplay: Innovations in attachment-enhancing play therapy* (pp. 117–138). Northvale, NJ: Aronson.

Booth, P. B., & Lindaman, S. (2000). Theraplay for enhancing attachment in adopted children. In H. G. Kaduson & C. E. Schaefer (Eds.), *Short-term play therapy for children* (pp. 194–227). New York: Guilford Press.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment* (2nd ed.). New York: Basic Books.

Campbell, S. B. (2002). *Behavior problems in preschool children: Clinical and developmental issues.* New York: Guilford Press.

Drewes, A. A. (2001). Developmental considerations in play and play therapy with traumatized children. In A. A. Drewes, L. J. Carey, & C. E. Schaefer (Eds.), *School-based play therapy* (pp. 297–314). New York: Wiley.

Drewes, A. A., Carey, L. J., & Schaefer, C. E. (Eds.). (2001). *School-based play therapy.* New York: Wiley.

Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive

process analysis. In L. Rice & L. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process.* New York: Guilford Press.

Eron, J. B., & Lund, T. W. (1996). *Narrative solutions in brief therapy.* New York: Guilford Press.

Fisher, P. A., Ellis, B. H., & Chamberlain, P. (1999). Early intervention foster care: A model for preventing risk in young children who have been maltreated. *Children Services: Social Policy, Research, and Practice, 2*(3), 159–182.

Frost, J. L., Wortham, S. C., & Reifel, S. (2001). *Play and child development.* Upper Saddle River, NJ: Prentice Hall.

Gallo-Lopez, L. (2000). A creative play therapy approach to the group treatment of young sexually abused children. In H. G. Kaduson & C. E. Schaefer (Eds.), *Short-term play therapy for children* (pp. 269–295). New York: Guilford Press.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children.* New York: Lexington.

Jernberg, A. (1983). Therapeutic use of sensory-motor play. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 128–147). New York: Wiley.

Jernberg, A. M., & Booth, P. B. (1999). *Theraplay: Helping parents and children build better relationships through attachment-based play* (2nd ed.). San Francisco: Jossey-Bass.

Kaduson, H. G., & Schaefer, C. E. (2000). *Short-term play therapy for children.* New York: Guilford Press.

Knoblauch, P. J. (2001). Play therapy in a special education preschool. In A. A. Drewes, L. J. Carey, & C. E. Schaefer (Eds.), *School-based play therapy* (pp. 81–102). New York: Wiley.

Landreth, G. (1991). *Play therapy: The art of the relationship.* Muncie, IN: Accelerated Development.

Lieberman, A. F., Silverman, R., & Pawl, J. H. (2000). Infant-parent psychotherapy: Core concepts and current approaches. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 472–484). New York: Guilford Press.

Lindaman, S., Booth, P., & Chambers, C. (2000). Assessing parent-child interactions with the Marschack Interaction Method. In K. Gitlin-Weiner, A. Sandgrund, & C. E. Schaefer (Eds.), *Play diagnosis and assessment* (2nd ed., pp. 371–400). New York: Wiley.

Lyman, R. D., & Hembree-Kigin, T. L. (1994). *Mental health interventions with preschool children.* New York: Plenum.

Maury, E. H., & Monzon-Kong, M. (2002). Topic 1: Strength-based interventions. In *Learning Lab B Curriculum for infant-preschool providers.* Unpublished document. Sacramento, CA: WestEd.

McDonough, S. C. (2000). Interaction guidance: An approach for difficult-to-engage families. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 485–493). New York: Guilford Press.

Muir, E., Lojkasek, M., & Cohen, N. J. (1999). *Watch, wait, & wonder: A manual describing a dyadic infant-led approach to problems in infancy and early childhood.* Toronto, Ontario: Hincks-Dellcrest Institute.

Munns, E. (Ed.). (1999). *Theraplay: Innovations in attachment-enhancing play therapy.* Northvale, NJ: Aronson.

Nicol, R., Stretch, D., & Fundudis, T. (1993). *Preschool children in troubled families: Approaches to intervention and support.* New York: Wiley.

O'Connor, K. J. (1997). Ecosystemic play therapy. In K. J. O'Connor and L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 234–284). New York. Wiley.

O'Connor, K. J. (2000). *Play therapy primer* (2nd ed.). New York: Wiley.

O'Connor, K. J., & Ammen, S. (1997). *Play therapy treatment planning and intervention: The ecosystemic model and workbook.* Orlando: Academic Press.

O'Connor, K. J., & Braverman, L. M. (Eds.). (1997). *Play therapy theory and practice: A comparative presentation.* New York: Wiley.

Pawl, J. H., & St. John, M. (1998). *How you are is as important as what you do in making a difference for infants, toddlers, and families.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Piaget, J. (1952). *The origins of intelligence in children.* Madison, CT: International Universities Press.

Proulx, L. (2002). *Strengthening emotional ties through parent-child-dyad art therapy: Interventions with infants and preschoolers.* London: Jessica Kingsley.

Reddy, L. A., Spencer, P., Hall, T., & Rubel, E. (2001). Use of developmentally appropriate games in a child group training program for young children with attention-deficit/hyperactivity disorder. In A. A. Drewes, L. J. Carey, & C. E. Schaefer (Eds.), *School-based play therapy* (pp. 256–274). New York: Wiley.

Shelby, J. S. (2000). Brief therapy with traumatized children: A developmental perspective. In H. G. Kaduson & C. E. Schaefer (Eds.), *Short-term play therapy for children* (pp. 69–104). New York: Guilford Press.

Steiner, H. (Ed.). (1997). *Treating preschool children.* San Francisco: Jossey-Bass.

Timberlake, E. M., & Cutler, M. M. (2001). *Developmental play therapy in clinical social work.* Boston: Allyn & Bacon.

Van Dyk, A., & Wiedis, D. (2001). Sandplay and assessment techniques with preschool-age children. In A. A. Drewes, L. J. Carey, & C. E. Schaefer (Eds.), *School-based play therapy* (pp. 17–37). New York: Wiley.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood.* Ithaca, NY: Cornell University.

Westby, C. (2000). A scale for assessing development of children's play. In K. Gitlin-Weiner, A. Sandgrund, & C. E. Schaefer (Eds.), *Play diagnosis and assessment* (2nd ed., pp. 15–57). New York: Wiley.

Weston, D. R., Ivins, B., Heffron, M. C., & Sweet, N. (1997). Applied developmental theory: Formulating the centrality of relationships in early intervention: An organizational perspective. *Infants and Young Children, 9*(3), 1–12.

Willemsen, H., & Anscombe, E. (2001). Art & play group therapy for preschool children infected & affected by HIV/AIDS. *Clinical Child Psychology and Psychiatry, 6*(3), 339–350.

Wood, M., Davis, K., Swindle, F., & Quirk, C. (1996). *Developmental therapy-developmental teaching* (3rd ed.). Austin, TX: ProEd.

CHAPTER ELEVEN

Intensive Day Treatment for Very Young Traumatized Children in Residential Care

Leena Banerjee, Ph.D., and Lorraine E. Castro, M.A., M.F.T.

In the United States, sweeping mandates protect victimized children and result in their identification in large numbers each year. After a peak in 1993, the reported rate of child abuse and neglect continues to be high and was recorded at 11.8 per thousand children in 1999 (Wekerle & Wolfe, 2003). These reported cases fall into one or more of the following maltreatment categories: physical abuse, sexual abuse, emotional abuse, and neglect (MacMillan, 2000). A primary unmet health care need of children in foster care is mental health evaluation and treatment (Szilagyi, 1998). This chapter discusses some of the mental health services that can be provided to very young, traumatized, severely dysfunctional children in foster care.

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VERY YOUNG TRAUMATIZED CHILDREN

Among the children removed from the care of their families due to maltreatment are a small proportion who are very young, severely traumatized, and severely dysfunctional. Due to the severity of their needs, these young children may require residential care.

These traumatized children are at high risk for developing mental disorders and experiencing serious developmental challenges, especially in the area of socioemotional development. Developmental psychopathology indicates that combinations of risk factors, both biological and psychosocial, affect the development of mental disorders in children. In the general population, 20 percent of children and adolescents experience signs and symptoms of mental disorders, and 5 percent experience extreme functional impairments due to the disorders (Department of Health and Human Services, 2000).

Traumatized young children typically experience a preponderance of risk factors, including prenatal exposure to alcohol, tobacco, and illegal drugs, low birth weight, difficult temperaments, poverty, deprivation, abuse or neglect, parental mental health disorder, and exposure to traumatic events such as domestic and community violence. Kraemer and colleagues (Kraemer et al., 1997) have organized these and other risk factors by type of maltreatment to allow researchers to further differentiate the factors and combinations that may have causal significance in the etiology of mental disorder for children.

The *Report of the Surgeon General's Conference on Children's Mental Health* (Department of Health and Human Services, 2000) indicates that physical abuse is associated with insecure attachment (Main & Soloman, 1990), post-traumatic stress disorder, conduct disorder, attention deficit hyperactivity disorder (Famularo, Kinscherff, & Fenton, 1992), depression (Kaufman, 1991), and impaired social interactions with peers (Salzinger, Feldman, Hammer, & Rosario, 1993). Emotional abuse and neglect are associated with depression, conduct disorder, delinquency (Kazdin, Moser, Colbus, & Bell, 1985), and impaired social and cognitive functioning (Smetana & Kelly, 1989). Sexual abuse is associated with sexualized behaviors, depression, anxiety, and aggression (Wekerle & Wolfe, 2003). Traumatized young children, in general, suffer disproportionately higher rates of physical, developmental, and mental health problems as well as significant barriers in access to appropriate reparative care to ameliorate such problems (American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care, 2000).

Neural Development and Early Trauma

Some of the most recent advances in our knowledge base on early childhood have come from neuroscience. Experiences in infancy and early childhood significantly affect the development of the brain and nervous system, can permanently damage neural structures and function, and affect a person's ability to become a contributing member of society (Teicher, 2002; American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care, 2000).

Maltreated children are chronically stressed, and therefore their stress response systems are overactivated. These systems include the brain stem, which regulates key physiological systems; the locus coeruleus, a brain stem nucleus critical to arousal in response to threat; the reticular activating system, which regulates anxiety and modulates limbic and cortical processing; the hippocampus, key center for spatial memory and learning; and the amygdala, key center for processing emotion (Perry, 2003).

Maltreatment results in brain stem dysregulation, which negatively affects the functioning of higher levels of the brain (Perry, 2003). The impact may be seen in abnormalities of brain wave patterns in the frontal and temporal brain regions, limbic irritability, and dysregulation of the cerebellar vermis. Maltreatment can atrophy the amygdala and possibly the hippocampus, though the evidence on the latter is mixed (Teicher, 2002).

The greater the brain stem dysregulation and dysregulation of neurotransmitters in the chronically traumatized, the higher the chances of aggressive, impulsive, out-of-control behavior, anxiety, poor affect regulation, poor cardiovascular regulation, sleep problems, and motor hyperactivity (Perry, 2003). Building on this, the lesser the moderating impact of the limbic or cortical areas in neglectful or chaotic environments, the lesser the empathy, learning, attention, and problem-solving abilities. Traumatized children are not only at increased risk for mental disorders but also at risk for physical disorders such as hypertension, type 2 diabetes, and obesity, because their developing brains are exposed to toxic stress (Teicher, 2002; De Bellis, 2001).

Early Intervention: Why and for Whom It Makes Sense

Early environments that are nurturing and without excessive stress and that are consistent, predictable, and warm are more conducive to the development of a hemispherically integrated, less aggressive,

emotionally stable, empathic, social, and creative adult (Teicher, 2002). The effort in early intervention with traumatized young children is to capitalize on an early window of opportunity of neural plasticity that may be much harder to reach in later years, when anomalies in the brain apparatus may become more well established and may be less malleable.

Warm, positive, nurturing relationships with alternative primary caregivers and a familiar team of professionals, from social workers to therapists to nurses and physicians, are important mediating influences for a child traumatized in early, close relationships. A few such relationships in these circumstances seem to be vital to creating a sense of security, a desire to turn toward and connect with caregiving adults and feel their caring and empathy. Such experiences of collaboration and attuned interaction are vital to emotional well-being and brain development (Siegel, 1999). The new relationships can help the child in the achievement of psychosocial goals (Erikson, 1963), such as establishing a balance of trust over mistrust, of autonomy over doubt and shame, of initiative over guilt, and of industry over inferiority. They can also be useful in altering maladaptive responses to stress, such as moodiness, hyperactivity, impulsivity, and anxiety.

Perry (2003) describes *hope* as a neural phenomenon that represents an internal representation of a better world for our communities and ourselves. The development of such an internal representation, based on repairing essential ties to others, is a major goal in intervention with this population of children. When successful, intervention can build resilience and reverse intergenerational patterns of harm and violence. Very young children, who are at the highest risk for maltreatment and suffer the greatest recurrence of maltreatment (Fluke, Yuan, & Edwards, 1999), are also highly adaptable. They are, therefore, excellent candidates for early intervention services, including intensive day treatment.

INTENSIVE DAY TREATMENT FOR TRAUMATIZED YOUNG CHILDREN

For those very young, traumatized children with severe behavioral symptomatology and functional impairments that result in situations such as multiple failed foster placements and risk for psychiatric hospitalization, short-term residential care with intensive day treatment (IDT) or day rehabilitation services is appropriate to consider. Even

in situations where a severely impaired child is at home or in and out of home placement, intensive day treatment in the geographical vicinity is appropriate to consider, if it is available.

The intensive day treatment modality grew out of a combination of preschool education and psychotherapy (Lesh, Banerjee, Castro, & Zableckis, 2002). It is, therefore, a developmentally oriented therapeutic intervention that is delivered in an intensive mode. The program resembles a preschool program in its curriculum and milieu, but the training of the staff is developmental and clinical. The curriculum is therefore different from the curriculum at a regular preschool. The focus is on the emotional stabilization and healing of each child and the facilitation of socioemotional growth, which needs to precede a cognitive focus in this population (Perry, 2003). These overall goals are translated into a treatment plan for each child, with prioritized treatment goals that guide the work of the therapist and behavior specialist team in each classroom.

Children in intensive day treatment will tend to be aggressive, defiant, oppositional, assaultive, withdrawn, hyperactive, worried, anxious, and prone to regression in their eating, toileting, and sleeping behaviors (Lesh et al., 2002). They may also be self-injurious and have delusions and hallucinations. In addition, they are likely to be hypervigilant and hyperresponsive, states that interfere with attention, concentration, processing of complex information, and learning (Frankel, Boetsch, & Harmon, 1998).

The hypervigilance seems to be associated with a readiness to read danger, which was adaptive in abusive environments. Abused children, for example, have been found to be far quicker than controls to spot facial cues of fear and sadness, and they may be at greater risk of responding aggressively to nonexistent threats (Pollack, Cicchetti, Hornung, & Reed, 2000). Such high arousal behavior can impair their socioemotional development and their relationships with others in their homes, preschools, day-care settings, and in the community. In turn, their cognitive development may also be affected.

Intensive day treatment programs have typically emphasized socioemotional development, though some have integrated cognitive development in the mix. Social-skills training and academic mainstreaming have been major goals of the programs. Evaluations of intensive day treatment programs have so far been limited by small sample sizes and a lack of control groups. Nonetheless existing evaluation studies point hopefully in the following directions.

Grizenko, Papineau, and Sayegh (1993), Baenen, Stephens, and Glenwick (1986), and Gabel and Finn (1986) all report a reduction in behavioral symptoms and maintenance of these results after discharge. Other improvements include increased social skills and increased interactive play (Reams & Friedrich, 1994), which is positively correlated with social skills (Darwish, 2000). In addition, there are reported increases in self-esteem (Grizenko, 1997; Culp, Little, Letts, & Lawrence, 1991) and cognitive as well as academic improvements (Gray, Nielsen, Wood, Andresen, & Dolce, 2000). There is some available evidence that more costly and restrictive placements can be prevented through the use of intensive day treatment (Kutash & Rivera, 1996) and that reintegration into regular public school can be facilitated (Oates, Gray, Schweitzer, Kempe, & Harmon, 1995).

In summary, intensive day treatment seems to hold promise as an intervention program for severely maltreated young children. Well-designed empirical evaluations are awaited to guide further program development and refinement efforts. The existing literature on intensive day treatment indicates that the use of a theoretical orientation and multiple program components is important to meeting program objectives. A structured environment, small group size and small staff-to-child ratios are thought to be associated with positive outcomes as well (Lesh et al., 2002).

INTENSIVE DAY TREATMENT AT BIENVENIDOS CHILDREN'S CENTER

Intensive day treatment at Bienvenidos Children's Center (BCC) is just completing its third year. It is one of the programs offered to residents of Bienvenidos Village, a short-term residential care facility for very young maltreated children (Banerjee, Castro, & Stone, 2003). Nestled in the hills of Altadena, California, the village has five acres of rolling green landscape with large pine trees in which are housed the residential cottages and staff work space.

Intensive day treatment at BCC was set up as part of a unique public-private collaboration in Los Angeles County between the County Departments of Children's and Family Services (DCFS), Mental Health (DMH), and a private nonprofit provider to form a children's system of care. The children's placements occur under the direction of DCFS, as do their medical and dental treatment and care. Their psychosocial evaluations, mental health treatment, and coordination of mental health care occur through DMH.

A descriptive analysis of the ninety-four children admitted to intensive day treatment during the past two years indicates that the young children served have all experienced maltreatment. They range in age from three to eight, with approximately 25 percent between ages three and five, 50 percent between ages five and six, and 25 percent between ages six and eight. Seventy-five percent of the children are minority in ethnicity (African American and Latino), and most are male (69 percent).

Because the majority of children who are seen are minorities, issues related to color and ethnicity are important to consider in addition to their experiences of trauma. Moments of "color cognition" can themselves be experienced as "violent and visceral" for children "ignored (or injured) by overburdened families, inefficient schools and a generally neglectful society" (Lal, 2002, pp. 20, 25).

The behavioral symptoms in this severely dysfunctional group are most pronounced in the youngest and oldest children as well as in the females. The children's functioning is impaired across contexts. A key factor in their overall clinical histories is that the vast majority of them have experienced multiple placement failures due to their behavioral symptomatology and their impaired functioning. For the children, all of whom have experienced the traumas of early direct maltreatment or exposure to it as well as removal from birth families, there is retraumatization and intensification of symptomatology and impairments due to the rejection, confusion, and disorientation experienced in multiple placement failure.

Intake Assessment

Due to the very high-risk nature of the population entering the program, all children are provided a comprehensive psychosocial assessment at point of entry. The purpose of this step is to conduct a thorough analysis of each child's psychosocial impairments and needs as well as strengths, so that evidence-based, cost-effective, and targeted early intervention services can be provided as necessary.

The assessment is based on the empirically based assessment model for child assessment developed by Achenbach and McConaughy (1996). The behavior that is assessed is understood to be a result of the interplay between the individual child and the particular interactional context. It is therefore important to collect information from multiple key relationship sources and to observe the young child's actions in multiple contexts as well.

The assessment is conducted by a doctoral-level, licensed mental health clinician or by a master's level mental health clinician receiving clinical supervision from a doctoral-level licensed clinician. It contains four types of information. First, there is a multifaceted history following the Los Angeles County DMH guidelines. This includes child abuse and protective service history, family and placement history, developmental history, family mental health history, medical history, psychiatric history, school history, and past mental health treatment history. In rare cases, the areas of juvenile justice history and substance abuse history are also found applicable. The quality and extent of information available in these areas varies from assessment to assessment. However, every effort is made to obtain this information through collaboration with site social workers, county social workers, and others.

Second, behavior observations are conducted in two separate settings, such as indoor free playtime, organized center activity time, mealtime, quiet time, or outdoor free playtime. Information on interactions with birth parents and extended family members, past or prospective foster family members, or prospective adoptive family members are also incorporated from the reports of site social workers and caregivers or supervisors who have monitored these visits.

Third, there is a child clinical interview and mental status evaluation. Fourth, there are interviews with primary caregivers, site social workers, and county social workers to gain information on the child's presentation and functioning in relationships with them. Some of this information is used to complete broadband behavior rating scales, such as the Temperamental and Atypical Behavior Assessment Scale (Bagnato, Neisworth, Salvia, & Hunt, 1999) for eleven-month to four-year-olds, the Preschool and Early Childhood Education Functional Assessment Scale (Hodges, 1998) for four- to seven-year-olds, and the Child and Adolescent Functional Assessment Scale (Hodges, 2000) for seven- to eight-year-olds.

Broadband evaluation of contextual factors is also done using the Community Functioning Evaluation, in order to assess service needs and strengths. Ongoing medical and psychiatric treatment is coordinated by the site nurse and provided to the assessment team as well.

All of this information is pulled together into a developmentally oriented, clinical summary and formulation and five-axes diagnosis, based on the *Diagnostic and Statistical Manual of Mental Disorders:*

DSM IV, Text Revision (American Psychiatric Association, 2000) and reconciled where applicable with the *Diagnostic Classification: 0–3. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood,* developed by Zero to Three (1994). The overall level of functioning as captured by a score on axis V, referred to as the Global Assessment of Functioning (GAF) score, is important in making differentiations in clinical and service recommendations. These are discussed and finalized during staffing at weekly clinical meetings. The assessment process is completed within a week to allow for directed and maximum interventive services to occur during the child's short stay. In-depth developmental and psychological testing is not routinely conducted. Such evaluation occurs selectively, in consultation with DMH when clarification of specific clinical issues warrants it.

Referrals for Treatment

If referrals for mental health treatment are made following the assessment, they follow the trajectory in Figure 11.1 and are guided by the following considerations. In addition, psychiatric consultations are sought and coordinated as needed.

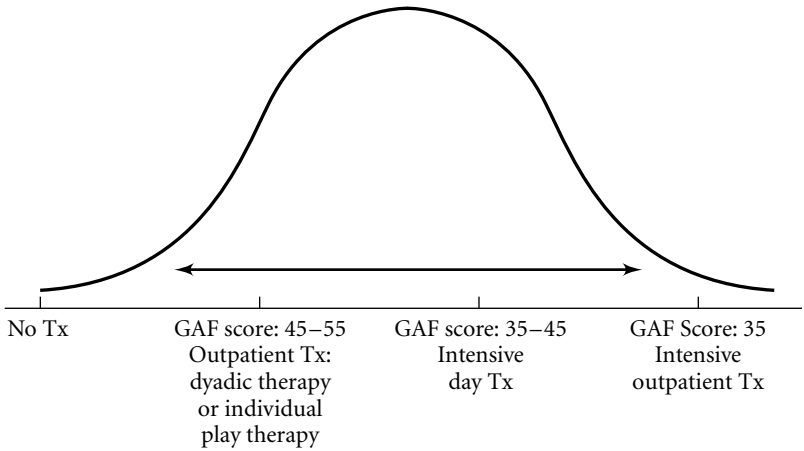

Figure 11.1. Trajectory for Mental Health Treatment Referrals.
Note: Tx = treatment; GAF = Global Assessment of Functioning.

1. If children are found to be socioemotionally resilient and unimpaired in their functioning, they require no further referral. For example, one-year-old Jake, an African American boy who had suffered extensive parental neglect since birth, had grown to rely on his bond and relationships with his siblings. He was doing well affectively, socially, and developmentally in all areas, with some lag in language development. He was referred for speech and language therapy and not referred for mental health services.

2. If children have mild impairments and symptoms, they are referred to weekly individual play therapy if they are three to eight years of age or to dyadic therapy if they are newborn to three years of age. For example, Celina, a two-year-old Hispanic American girl, was placed with her sibling cohort at Bienvenidos after removal from their parents' care. She had suffered physical abuse, emotional abuse, and general neglect and had witnessed parental domestic violence. She had difficulty falling asleep, was impulsive and aggressive, often communicated by hitting others or scratching their faces, and screamed every time her hair was combed. She was referred to dyadic treatment with her caregiver to address her impulsive-aggressive-anxious behaviors as well as her hyperreactivity to having her hair combed.

3. If children are assessed to have moderate to severe symptoms and impairments and have no significant cognitive delays, they are referred to intensive day treatment. These delays are ruled out by using a quick screen (that is, the matrices subtest of the Kaufman Brief Intelligence Scale) (Kaufman & Kaufman, 1990), as children with these delays have not been shown to gain from the short-term treatment modality that we offer (Cohen, Bradley, & Kolers, 1987). A nonverbal measure of cognitive functioning is used to get an accurate assessment of the child's abilities and prevent underestimation of them, a problem frequently experienced by vulnerable, minority children and youth who have lacked stimulation and developmental opportunities.

Regus, a four-year-old African American boy, suffered endangerment in the care of a young and depressed mother and had failed placements with his sister toward whom he acted out a great deal of rage and jealousy. Several times each day, in a variety of interpersonal interactions, Regus would fly into a rage—baring his knuckles aggressively, hitting, kicking, and cursing at others, and destroying property. He was referred to intensive day treatment to help him cope with these intense feelings and to learn to express them in socially appropriate ways. The goal was to allow Regus to maintain and build social relationships.

4. If children fall in the third category but are too fragile for treatment in a milieu setting, they are referred to intensive outpatient therapy as a preparation for intensive day treatment. In this program, they receive daily group therapy and daily individual play therapy.

In cases where family therapy is appropriate prior to reunification with the birth family or to facilitate transition into a new foster family, services are provided following day treatment. This occurs through outpatient services prior to discharge from BCC.

Deana, an African American girl of six, was in IDT for several months, when out of the blue, news of her mother reentering her life came up. Deana had deep and unresolved issues of abandonment and lack of safety relative to her mother, borne out of multiple experiences of victimization. She decompensated quickly into a mania, running out of IDT into the street, attempting to undress in public, and throwing tantrums many times each day. She needed to be removed from the structure and stimulation of the milieu to a more individualized treatment context to stabilize her, prevent hospitalization, and allow her to eventually return to IDT.

Intensive Day Treatment Programming

Intensive day treatment occurs within the continuum of services at BCC. Children receive mental health intervention for four and a half hours each day, five days each week. In addition, they live at the BCC Village and have a structured and nurturing environment created by a system of primary caregiving and small ratios of one caregiver to every three children.

The milieu has been created for young children with their safety, curiosity, and abilities in mind, and their routines are carefully and thoughtfully structured. The children attend one of the two day treatment classrooms that are separated by age (three to five years and six to eight years). Each class has a master's or doctoral-level mental health clinician heading the class and a team of two and a half additional behavior specialists, one with at least an associate degree and one with at least a bachelor's degree and experience in working with young children.

The three members of the clinical team in intensive day treatment work with a maximum of eight children, keeping the staff-to-child ratio low. The day consists of three program components, beginning with three hours of milieu therapy in the classroom, divided between indoor and outdoor time.

Socialization skills are modeled and reinforced in this context using a token system as well as encouragement and praise. The identification, labeling, and appropriate communication of feelings is taught and facilitated. Conflict resolution and impulsivity and aggression control are also taught through redirection, modeling, and role-play. A social-skills curriculum that was developed by McGinnis and Goldstein (1990) is used. Cognitive skills and competencies as well as physical development activities are provided, but the focus is on socioemotional development and healing.

After the milieu therapy, reintegration occurs for an hour and a half. During this time, behavior specialists take the children back to their cottages and stay there to work together with the primary caregiving staff on socialization skills. They start with lunch, clean up, and stay through an art or play project and the start of quiet time. This affords the staff in residence and in day treatment time to dialogue and come together regarding the care, needs, sensitivities, and progress of each child. It is analogous to working with parents and children and integrating care, insights, and experiences at home with those in the treatment setting.

During the reintegration time, the therapist for each classroom takes each child in the class for individual play therapy twice a week. During this time, the therapeutic relationship with each child is deepened and play is used to express, resolve, and heal emotional trauma.

Program Goals and Theoretical Orientation

The BCC program is motivated by the humanitarian and practical goals of achieving stable residence at discharge as well as successful school adjustment and wherever possible mainstream classroom placement. The nature of the population at the residence is such that the majority of children have either had very erratic or no contact with birth families and need long-term kinship or foster placement. Though family reunification is theoretically being pursued, the families are frequently either unable to make regular contact with their children or have completely disappeared from the picture.

For a small proportion, birth family contact is active, and appropriate services, such as family therapy, monitoring of visits if required, court testimony, and preparation for reunification, are provided. For another small proportion for whom permanency planning has already occurred and parental rights have already been terminated,

foster-adopt or adoptive family placement issues are coordinated in a similar fashion by site social workers.

The theoretical orientation of the program is developmental and relational. The program is delivered with an awareness of multicultural issues in a humanistic attitude of unconditional positive regard. The operating assumptions of the program, therefore, are that organic processes of growth in the young child and the young brain occur in interaction with the caregivers and caregiving environments at expectable times, with variation for individual differences and cultures.

Trauma, when it occurs in the context of primary caregiving relationships by acts of commission or omission involved in maltreatment, results in developmental arrests or regressions that manifest as symptoms and functional impairments. Repair of trust in others can come from reparative experiences in primary caregiving relationships and through therapeutic relationships. This facilitates trust in oneself, fuels exploration of the environment, and assists in the acquisition of age-appropriate competencies, along with willpower and purposefulness.

As such experiences accumulate, so do experiences of joy and enjoyment and the basic human capacity to hope. International research on child resiliency (Grotberg, 1998) indicates that these experiences emerge as children develop self-confidence and a positive sense of self-worth, experience dependable, nurturing relationships and role models, and develop age-appropriate skills and competencies.

As the first three-year contract on this intensive day treatment program rolls over, one of the changes being implemented through Los Angeles County's initiative is to differentiate between intensive day treatment and day rehabilitation programs by level of intensity of service needs and programming. In the new contract year, moderately impaired children will be assigned to day rehabilitation, with a therapist, two and a half behavior specialists, and ten children (in place of eight) per classroom.

The severely impaired children will go to intensive outpatient therapy to stabilize and prepare for placement in intensive day treatment or day rehabilitation based on assessed severity at the time. Our clinical experience indicates that many severely impaired children find a half day of intensive day treatment too socially threatening and demanding and need more individualized treatment. It is therefore important for there to be a good fit between treatment modality and severity of impairments.

CASE EXAMPLE

Five-year-old Ana came to BCC with her brother, having been removed from the care of their mother and after having failed four foster placements. Ana's mother had a history of substance abuse and neglect of her children. She had entered a residential detoxification program, was receiving therapy, and was making visits to see her children.

Ana presented with intense anxiety, accident-proneness, self-injurious behaviors such as poking her eyes with a finger or a pencil, picking her skin, and making self-deprecating statements. She had restricted, incongruous affect and was also shy and dependent with adults and bossy and rivalrous with peers.

Ana had developmental arrests at the first psychosocial stage of trust versus mistrust, in the second phase of self-regulation, as well as in the second psychosocial stage of autonomy versus doubt and shame. In other words, she was amenable to approaching and connecting with others, but she was prone to affective and behavioral dysregulation in doing so, and she was struggling with establishing an appropriate sense of autonomy as well.

Ana's treatment goals were (1) to increase her trust and self-regulation by increasing her socializing with peers while utilizing appropriate boundaries five to seven times a week, (2) to increase her safety by reducing unsafe behaviors from five to seven times a week down to one to two times a week, (3) to increase her autonomy and self-regulation by verbalizing her feelings appropriately from one to three times a week up to five to six times a week, and (4) to learn to speak for herself and not for others from two to three times a week up to five to six times a week.

In the milieu in IDT, she was given consistent encouragement and positive feedback on her appropriate behaviors and was rewarded for daily goal achievement. Modeling, matching with similar-level peers, and peer mentoring were used to help her learn to "play with her friends," in her own words. Reminders to be safe and recognition of appropriate behaviors were given with high frequency every day both in the classroom milieu and in her cottage during reintegration. In play therapy, the therapist built trust and initiated dialogue and play. Ana, a shy girl in milieu, was a "chatterbox" in play therapy.

The natal scene of being removed from her mother seemed to be a primary trauma for her, in which she felt like she "was waiting forever" to be protected and kept safe. Self-blame for her mother's alcohol use and finally anger at her mother for the neglect surfaced progressively and was supportively processed.

Now awaiting discharge after three three-month cycles of IDT, Ana's self-injurious behaviors and self-disparaging remarks have disappeared completely. She expresses her feelings clearly and appropriately, asking adults for help with intense feelings by saying that she "needs to talk." She engages actively with her peers, sharing her bright

ideas and her affection appropriately. Ana's developmental abilities to trust others and be appropriately autonomous have blossomed, and she is moving on to take initiative in her social world.

Ana is currently awaiting placement direction from the court. After that, closure issues and transition to reunification will be addressed. Ana's socioemotional healing gives hope for successful placement and school functioning in the future.

TRAINING AND SUPERVISION

Staff at Bienvenidos Children's Center, both paraprofessional and professional, receive monthly training in child development topics and parenting issues. In addition, daily and weekly supervisory support is provided at all levels for processing and integration of new materials and new and ongoing issues. The paraprofessional staff is scheduled once a month for a full day of training. For that day, they have no line responsibilities.

The topics that the trainings cover run the gamut of child development, child protection, and child-care issues that staff must understand in order to offer competent nurturing caregiving. Topics such as CPR and first aid training and PART training are covered annually to ensure the children's physical well-being.

Issues pertaining to developmental psychopathology, diagnosis, treatment planning, interventions, countertransference, interdisciplinary collaboration, leadership, and advocacy are provided to the clinical professional staff in weekly individual and group supervision by licensed and experienced clinicians. Current literature is reviewed and discussed so as to integrate it into program practice. This is done once per month in a clinical study circle.

In addition, staff members are exposed to the workings of the various aspects of the protective system, including dependency court. Two other issues—multicultural knowledge, awareness, and skills and staff burnout prevention and rejuvenation—are also routinely woven into the trainings.

Consistent supervision of staff is necessary. At BCC, lack of involvement from supervisory staff is often interpreted as a lack of caring for the staff, the children, and the outcomes on the part of caregiving staff. At the same time, acknowledgment of work well done by staff goes further than any other type of incentive or reward.

STANDARDS, COMPETENCIES, AND SCOPE OF PRACTICE FOR PARAPROFESSIONALS AND PROFESSIONALS

As one of the original three residential shelters for young children in Southern California and the only remaining one, BCC was involved in a collaborative effort with other community agencies and the legislature to create standards of care for the residential setting. These standards eventually became part of California Assembly Bill 1197, in 1993, which led to regulatory changes in Title XXII under California's Community Care Licensing. These new regulations applied specifically to children under age six in group care and mandated many of the operating criteria, such as a one-to-three caregiver-to-child ratio as a minimum standard for children of this age group.

Another critical standard for young children is the assignment of primary caregiving responsibilities to provide the maximum familiarity, safety, bonding, and emotional stabilization to young children in the residential care process. At BCC, each child has assigned primary caregivers who provide daily care in eight-hour shifts.

Critical human qualities that cut across paraprofessionals and professionals in the program are natural human warmth, compassion, and dedication that translate into a commitment to learn about and serve in the healing and rehabilitation process of traumatized young children. Other qualities such as patience, resilience, and openness to learning and growth in order to do the job well are important.

Knowledge, skills, and awareness in the areas of child development, child rearing and parenting practices that facilitate development, child trauma, and multicultural issues are also essential at all levels of the program. Finally, and equally as important, is the ability to work collaboratively in an environment that is made up of paraprofessionals as well as professionals across disciplines.

At the Bienvenidos Village, a central focus was placed on creating a climate of nurturance and interdisciplinary collaboration from the outset. The tone for this was set from the top, such that the program is administered in an accessible, transparent manner. Staff have clear role expectations and responsibilities as well as support. There is a clear and operative hierarchy by which decision making occurs and responsibilities are shouldered.

At the same time, the feel of the environment is collaborative due to the value placed on coming together to serve the children and the openness of the communications systems that create strong working

relationships. This is obviously important for the professionals and paraprofessionals on staff, but it is also very important for the children because it is a model of appropriate adult behaviors, something that has not typically been present in their lives.

Staff at all levels are asked to understand child development issues and child-rearing beliefs and practices relative to the nature of the trauma and chaos that the children have experienced. Such experiences can result in regressed behaviors that the staff would not ordinarily expect to see in another population of similarly aged children.

What that means is that the staff do not pull the thumbs out of the mouths of three-year-olds, nor do they impose toilet training on a child of the correct developmental age unless a complete assessment has been done and it would be an appropriate goal for the child. The ability to withhold their own beliefs about child rearing can be especially difficult for staff and can initially conflict with the behaviors the program asks of them.

The ongoing training, supervision, and support are vital to shaping appropriate staff behaviors in the program. Due to the existing village culture, new staff whose behavior falls outside the nurturing guidelines that the culture has created are mentored by their peers. If behaviors cannot be modified, those individuals are not retained as Bienvenidos employees.

Acquiring Skills to Provide Services in Intensive Day Treatment Settings

Persons who aspire to work in intensive day treatment settings can acquire the necessary skills through a variety of sources. On the paraprofessional level, classes are offered at neighboring community colleges on child development, psychology, and child care in day-care settings. There are combinations of courses that lead to certifications for those who want to work in the child development arena or in preschool settings.

Volunteering in an actual setting is probably the best source of firsthand training for paraprofessional and professional staff. Having a strong theoretical basis provides a foundation, but experience is truly the best teacher, especially when one is afforded the observation of highly competent staff interacting appropriately in all types of situations with children. It is also important for seasoned professional and supervisory staff to take frequent opportunities to observe new staff and their interaction within their context in the program.

Hiring New Staff: Recommended Questions and Issues for Exploration

Young children in residential care and in day treatment are at risk emotionally. They are undergoing the most rapid, richest period of the entire human growth experiences, while at the same time having to suffer one of the most potentially damaging psychosocial injuries: separation from family. Separation is always experienced as trauma, even when the child is removed to a safer, more nurturing stable environment.

Younger children can regress in their adaptive skills and can become more clingy and demanding. Staff who provide direct care must have training and experience in child maltreatment in order to react appropriately to the children's presenting behaviors in these types of situations.

The screening process that BCC uses in hiring paraprofessionals includes consideration of education, experiences, and attitudes. Although an associate degree is preferred, someone who has a high school degree and who has taken classes in child development or worked at a therapeutic day care may be an appropriate, nurturing paraprofessional staff member.

Day treatment therapists are required to have master's or doctoral-level training in a mental health profession, and their support staff should have bachelor's or associate-level training in the area as well as field experience. Most important, factors such as experience and interpersonal abilities are considered. Daniel Goleman (1995), in his book *Emotional Intelligence,* addresses one of the primary factors that make one staff person more effective than another. *Emotional intelligence,* or EI, is the ability to read the cues of others by their facial expressions, body language, and tone of speech, in order to react to them in an appropriate way. EI also supports the appropriate interpretation of any given social interaction witnessed.

Many of the families of the maltreated children have severe inabilities in their responsivity to interpersonal cues. The children therefore may not have learned how to express their desires and needs through socially acceptable means. If staff have sufficient EI and training to understand what an appropriate reaction to a given situation would be for a child within that child's context of interaction, they will spontaneously model that behavior for the child.

One of the most important belief areas to explore with potential staff at any level is their own history and attitudes in terms of discipline.

Discipline must be viewed as an educational process that is delivered in a manner appropriate to the developmental level of the child. A uniform discipline policy based on age alone will never take into consideration each child's individual developmental capacity to learn from the intervention.

In addition, there needs to be realistic expectations of the child considering the developmental arrests that may be operative due to trauma. Many of these areas can be explored during the hiring process by a two-person interview team who ask open-ended questions, which involve the candidate's ability to "think on her feet." Giving hypothetical scenarios from which the potential employee must explain her analysis of the factors involved and how she would respond in those instances provides valuable information on attitudes and abilities to problem solve. Staff who are unable to think abstractly and appear to have rigid personalities and worldviews are less likely to do well in this type of setting.

It is essential to determine whether a newly hired staff member is competent for the job early in the process. This can only happen through conscientious oversight from the start. Competency must be expected in the interactions with the children, in completing progress notes in a timely manner, in teamwork, in dealing with the public, and in being self-motivated to complete all required tasks independently, without the need for constant supervision.

In addition, professional staff must be able to manage their countertransference issues and know when to seek additional supervision and how to make good use of it. At BCC, we have learned that serving high-risk preschoolers needs to be accomplished by low-risk hires.

On the paraprofessional level, BCC recently celebrated fifteen years of continuous employment for eleven staff, who have been with the agency since the doors first opened in 1987. Because retention of good staff is just as important an issue as the hiring of new competent staff, a system that recognizes individuals for best practices and rewards their dedication with acknowledgment is an essential part of programming as well. In the end, this staff is essential to the process of healing young maltreated children and contributing to planting seeds of hope in their lives and in our collective futures.

References

Achenbach, T. M., & McConaughy, S. H. (1996). *Empirically based assessment of child and adolescent psychopathology: Practical applications* (2nd ed.). Thousand Oaks, CA: Sage.

American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care. (2000). Developmental issues for young children in foster care, *Pediatrics, 106*(5), 1145–1150.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th. ed., Text Revision). Washington, DC: Author

Baenen, R. S., Stephens, M. A., & Glenwick, D. S. (1986). Outcome of psychoeducational day school programs: A review. *American Journal of Orthopsychiatry, 56,* 263–270.

Bagnato, S. J., Neisworth, J. T., Salvia, J., & Hunt, F. M. (1999). *Temperament and Atypical Behavior Scale: Early childhood indicators of developmental dysfunction.* Baltimore: Brookes.

Banerjee, L., Castro, L., & Stone, N. (2003). Early intervention and children's system of care: A three part exposition of the challenges of direct service, quality assurance and advocacy. *Psychological Foundations, The Journal, IV*(2), 172–181.

Caspi, A., McClay, J., Moffitt, T. E., Mill, J., Martin, J., Craig, I. W., Taylor, A., & Poulton, R. (2002). Role of genotype in the cycle of violence in maltreated children. *Science, 297,* 851–854.

Cohen, N. J., Bradley, S., & Kolers, N. (1987). Outcome evaluation of a therapeutic day treatment program for delayed and disturbed preschoolers. *Journal of the American Academy of Child and Adolescent Psychiatry, 26,* 687–693.

Culp, R. E., Little, V., Letts, D., & Lawrence, H. (1991). Maltreated children's self concept: Effects of a comprehensive treatment program. *American Journal of Orthopsychiatry, 61,* 114–121.

Darwish, D. (2000). A comparison of maltreated and non-maltreated preschoolers' social skills and play in peer interactions. *Dissertations Abstracts International, 60*(3559).

De Bellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. *Development and Psychopathology, 13,* 539–564.

Department of Health and Human Services. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Author. [http://www.surgeongeneral.gov/topics/cmh/childreport.htm].

Diagnostic classification: 0–3. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (1994). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Erikson, E. (1963). *Childhood and society.* New York: Norton.

Famularo, R., Kinscherff, R., & Fenton, T. (1992). Psychiatric diagnoses of maltreated children: Preliminary findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 863–867.

Fluke, J. D., Yuan, Y. T., & Edwards, M. (1999). Recurrence of maltreatment: An application of the National Child Abuse and Neglect Data System. *Child Abuse and Neglect, 7,* 633–650.

Frankel, K. A., Boetsch, E. A., & Harmon, R. J. (1998). Elevated picture comparison scores: A possible indicator of hypervigilance in maltreated preschoolers. *Child Abuse and Neglect: The International Journal, 24,* 63–70.

Gabel, S., & Finn, S. (1986). Outcome in children's day treatment programs. *International Journal of Partial Hospitalization, 3,* 261–271.

Goleman, D. (1995). *Emotional intelligence.* New York: Bantam Books.

Gray, J., Nielsen, D. R., Wood, L. E., Andresen, M., & Dolce, K. (2000). Academic progress of children who attended a preschool for abused children: A follow up of the Keepsafe Project. *Child Abuse and Neglect, 24*(1), 25–32.

Grizenko, N. (1997). Outcome of multimodal day treatment for children with severe behavior problems: A five year follow up. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(7), 989–997.

Grizenko, N., Papineau, D., & Sayegh, L. (1993). Effectiveness of a multimodal day treatment program for children with disruptive behavior problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(1), 127–134.

Grotberg, E. (1998, Spring). I am, I have, I can: What families worldwide taught us about resilience. *Reaching Today's Youth, 2*(3), 36–39.

Hodges, K. (1998). *Preschool and Early Childhood Functional Assessment Scale.* Ann Arbor, MI: Kay Hodges.

Hodges, K. (2000). *Child and Adolescent Functional Assessment Scale.* Ann Arbor, MI: Kay Hodges.

Kaufman, J. (1991). Depressive disorders in maltreated children. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 257–265.

Kaufman, A. S., & Kaufman, N. L. (1990). *K-BIT: Kaufman Brief Intelligence Test.* Circle Pines, MN: American Guidance Service.

Kazdin, A. E., Moser, J., Colbus, D., & Bell, R. (1985). Depressive symptoms among physically abused and psychiatrically disturbed children. *Journal of Abnormal Psychology, 94,* 298–307.

Kraemer, H. C., Kazdin, A. E., Offord, D. R., Kessler, R. C., Jensen, P. S., & Kupfer, D. J. (1997). Coming to terms with the terms of risk. *Archives of General Psychiatry, 54,* 337–343.

Kutash, K., & Rivera, V. R. (1996). *What works in children's mental health services: Uncovering answers to critical questions.* Baltimore: Brookes.

Lal, S. (2002). Giving children security: Mamie Phipps Clark and the racialization of child psychology. *American Psychologist, 57*(1), 20–28.

Lesh, A. T., Banerjee, L., Castro, L., & Zableckis, D. (2002, May–June). Innovative children's services: Intensive day treatment at Bienvenidos Children's Center. *Los Angeles Psychologist, 16*(3), 22–25.

MacMillan, H. L. (2000). Child maltreatment: What we know in the year 2000. *Canadian Journal of Psychiatry, 45,* 702–709.

Main, M., & Soloman, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment during preschool years* (pp. 121–160). Chicago: University of Chicago Press.

McGinnis, E., & Goldstein, A. (1990). *Skill streaming in early childhood.* Champaign, IL: Research Press.

Oates, R., Gray, J., Schweitzer, L., Kempe, R., & Harmon, R. (1995). A therapeutic preschooler for abused children. *Child Abuse and Neglect, 19,* 1379–1386.

Perry, B. (2003). *Nature and nurture of brain development.* Paper presented at From Neurons to Neighborhoods Conference, Los Angeles, CA. [http://www.childtrauma.org].

Pollack, S. D., Cicchetti, D., Hornung, K., & Reed, A. (2000). Recognizing emotion in faces: Developmental effects of child abuse and neglect, *Developmental Psychology, 36,* 679–688.

Reams, R., & Friedrich, W. (1994). The efficacy of time-limited play therapy with maltreated preschoolers. *Journal of Clinical Psychology, 50*(6), 889–899.

Salzinger, S., Feldman, R. S., Hammer, M., & Rosario, M. (1993). The effects of physical abuse on children's social relationships. *Child Development, 64,* 169–187.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York: Guilford Press.

Smetana, J. G., & Kelly, M. (1989). Social cognition in maltreated children. In D. Cichetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 620–646). New York: Cambridge University Press.

Szilagyi, M. (1998). The pediatrician and the child in foster care. *Pediatrics in Review, 19*(2), 39–49.

Teicher, M. H. (2002, March). Scars that won't heal: The neurobiology of child abuse. *Scientific American, 19*(2), 68–75.

Wekerle, C., & Wolfe, D. A. (2003). Child maltreatment. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (pp. 632–684). New York: Guilford Press.

CHAPTER TWELVE

Kitchen Therapy and Beyond

Mental Health Services for Young Children in Alternative Settings

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The title of this chapter borrows from Selma Fraiberg's classic treatise on infant mental health (Fraiberg, 1987), in which she refers to infant mental health intervention as "psychotherapy in the kitchen" (p. 100). These words underscore the power of infant mental health service delivery in a setting in which the participant feels comfortable, secure, and contained. Although Fraiberg's work was typically conducted in the home environment, there are many other venues that provide the intimacy and familiarity that may enhance mental health service delivery to young children and families. Such settings capitalize on day-to-day experiences of young children and their parents, which can be incorporated into mental health interventions. Services provided in these contexts may be more acceptable and beneficial to high-risk families in particular (for example, Knitzer, 2000; Harden, 1997).

This chapter considers the delivery of mental health services to young children in these alternative settings. The basic principles of infant- and young-child mental health practice are briefly reviewed, with a consideration of how these principles can be integrated into existing service settings. However, the main thrust of this chapter is to

address the unique approaches and essential strategies for *delivering* young-child mental health services in alternative settings. Particular emphasis will be placed on mental health intervention with high-risk families in their homes, in early childhood centers, and in settings that provide other services. Exemplars of young mental health initiatives will be provided throughout the chapter.

PRINCIPLES OF YOUNG-CHILD MENTAL HEALTH

Mental health intervention with young children is informed by the tenets of various theoretical frameworks and the practices of multiple professional disciplines. For example, the field of infant mental health has been defined as "multidisciplinary approaches to enhancing the social and emotional competence of infants in their biological, relationship, and cultural contexts" (Zeanah & Zeanah, 2001, p. 14). In a more expanded definition, Knitzer (2000) describes early childhood mental health intervention as an array of strategies to promote the social-emotional well-being of young children, to help families support their children's social-emotional development, to enhance the capacity of nonfamilial caregivers to promote social-emotional well-being, and to ensure the receipt of mental health services to young children who need them.

Several core principles of young-child mental health programs have been articulated in the literature (Zeanah & Zeanah, 2001; Weatherston, 2000). The overarching principle is that relationships (for example, parent-child, family-interventionist) are the conduit for change in the children and families served. Other principles include promoting positive parent-child interaction, focusing on the development of the child, following the cues of the child and parent, affirming the parent's positive identity, and training parents on specific child management techniques.

Scholars and practitioners have advocated for incorporating such mental health principles into the services provided in home visiting, child-care, early intervention, health, and judicial settings. Graham, White, Clarke, and Adams (2001) have delineated four principles that traverse all such programs: strengthening the caregiver-child relationship, responsive caregiving, continuity of care, and emotional nurturance. Similarly, Knitzer (2000) underscores the potency of a relationship-based approach and further postulates that the use of

clinical supervision, on-site consultation, and system of care (that is, wraparound) efforts will optimize mental health service provision in these settings. We now turn to describing specific strategies for delivering mental health intervention to young children and their families in these various settings.

MENTAL HEALTH SERVICES IN HOME SETTINGS

Home-based intervention programs for young children have burgeoned in the last few decades (see Gomby, 1999). Historically, these programs have targeted young children's physical health and cognitive-language development (Klass, 2000; Gomby, 1999). Recently, several attachment-based infant mental health interventions in the home have been reported in the clinical and research literature. These home-based models exemplify many practice strategies that should be undertaken to optimize the benefits of such programs for families of young children (see Weatherston, 2000).

First, successful programs tend to focus on parent-child interaction, instead of individual parent psychotherapy or child-directed services. Second, therapists create emotional connections with the families, which in many ways offer experiences that "correct" their perceptions of interpersonal relationships as inherently hostile, unpredictable, and untrustworthy (see Lieberman, Weston, & Pawl, 1991). Developmental guidance is also provided for these families, who often have inaccurate developmental expectations for their children. This guidance is not provided didactically, but in the context of the interactional experiences in which the therapist can coach the parents to respond to their children in a developmentally appropriate manner. Finally, addressing families' concrete needs are often components of such programs, particularly if they are serving environmentally at-risk families.

For example, the Parent Child Communication Coaching program was designed to promote healthy mother-child relationship outcomes among low-income pregnant mothers (Solchany, Sligar, & Barnard, 2002). The program focuses on five different elements of a healthy pregnancy: (1) acceptance of the pregnancy, (2) creation of a fantasy baby, (3) development of parenting behaviors, (4) redefinition of the self, and (5) reworking of personal relationships. Following the intervention, mothers were more aware of the fetus, the maternal role, and their support systems and expressed more comfort relating to professionals.

In a program for mothers at risk for attachment disorders, infant-parent psychotherapy was provided in the home for one year (Lieberman et al., 1991). Therapists focused on the affective experiences of the mother and child, and particularly the mother's psychological conflicts about her child. Developmental intervention was provided in the context of the interaction and focused primarily on attachment-related behaviors. Although intervention dyads were not more likely to be securely attached than controls, they engaged in more frequent partnered interactions. In addition, mothers in the intervention group expressed greater empathy toward their children and communicated more frequently with them. Infants expressed less anger, demonstrated less avoidance, and were less resistant to maternal requests.

Employing a combination home- and clinic-based model, Heinicke and colleagues (1999) provided mental health services to mothers at risk for psychological difficulties for two years. Therapists focused on "enhancing the mother's communication and personal adaptation, alternate approaches to her relationships to her child and direct affirmation and support" (p. 356). After the intervention, mothers were less likely to be restrictive and punitive and more likely to promote their infants' autonomy. Infants were less likely to be insecurely attached, demonstrated a greater sense of a separate self, and seemed to have greater expectations that their needs would be effectively met.

Gelfand, Teti, Seiner, and Jameson (1996) used nurses to provide home visits to depressed mothers during their infants' first year of life. Although the mothers' mental health difficulty was the primary eligibility criterion, nurses focused on promoting the health and development of the infants. To that end, the intervention consisted of enhancing the parenting skills and health care practices of the mothers. Mothers who received the intervention exhibited fewer depressive symptoms and reported fewer daily hassles than those who did not. In addition, mothers without the intervention reported fewer social supports over time, and if they were depressed, they became more punitive toward their children over time.

Mental Health Practice in the Home

The home as a mental health setting has many unique characteristics that could potentially enhance intervention effectiveness. First and foremost, although many families receiving mental health services live in high-risk environments, their homes represent bases of physical

and psychological security (Wasik & Bryant, 2001; Harden, 1997). The intimacy of the parent-infant and therapist-parent relationship is reflected in the intimacy of home-based therapeutic services. The home allows for intervention on the family's turf, which has the potential to jump-start the relationship. Families may be able to trust mental health interventionists more because they are willing to put the family's comfort and security before their own comfort and security.

In addition, the home enables the mental health therapist to witness the realities of participant families' lives. Therapists can assess the parent and child in the larger context of the household and can examine spousal relationships, sibling relationships, extended family relationships, and the quality of the global family and home environment. Family psychological resources and concrete resources can be used in the context of the treatment. For example, if there is a grandmother in the home who is a strong, positive force in the family, she can be a support in the work with the parent and child. Similarly, the provision of concrete resources can facilitate treatment and promote development of the relationship between therapist and family.

Mental health interventionists also have the opportunity to experience the day-to-day rituals and interactions of participant families in their homes. For example, infant developmental and mental health interventionists often use routines that occur in the home, such as feeding, bathing, and dressing to promote positive parent-child interaction. Mental health interventionists can serve as scaffolds during these naturally occurring interactions to support parents' emotional availability to the infant, to encourage parents to follow the infants' cues, and to facilitate parental recognition of infant signals and emotional expression.

A more traditional approach to providing young mental health services in the home is to use Floor Time (Greenspan et al., 1987; Greenspan, 1992; Wieder & Greenspan, 2001; Wieder & Greenspan, Chapter Eighteen, this volume). In this model, parents are coached to be emotionally available and to follow their child's lead in an unstructured play experience. Facilitating parents' responsiveness to their children, using their floor, furniture, toys, and household items as therapeutic props, may increase the likelihood that parents will repeat these play activities with their children when the home visitor is not present.

Special Challenges in Home Visiting

Therapists who provide mental health services in the home must contend with myriad challenges that other mental health service providers do not confront. Often families who need home-based intervention are characterized by multiple environmental risks, including family and community violence, substance use, and the many correlates of poverty such as housing instability, lack of nutrition, inadequate clothing, and poor medical care.

CONCRETE SERVICES. Although addressing concrete needs is not the typical purview of the mental health therapist, it is difficult and perhaps unethical to ignore these issues when working with a family. Mental health home visitors should be trained to provide basic case management and referral services. This is not to suggest that they take over the role of other case managers in the families' lives, but often the mental health person may be the only professional who has the knowledge of family needs and the alliance with the family to accomplish concrete goals.

In addition, there is much that can be accomplished by way of therapeutic goals through accessing concrete services. For example, issues of parental self-regulation and child responsiveness will emerge while the therapist waits with a parent and child to be seen in a public health clinic or a welfare office. Helping parents to strategize how to meet the multiple needs of their children, including concrete needs, can occur in the context of parent-child interactions or individual therapeutic discussions. It becomes essential, in the training and supervision of mental health workers who do provide case management services, to assist them to prioritize how to meet the social-emotional needs of young children and their families.

REFLECTIVE SUPERVISION. Because of the intensity of these and other experiences that home-based therapists have with families, they may require a more extensive base of support than other therapists. That being the case, the reflective supervision (Shanok, Gilkerson, Eggbeer, & Fenichel, 1995) that is an essential component of mental health service delivery may take on particular characteristics in home-based programs.

Issues of boundaries should be addressed constantly, to help therapists manage urges to take care of the family financially or psychologically. Often therapists overidentify with the children in these situations and have

to be helped with feelings of wanting to take the children home or to take care of them in a more intensive way than weekly therapy. In contrast, some therapists may be so overwhelmed with the concrete problems that families experience that they shortchange the families' psychotherapeutic experience and focus singularly on their concrete needs. Whatever the therapist's reactions, it is the responsibility of the supervisor in these situations to anticipate such issues and support direct service providers through the challenging process of setting clear boundaries with families while maintaining positive, supportive relationships with them.

SAFETY ISSUES. A discussion of home-based mental health intervention is woefully incomplete without addressing the safety issues that are inherent in this mode of service delivery. Home visitors, no matter what their educational and experiential background, may be putting themselves at some level of risk when they leave the structure and security of an agency building. Depending on the neighborhood or community they are serving, they may encounter gang activity, drug-related violence, or other by-products of impoverishment. The families that they are serving may be experiencing intrafamilial violence, substance abuse, severe mental illness, or other conditions that could endanger home visitors.

Organizational attention to the basic need for safety gives a strong message to home visitors that they are being nurtured (Harden, 1997). Home visiting organizations should provide some modicum of training to their staffs regarding safety, including basic self-defense and a focus on exiting from dangerous situations. Law enforcement agencies will often provide these services at no charge to community groups. Parents can also be helpful in advising home visitors about dangerous locations or times in the neighborhood.

In addition, training of home visitors on how to manage crises in the homes is imperative. For example, home visitors should have rehearsed protocols for responding to high-risk situations such as child maltreatment, spousal violence, and suicidality. Home visitors should also be provided with cell phones or other means of communicating with their agencies while they are in the field. Protocols can be devised to avoid misuse of these phones, as well as to inform a home visitor's supervisor quickly when a home visitor needs immediate assistance.

Finally, and perhaps most important, a home visitor should always have access to an agency supervisor for support, problem solving, or assistance in a dangerous situation or crisis. This is particularly relevant given that home visitors are often asked to work evenings and weekends when traditional agencies may be closed. Agency supervisors can rotate being on call so that someone will always be available to home visitors in the field.

MENTAL HEALTH SERVICES IN CHILD-CARE AND EARLY CHILDHOOD EDUCATION SETTINGS

Increasingly, young children are spending their entire days in child-care or early childhood education centers, such as preschools and Head Start programs (National Institute of Child Health and Human Development, 1997; Scarr, 1998). For the most part, group-care and education settings address the cognitive, language, and social development of children. Far less emphasis has traditionally been placed on the mental health needs of young children in these settings. However, there has recently been a groundswell of interest in addressing the mental health of young children in center-based care or educational programs.

For example, scholars and practitioners have registered concerns about the impact of infant child care on children's social-emotional development, particularly their attachment (Hungerford, Brownell, & Campbell, 2000). At the preschool level, teachers and caregivers who encounter children on a daily basis have observed increasing levels of behavior problems in young children (see Yoshikawa & Knitzer, 1997). The young-child mental health literature has also highlighted the importance of initiatives in this venue established at three distinct intervention tiers: (1) promotion, (2) prevention, and (3) treatment (Zeanah & Zeanah, 2001; Heffron, 2000).

Activities to Promote Mental Health

Mental health promotion activities are designed to support the social-emotional well-being of all program participants. The mental health consultant may be involved in assisting schools and centers to develop overall practice strategies that optimize the mental health of all children and families. Structural characteristics that are often indicators

of quality, such as small group size and low teacher-to-child ratios, have been found to support the social-emotional functioning of young children (National Institute of Child Health and Human Development, 1996; Lamb, 1998). Another important factor pertains to the affective quality of the center, including the relationships between the child and teacher, between parents and staff, and between frontline staff and management (Raikes, 1996; Honig, 1993).

In infant-care centers, such practices as providing each infant with a primary caregiver, maintaining continuity of care, and making a strong connection between home and school have been found to enhance the emotional experiences of young children. Experts on care for infants and toddlers assert that the infant's sense of self, connection to important adults, and behavioral adjustment are enhanced through these types of child-care experiences (Raikes, 1993; Fenichel, 1999; Phillips & Adams, 2001).

In preschool programs, promotion activities would include opportunities for children to work on self-regulation and empathy with others, an emphasis on learning and talking about emotions, and the provision of sufficient structure and choices so that behavioral problems would be diminished (Raver & Knitzer, 2002; Walker et al., 1998). Intervention studies that have utilized social problem-solving skills and peer interaction training for young children offer examples of mental health promotion activities geared at improved social skill (for example, Fantuzzo et al., 1996; Shure & Spivack, 1982).

Incorporating social-emotional components into ongoing screening and assessments of children in center-based care also helps programs focus more on this aspect of child development. Head Start programs are now mandated to complete social-emotional assessments of children on an ongoing basis (U.S. Department of Health and Human Services, 1997). Obviously, this requires that child development specialists and teachers be trained to complete these assessments. In response to the need for teacher-friendly assessments of social-emotional functioning, tools such as the Ages and Stages Questionnaire: Social Emotional (ASQ:SE) (Squires, Bricker, & Twombly, 2003) delineate behaviors to which teachers should attend to assess children's functioning in that domain.

Similarly, the integration of social-emotional issues into the ongoing curriculum, routines, and activities is essential. Some available curricula do address young children's social-emotional development (Hyson, 1994), even if it gets short shrift compared with the curricula on cognition and language. Integrating social-emotional content into

literacy activities, providing toys that encourage preschoolers to deal with social-emotional issues, and using teachers as scaffolds for emotional regulation are just some examples of how social-emotional functioning can be addressed in the day-to-day activities of the child-care–early education environment.

Prevention of Mental Health Difficulties

Preventive intervention attempts to alter risk conditions that lead to mental health problems. Parent and teacher education around children's mental health is a preventive approach that has been implemented in many programs. For infants, toddlers, and their families, Early Head Start mental health initiatives incorporate different parent education approaches. A partnership between an Early Head Start program and a university in Louisiana is delivering the Nurturing Parent Program, a group-based parent education model, to high-risk adolescent mothers in a local high school (Bavolek, Comstock, & McLaughlin, 1983). Adolescent mothers in this program may also have the opportunity to participate in an attachment-based group experience called the Circle of Security (Heller & Boris, 2004).

Webster-Stratton and colleagues have developed a program called The Incredible Years, which trains parents and teachers of preschool children to provide appropriate structure, feedback, and discipline to children who show high levels of aggression or are at risk for conduct problems (Webster-Stratton & Hammond, 1997, 1998). The parent version of this model consists of twelve weekly group sessions led by professional therapists to train parents to manage young children's behavior problems in the home. Similarly, teachers are trained to provide structure, limit setting, and behavioral reinforcement in the classroom. Both the parent and teacher versions of the program have been documented to be successful in improving problem-solving and conflict management skills in preschool children, as well as in enhancing parent-child interactions.

Parent-child interaction programs have been developed at both the infancy and preschool levels. Therapists coach the parents in how to relate more optimally to their children in the context of live interactions. At the infancy level, such programs often target parent-child dyads at risk for attachment difficulties. For example, an Early Head Start program in the District of Columbia has been awarded a grant to provide home visits and group experiences for at-risk families that capitalize on parent-infant interaction to enhance attachment in the

dyad (Harden, 2004b). At the preschool level, parent-child interaction interventions tend to focus on specific behavioral problems in the child, such as oppositionality and aggression. For example, Parent-Child Interaction Training (Chaffin et al., 2003; Eyberg & Robinson, 1982) is a behaviorally oriented model in which parents are coached by group therapists to respond more appropriately to the misbehavior of their children through praise, modeling, reinforcement, and limit setting.

An additional example of preventive mental health activities is a collaboration between a Baltimore, Maryland, Head Start Center and a university psychiatry department that created a therapeutic nursery for preschool children (Munoz-Millan & Herbert, 1998). The program is designed to provide psychiatric services to Head Start children and their families in a setting that is accessible and familiar. For the children, prevention is aimed at everyone in the classroom and focuses on three specific behaviors that are not conducive to learning and are associated with negative long-term outcomes: aggression, social withdrawal, and inattention. The program's preventive intervention for children includes a behavior management game and social-skills training. For the parents, preventive intervention entails training in parenting skills, child development, and conflict resolution.

Treatment of Diagnosed Mental Health Problems

Treatment-oriented activities represent the most conventional use of mental health consultants within child-care centers, early childhood development and education programs, and primary schools. Mental health treatment activity involves the provision of interventions for children who have been identified with a specific mental health difficulty. Because diagnoses are not often given during the birth-to-five period, these children may not have been officially designated as in need of mental health treatment.

It is often the case that mental health consultants observe children in the classroom, complete mental health assessments of the children, and identify those who require treatment. Depending on the amount of consultation time funded, the consultant may either refer the child for treatment or provide the treatment herself. Sometimes the treatment is offered individually, and at other times it is provided in small groups. Treatment may take the form of play therapy with the children, parent-child interaction therapy, family therapy, or individual therapy for parents.

The program staff of the Head Start therapeutic nursery described previously also conducts assessment, diagnosis, and treatment of identified children. Psychiatric assessment includes both variables pertaining to the child as an individual (that is, verbal skills, motor skills, social skills, temperament) and variables pertaining to the parent-child relationship (that is, interactions between the parent and child). Individualized treatment, provided for parent-child dyads deemed to be at highest risk, is threefold: (1) directed solely toward the child, (2) directed solely toward the parent, and (3) directed toward the parent-child dyad (Munoz-Millan & Herbert, 1998).

Some infant-care centers also provide psychotherapeutic interventions for families with mental health problems. Through a Head Start Bureau award, Early Head Start programs in North Carolina are able to provide individual psychotherapy to depressed mothers (Beeber, 2004). This same funding mechanism has allowed specific Early Head Start programs in Florida to provide parent-infant psychotherapy to dyads at risk for mental health difficulties due to psychological and environmental factors (Malik, 2004).

Special Challenges in Early Childhood Programs

One of the basic tenets of young-child mental health practice that is exceedingly applicable to the early childhood setting is *parallel process.* This principle postulates that if the young children in these centers are to be provided optimal care, their teachers should be nurtured by their superiors and the organization at large. This notion underscores the importance of organizational health for early childhood programs. Mental health consultants to early childhood programs are often clinicians to the organization. Their ultimate goal is to change the infrastructure of the organization so that it promotes not only the mental health of children and families served but also the mental health of the staff providing services.

Multiple infrastructure adaptations need to occur at all levels to render child-care and early childhood center organizations capable of promoting the mental health of children, parents, and staff (Knitzer, 2000; Weston, Ivins, Heffron, & Sweet, 1997). First, the commitment to change and become a more mental health–oriented organization must emanate from top management. Ideally, the agency director should participate in mental health–oriented activities and be committed to addressing her own mental health. If this is not possible, she must be willing, at the very least, to commit staff time and agency

funding to the implementation of policies and practices that promote organizational, staff, family, and child mental health. An essential step is moving beyond a narrow definition of child development that focuses on cognitive and language development to a more comprehensive perspective that includes child mental health.

A commitment to changing agency policies about staffing, recruitment and enrollment, and classroom assignment is also necessary. For example, although it does not cost more to make primary caregiver assignments in order to maintain continuity of care, many agency administrators are reluctant to do so because it goes against conventional agency practices of moving children every year. In addition, allocating funding and staff time for a different set of services is sometimes challenging for administrators who are faced with meeting multiple federal, state, and private mandates regarding child care. At any rate, consideration should be made as to the timing of service delivery (for example, beginning in pregnancy), the individualization of service delivery, and the comprehensiveness of service delivery.

An important component of promoting the mental health of a child-care or early childhood center is the existence of reflective supervision for staff (Shanok et al., 1995). This is no small feat, as child-care staff are paid to be with children in a classroom while they are at work. Time away from children for meetings, whether involving reflective supervision or not, costs the agency because of the need to retain appropriate ratios. That being the case, an agency would need to pay for substitute caregivers unless some creative approach is used to devise strategies for reflective supervision. For example, an agency might develop on-site, in vivo reflection by the supervisor while staff are working with children, or they might have less frequent reflection activities during regularly scheduled staff meetings.

The question of who should provide the "supervision" is also important. Often child-care and early childhood centers perceive supervision from the vantage point of accountability and do not regard reflective practice as important (see Chapter Six). Using supervisors for reflection who have been trained to provide supervision based on program accountability is often untenable, unless the supervisors are open to the challenge of integrating reflection and accountability in their work with staff. Using mental health consultants in this regard has the potential to encourage "splitting" (that is, agency supervisor is bad and mental health consultant is good) and to confuse the chain of authority. Whichever approach is selected, it is important to

acknowledge how difficult it is to incorporate such a model into a program that has not previously emphasized mental health.

It should be stated very clearly that programs that address the mental health needs of youngsters generally have higher and more flexible funding than those that do not. For this reason, child-care programs are often the least likely to deliver mental health services for children, particularly if they serve low-income populations.

Head Start and other comprehensive child development programs generally are funded at a higher cost-per-child level and therefore can afford to offer ancillary services such as direct mental health intervention. In addition, Head Start programs are often approached to implement collaborative projects funded under other auspices. For example, the therapeutic nursery that resulted from the university–Head Start collaboration described previously was underwritten by several sources that included university funds and public and private grants.

Child-care centers and other programs can conduct activities that do not require additional funding but require infrastructure adaptation, including changes in staffing, training content, and policy (for example, continuity of care). Leaders in the early child-care arena could disseminate ways for programs to be more flexible in how they meet state and local mandates. Child-care programs can benefit from the impetus at the federal level for the integration of Head Start and child-care programs, by drawing on the training and experiences of Head Start and other more comprehensively funded programs. Joint training activities, shared mental health consultation, and collaborative programming would allow for less-well-funded programs to deliver some of the mental health services discussed in this section.

MENTAL HEALTH SERVICES IN OTHER VENUES

Although this chapter was conceptualized to address mental health services for young children in physical settings other than the typical mental health clinic, it is important to consider the delivery of these services in specific agency–programmatic settings as well. Recent social trends have also led to a greater likelihood of early identification of vulnerable populations of families of infants who can benefit from mental health services. As a result, it behooves service settings of various types to capitalize on extant young-child mental health models

to enhance the social-emotional functioning of participant children and families. After a consideration of general mental health practice strategies that would be useful in almost any human service setting, specific strategies for delivering young-child mental health interventions in the contexts of child welfare, substance abuse, and early intervention service settings are discussed.

Mental Health Practice in Human Service Settings

Scholars and practitioners in the area of young-child mental health have long seen the need for the extension of therapeutic services beyond the traditional office (Knitzer, 2000; Osofsky, 1998). As a result, mental health practice in alternative human service settings is becoming more commonplace. Specific practice strategies are similar across these settings and allow for the optimal provision of these specialized services. This section considers practice strategies from the perspectives of assessment, intervention, and systemic factors.

ASSESSMENT. Comprehensive assessments of participant children and families are invaluable for the employment of appropriate intervention strategies in child welfare, substance abuse, and early intervention and other human service programs. Such assessments should have a mental health component, in which the social-emotional functioning of parents and children is examined. For example, screenings for parental depression (for example, CES-D) (Radloff, 1977) are readily available and should be routinely conducted. Screening tools for young-child social-emotional functioning have recently been developed (for example ASQ: SE) (Squires et al., 2003) and should be standard components of assessment protocols. Because such measures are fairly easy to administer, practitioners from various backgrounds can be trained to use them in their ongoing work with families and young children.

Mental health functioning is arguably more contingent on parent-child relationships during the birth-to-five period than at any other period of development. So the assessment of the parent-child relationship takes on increased significance for mental health service delivery. As in home visiting and early childhood programs, observation of parent-child interactions in various human service settings can provide important information about attachment, joint attention and reciprocity, parental emotional availability, and mutual responsivity in the parent-child pair.

INTERVENTION. Alicia Lieberman, a pioneer in young-child mental health intervention, has been quoted as saying, "You don't have to be a therapist to be therapeutic." Certainly, in the context of human services for high-risk families, it is often the frontline clinician, such as the child welfare worker or early interventionist, who has the most impact on the social-emotional well-being of children and parents. Clinicians working in these service settings have the opportunity to provide mental health–oriented intervention that families will not or cannot obtain from traditional mental health service settings. Given the fragmentation that can occur when multiple service providers are working with one family, it may be more beneficial for families to have only one interventionist. As such, it becomes crucial for these frontline service providers to have training, supervision, and support around delivering mental health interventions.

The field of young-child mental health is steeped in a philosophy that emphasizes the importance of a relationship-based, developmental approach to intervention. It is the affective connections between parents and children, as well as those between parents and interventionists, that become the foundation of the mental health intervention. For example, parent-child interaction is a primary strategy in many young-child mental health approaches. In service settings that have relied on individual approaches to intervention, staff have to be trained to use such dyadic approaches in their work. Service providers in the fields of child welfare, substance abuse, and early intervention can build on the relationships that parents naturally have with their children to accomplish the specific goals of their programs as well as deliver mental health–oriented services.

In addition, young-child mental health therapies are built on an understanding of the child's developmental level. For example, the evidence for symbolic play in preschool children suggests that mental health intervention for this population should capitalize on young children's involvement in fantasy and pretense as a way to resolve psychological issues. Many services for high-risk families use a parent-directed approach, which does not consider whether interventions should be informed by the developmental level of the child. For example, many parent education programs in the child welfare field are global and do not distinguish which parenting strategies may be appropriate for which developmental period (Littell & Schuerman, 1995). It is imperative that clinicians from child welfare and substance abuse gain more knowledge about the developmental issues that inform young-child mental health service delivery.

SYSTEMS ISSUES. Finally, the multiple needs of high-risk families point to the importance of a comprehensive approach to service delivery for these families. Mental health intervention should not be delivered in a vacuum. It should exist alongside child health and developmental services, parenting interventions, and services to support the well-being of the adults who are caring for the children. The burgeoning work on the development of systems of mental health care for young children begs the question of how the various systems involved in these children's lives can be integrated to best meet their needs (Knitzer, 2000).

For example, children in the child welfare system are highly likely to be drug exposed (Wulczyn, Hislop, & Harden, 2002) and are more likely to have developmental delays (Leslie, Gordon, Ganger, & Gist, 2002). However, there are few substance abuse programs that concurrently address the needs of the drug-using mother and her drug-exposed child (Kaplan-Sanoff & Lieb, 1995). In addition, infants and toddlers in the child welfare system do not receive early intervention services at the level that their rates of developmental delay would suggest (Leslie et al., 2002). This evidence calls for the integration of the multiple service strands that affect all of these children, so that a more cost-efficient, responsive, and effective set of services can be provided to them.

STAFF SUPPORTS. It is essential that there be significant funding allocations for mental health consultation for programs. Such consultants can provide mental health training and supervision to frontline staff, can consult with program managers on incorporating mental health principles into their ongoing programs, and can even provide treatment to families with particularly difficult mental health problems. Whether through consultants or external experiences, staff in each of these venues must receive training on young-child mental health in general, the specific mental health issues of the populations they serve, and the particular ways mental health services can be delivered in their programs.

Reflective supervision, which is a hallmark of mental health programs, is often absent from the experiences of staff in these programs, despite the fact that they are charged with service delivery to highly challenging populations. Consistent opportunities for reflection in a safe, supportive environment on the mental health needs of the families they are working with, on their delivery of mental health–oriented intervention, and on the use of self with families is crucial for the staff in these settings.

Staff in the child welfare system could benefit from supervision that addresses potential feelings of overidentification with the maltreated child, anger at the maltreating parent, and inadequacy in the face of the multiple problems families have. Similarly, staff working with drug-using parents may need to address their feelings of failure in facilitating abstinence in the parent and feelings that the parent will never be able to parent the child appropriately. Early intervention specialists may feel ill equipped to address mental health issues and to work with families who present with such intractable social problems. It is important that staff have regular opportunities to address these and other issues in the context of reflective supervision.

Mental Health Practice in Child Welfare

The child welfare system is charged with promoting the safety, permanency, and well-being of America's children (Berrick, 1998). As such, the child welfare system encompasses child protection investigations, preventive services for families at risk for child maltreatment, foster care placement, and adoption. Recent trends have pointed to an escalating number of young children in the child welfare system (Wulczyn et al., 2002; Chapter Nine, this volume).

The child welfare practice arena has not generally placed a priority on services uniquely designed for the young-child population. However, there are models of effective service delivery to young children in the child welfare system that may be geared to support children to remain with their biological families or to promote the well-being of children in substitute care. Some interventions are designed to assess and treat the impact of trauma that children may experience as a result of child maltreatment (Finkelhor & Berliner, 1995; Wolfe & Wekerle, 1993).

The majority of interventions are designed to assess and to promote parent-child attachment, which is arguably the most important aspect of mental health functioning for children in the child welfare system. Because of the impact of child maltreatment and multiple moves (that is, unstable foster home placements) on young children, it would be important to consider whether these children are exhibiting any symptoms of disordered attachments (Harden, 2004; Zeanah & Boris, 2000).

THERAPEUTIC PROGRAMS FOR BIOLOGICAL FAMILIES. The Family School was developed as a collaboration between a Philadelphia hospital and the Department of Human Services as an alternative to

out-of-home child placement for designated families with infant, toddler, and preschool children (Peckham, 1999). Each family attends Family School two days per week and is accompanied by their social worker on one of these days. During the school day, parents and children engage in structured and unstructured interaction experiences via thematic activities, outdoor play, and meals. In addition, parents participate in groups with a parent educator that focus on interacting with their children, child development, behavior management, and issues relevant to their personal development.

In contrast to this school-based initiative, the Infant-Parent Program (IPP) in San Francisco was developed as a home-based infant mental health program (Lieberman, 1985; Lieberman & Zeanah, 1999). This program worked in collaboration with service delivery systems already existing in the community, including child protective services. At its core, the IPP provides assessment and treatment to infants in the birth-to-three age range and to families in situations involving potential or actual child abuse and neglect. Intervention takes place primarily in the home and involves "a flexible combination of nondidactic developmental guidance, infant-parent psychotherapy, emotional support and practical assistance" (Lieberman, 1985, p. 197). The IPP therapist and the Department of Social Services (DSS) social worker jointly plan and make decisions regarding child custody, placement, and reunion. In addition, the IPP provides consultation and training to the DSS and provides clinical services to cases referred by or involved with the DSS.

ASSESSMENT AND INTERVENTION PROGRAMS FOR FOSTER CHILDREN. Because of their special status within the child welfare system, foster children are more likely to receive mental health services than their counterparts who remain with their families of origin (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Garland, Landsverk, Hough, & Ellis-McLeod, 1996). For example, a multidisciplinary assessment clinic serving children in foster care ranging from birth to forty-eight months of age was initiated in a parish in Louisiana (Zeanah et al., 2001). The clinic was designed to improve child welfare outcomes for young foster children and provided a broad array of services, including a comprehensive assessment of the child and the child-caregiver relationship, parent-infant psychotherapy, individual psychotherapy for the birth parents, a foster parent support and education group, crisis intervention, and case management.

Interestingly, fewer children receiving the intervention were reunified with their biological parents, and more were freed for adoption when compared with similar families who were in the child welfare system prior to the initiation of the intervention. The authors postulated that the intervention may have assisted caregivers in making a more expeditious permanency decision for their children.

Empirically based interventions have also been designed to address foster children's experiences through the provision of services to foster parents. For example, Dozier, Higley, Albus, and Nutter (2002) have implemented a theoretically and empirically based intervention for foster parents delivered in their homes over ten sessions. The intervention targets three caregiving needs of twelve- to twenty-four-month-old infants in the foster care system: (1) the provision of nurturing care, (2) the recognition of behavioral signals, and (3) the facilitation of behavioral regulation. Preliminary findings suggest that this intervention model has a beneficial effect on young children's behavioral regulation.

Focusing on preschool children (ages four to six), Fisher, Gunnar, Chamberlain, and Reid (2000) initiated an intervention designed to improve the behavioral functioning of young foster children and their caregivers. Both caregivers and children participate in short-term psychoeducational groups, informed by a cognitive-behavioral theoretical perspective. Families are trained to provide developmentally appropriate limit setting, quality time, praise, and positive reinforcement for positive behavior to their children. Preliminary results of this study suggest that the intervention reduces problematic behaviors in children and also has an impact on their behavioral regulation, as assessed by physiologic measures. In addition, foster parents exhibited more positive parenting strategies.

Mental Health Practice and Substance Abuse Programs

In recent decades, there have been an unprecedented number of women of childbearing age who have become substance abusers (National Institute on Drug Abuse, 1996). In particular, the cocaine epidemic has had and continues to have a devastating impact on impoverished communities and has adversely affected an entire generation of children, due primarily to the environments in which they are reared (Lester, LaGasse, & Seifer, 1998; Lester, LaGasse, & Brunner, 1997). Medical, child development, and social service professionals have

joined forces with substance abuse professionals to create programs that address the unique needs of drug-using women and their young children. These programs are generally comprehensive and attempt to meet the psychological needs of the mother, the child, and the dyad (Uziel-Miller, Lyons, Kissiel, & Love, 1998; Davis, 1997; Wobie, Eyler, Conlon, Clarke, & Behnke, 1997).

Such an approach may require a transformation of the roles assumed by many providers in other service settings. For example, counselors and therapists working with substance-using adults often take a more punitive approach to intervention (for example, confrontation, loss of privileges). Although a discussion of the merits of such an approach is beyond the scope of this chapter, certain of the strategies are inconsistent with the practice strategies extant in the young-child mental health arena.

The Infant Nursery Caregiver Parent Training (INCEPT) Program, a center-based nursery school targeted toward African American and Hispanic infants with histories of prenatal poly-drug exposure in Brooklyn, New York, is an exemplar of a substance abuse program embedded in a young-child mental health approach (Linares, Jones, Sheiber, & Rosenberg, 1999). Treatment is threefold (individual, dyadic, and systemic) and focuses on the child, the biological mother, and the foster mother. Services include infant developmental intervention, maternal counseling regarding substance abuse and entitlements, biological parent-child interaction, and intervention to support the biological parent–foster parent partnership. Evidence from a small sample of INCEPT participants revealed that children overall exhibited developmental improvements but increased externalizing behavior problems; fewer than half of the biological mothers were rated as having changed their stage of drug usage; and only 11 percent of the children were reunited with their biological mothers.

Substance abuse programs specifically designed to support families in which children live with their drug-using biological mothers are similarly intensive. In the most effective programs, such as the Women and Infants Clinic at Boston City Hospital, substance use treatment and child-directed intervention co-occur (Kaplan-Sanoff & Lieb, 1995). The clinic provides a comprehensive set of services, including pediatric care, drug treatment (for example, relapse prevention groups, urine screens, and twelve-step programs), parent support and education through weekly mother-child groups and individual sessions, as well as child intervention through developmental group play therapy.

In another project for biological mothers (Black et al., 1994), trained nurses provided biweekly home visits for a two-year period to drug-abusing women of low socioeconomic status. This was a relationship-based, ecological intervention that focused on attending to the mother's individual needs, promoting healthy parent-child interaction and development, and providing information regarding child care, child development, safety, and community resources. Mothers in the intervention group were less likely to report ongoing drug use, were more likely to complete pediatric appointments, and exhibited greater emotional and verbal responsiveness to their infants.

Mental Health Practice in Early Intervention Programs

The early intervention system, which has been charged with meeting the educational needs of children with disabilities, has had to contend with the enormous challenge of meeting the mental health needs of participant children on a variety of fronts. For example, mental health difficulties may arise from a problematic parent-child relationship. Although parental reactions to children born with any sort of disorder or disability are as varied as the types of disabilities themselves, it has been postulated that the parent-child relationship is often influenced by the parent's affective response to the child's condition (Turnbull et al., 1993). In addition, young children may present with bona fide diagnosable mental health problems as a result of biological, familial, or environmental risk factors. In addition, social-emotional risk is an eligibility criterion under Part C of the Individuals with Disabilities Education Act.

The assessment of, identification of, and intervention with young children who have mental health difficulties have lagged far behind that of children with physical or cognitive disabilities. Early intervention practitioners need to receive specific training on how to recognize mental health difficulties in young children. Incorporating a social-emotional screening tool in their developmental assessment of young children could benefit greatly in this area. In addition, early interventionists would benefit from supervisory support on how to manage potential feelings of discomfort and incompetence in dealing with mental health difficulties in children and adults.

Although early intervention practitioners with no background in mental health should not provide mental health treatment, there are various ways in which they can contribute to the mental well-being of

children in the early intervention system. For example, early interventionists can be trained to rely less on a child-directed therapeutic approach or a parent-directed didactic approach. The use of a parent-child interaction approach in all of the treatment modalities (for example, occupational therapy, physical therapy, speech therapy) is a mental health intervention (Gilkerson & Stott, 2000). That is, fostering positive parent-child interaction has the potential to address the essential social-emotional process of the infancy period—attachment.

Helping parents to focus on and promote the competence of children with disabilities has the potential to positively influence the development of self-identity and self-regulation, important social-emotional milestones of the early childhood period. In addition, assisting parents to see their children as individuals who are capable of a variety of feelings, thoughts, and behaviors could do much to positively influence the mental health of children with disabilities.

Finally, early interventionists can ensure that children who have social-emotional difficulties have an Individual Family Service Plan (IFSP) or Individual Education Plan (IEP) that delineates mental health therapy as one of the required interventions (Graham et al., 2001). It is important that young children with developmental disabilities should receive specialized interventions that address their social-emotional needs regardless of whether the mental health problems are associated with their developmental disabilities or not.

Children with pervasive developmental disorder, a significant portion of the early intervention population, represent an important example of the need for mental health services within early intervention. Because this disorder may severely affect children's language, social relationships, and behavioral functioning, these children have caught the attention of developmental and infant mental health practitioners alike (see Chapter Eighteen).

Early intervention specialists would benefit from learning the early signs and symptoms of the mental health difficulties associated with this disorder so that timely mental health referrals can be completed. Because children with this disorder should routinely receive mental health intervention as part of their IFSP or IEP, early intervention case managers in these cases could be mental health therapists. At the very least, they should be aware of the available treatment options for these children. For example, they should be able to contribute to the decision about which of the two most common approaches to mental health treatment for these children—relationship-based, developmental therapy (see Chapter Eighteen, this volume) or behaviorally

oriented treatment (for example, Lovaas, 1987)—would most benefit the child in question.

The therapeutic nursery at the Lexington School for the Deaf is an example of incorporation of mental health services for children with other disabilities. The nursery was established with a goal of strengthening the parent-child relationship, which is jeopardized by both the child's deafness and the parent's response to the deafness (Field, Blum, & Scharfman, 1993). Parent-infant dyads attend hour-and-a-half-long sessions twice per week for a minimum of eighteen months. Between two and four dyads are in the therapy room during each play-based session, with each dyad having its own therapist.

This type of intervention could be applied to children with other disabilities as well, including blindness, cognitive impairment, and motor disabilities. The mental health issues of children with less severe disabilities could be addressed through the more generic young-child mental health approaches. This includes parent-child interactional work that could be provided by an early intervention specialist with training and support regarding mental health.

Mental health intervention in the early years has the potential to alter the developmental pathways of infants and young children at risk for adverse social-emotional and other developmental outcomes. Unlike conventional psychotherapy, these interventions may be best implemented in the settings where young children spend most of their time, such as the home and early-care or education centers. Alternatively, mental health interventions can be delivered in the context of the human service programs in which families with young children are already involved. In this vein, young children and their parents can receive flexible, comprehensive interventions that best address their multiple needs during this stage of life.

Although there are considerable challenges to be faced in the incorporation of mental health services into these settings, there are multiple benefits to delivering the services in these contexts. For example, such approaches may be particularly beneficial for families at risk, who may be reluctant to participate in traditional, clinic-based therapeutic services. Moreover the interventions can capitalize on the natural interactions and routines in which families engage, thereby rendering the mental health experience more familiar for the family and more focused on the pivotal role of parent-child relationships. Facilitating staff competence to provide these services is essential. This can be

accomplished through focused training, reflective supervision, ongoing consultation, and organizational infrastructure adaptations.

The field of young-child mental health has made major strides toward becoming a powerful interdisciplinary force for the benefit of young children. As it continues to develop, it is essential that the therapeutic tools it spawns are applied to young children "where they are"—in their homes, early childhood care and development centers, and the service settings in which they are involved.

References

Bavolek, S. J., Comstock, C. C., & McLaughlin, J. A. (1983). The nurturing program: A validated approach for reducing dysfunctional family interactions. Final report, Project No. 1R01MH34862. Washington, DC: National Institute of Mental Health.

Beeber, L. (2004, February). *Supporting the mental health of children and families in Early Head Start: Part I: Therapeutic approaches.* Paper presented at the eighth annual Birth to Three Institute, Baltimore.

Berrick, J. D. (1998). When children cannot remain home: Foster family care and kinship care. *Future of Children, 8,* 72–87.

Black, M., Nair, P., Kight, C., Wachtel, R., Roby, P., & Schuler, M. (1994). Parenting and early development among children of drug-abusing women: Effects of home intervention. *Pediatrics, 94*(4), 440–448.

Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Breston, E., Balachova, T., Shultz, S., & Bonner, B. (2003). *Physical abuse treatment outcome project: Application of parent child interaction therapy to physically abusive parents.* Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect.

Clausen, J., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies, 7,* 283–296.

Davis, S. (1997). Comprehensive interventions for affecting the parenting effectiveness of chemically dependent women. *Journal of Obstetrics, Gynecology, and Neonatal Nursing, 26*(5), 604–610.

Dozier, M., Higley, E., Albus, K., & Nutter, A. (2002). Intervening with foster infants' caregivers: Targeting three critical needs. *Infant Mental Health Journal, 23*(5), 541–554.

Eyberg, S., & Robinson, E. (1982). Parent-child interaction therapy: Effects on family functioning. *Journal of Clinical Child Psychology, 11,* 130–137.

Fantuzzo, J., Sutton-Smith, B., Atkins, M., Meyers, R., Stevenson, H., Coolahan, K., Weiss, A., & Manz, P. (1996). Community-based resilient peer treatment of withdrawn maltreated children. *Journal of Consulting and Clinical Psychology, 64*(6), 1377–1386.

Fenichel, E. (Ed.). (1999). The quest for quality in infant/toddler child care. *Zero to Three, 19*(6).

Field, B., Blum, E. J., & Scharfman, H. (1993). Mental health intervention with very young children and their parents: A model based on the infant deaf. In E. Fenichel & S. Provence (Eds.), *Development in jeopardy* (pp. 9–49). Madison, CT: International Universities Press.

Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: A review and recommendations. *Journal of the American Academy of Child and Adolescent Psychiatry, 21,* 163–171.

Fisher, P., Gunnar, M., Chamberlain, P., & Reid, J. (2000). Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(11), 1356–1364.

Fraiberg, S. (1987). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In L. Fraiberg (Ed.), *Selected writings of Selma Fraiberg.* Columbus: Ohio State University Press.

Garland, A., Landsverk, J., Hough, R., & Ellis-McLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse and Neglect, 20,* 675–688.

Gelfand, D., Teti, D., Seiner, S., & Jameson, P. (1996). Helping mothers fight depression: Evaluation of a home-based intervention program for depressed mothers and their infants. *Journal of Clinical Child Psychology, 25*(4), 406–422.

Gilkerson, L., & Stott, F. M. (2000). Parent-child relationships in early intervention with infants and toddlers with disabilities and their families. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 457–471). New York: Guilford Press.

Gomby, D. (Ed.). (1999). Home visiting [Special issue]. *Future of Children, 3*(3).

Graham, M., White, B., Clarke, C., & Adams, S. (2001). Infusing infant mental health practices into front-line caregiving. *Infants and Young Children, 14*(1), 14–23.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International Universities Press.

Greenspan, S. I., Wieder, S., Lieberman, A. F., Nover, R., Lourie, R., & Robinson, M. (1987). Infants in multirisk families: Case studies in preventive intervention. *Clinical Infant Reports, No. 3.* Madison, CT: International Universities Press.

Harden, B. J. (1997). You can't do it alone: Home visiting with psychologically vulnerable families. *Zero to Three, 17*(4), 10–16.

Harden, B. J. (2004a). Safety and stability for foster children: A developmental perspective. *Future of Children, 14*(1), 31–47.

Harden, B. J. (2004b, February). *Project HAPPI (Healthy Attachment Promotion in Parents and Infants). Supporting the mental health of children and families in Early Head Start: Part I: Enhancing staff development.* Paper presented at the eighth annual Birth to Three Institute, Baltimore.

Heffron, M. C. (2000). Clarifying concepts of infant mental health: Promotion, relationship-based preventive intervention, and treatment. *Infants and Young Children, 12*(4), 14–21.

Heinicke, C., Fineman, N., Ruth, G., Recchia, S., Guthrie, D., & Rodning, C. (1999). Relationship-based intervention with at-risk mothers: Outcome in the first year of life. *Infant Mental Health Journal, 20*(4), 349–374.

Heller, S., & Boris, N. (2004, February). *Supporting the mental health of children and families in Early Head Start: Part I: Therapeutic approaches.* Paper presented at the eighth annual Birth to Three Institute, Baltimore.

Honig, A. (1993). Mental health for babies: What do theory and research teach us? *Young Children, 48,* 69–76.

Hungerford, A., Brownell, C. A., & Campbell, S. B. (2000). Child care in infancy: A transactional perspective. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 519–532). New York: Guilford Press.

Hyson, M. (1994). *The emotional development of young children: Building an emotion-centered curriculum.* New York: Teachers College Press.

Kaplan-Sanoff, M., & Lieb, S. (1995). Model intervention programs for mothers and children impacted by substance abuse. *Family Relations, 24*(2), 186–200.

Klass, C. (2000). *The home visitor's guidebook.* Baltimore: Brookes.

Knitzer, J. (2000). Early childhood mental health services: A policy and systems development perspective. In J. Shonkoff & S. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 416–438). New York: Cambridge University Press.

Lamb, M. (1998). Nonparental child care: Context, quality, correlates. In W. Damon, I. Sigel, & K. Renninger (Eds.), *Handbook of child psychology* (pp. 73–134). New York: Wiley.

Leslie, L., Gordon, J., Ganger, W., & Gist, K. (2002). Developmental delay in young children in child welfare by initial placement type. *Infant Mental Health Journal, 23*(5), 476–495.

Lester, B., LaGasse, L., & Brunner, S. (1997). Data base of studies on prenatal cocaine exposure and child outcome. *Journal of Drug Issues, 27*(2), 487–499.

Lester, B., LaGasse, L., & Seifer, R. (1998). Cocaine exposure and children: The meaning of subtle effects. *Science, 282,* 633–634.

Lieberman, A. F. (1985). Infant mental health: A model for service delivery. *Journal of Clinical Child Psychology, 14,* 196–201.

Lieberman, A. F., Weston, D., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62,* 199–209.

Lieberman, A. F., & Zeanah, C. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment* (pp. 555–574). New York: Guilford Press.

Linares, L. O., Jones, B., Sheiber, F. J., & Rosenberg, F. B. (1999). Early intervention for drug-exposed infants in foster care. In J. Silver, B. Amster, & T. Haecker (Eds.), *Young children and foster care* (pp. 373–397). Baltimore: Brookes.

Littell, J., & Schuerman, J. (1995). *A synthesis of research on family preservation and reunification programs.* Chicago: Westat, James Bell Associates, and the Chapin Hall Center for Children at the University of Chicago.

Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology, 55,* 3–9.

Malik, N. (2004, February). *Supporting the mental health of children and families in Early Head Start: Part I: Therapeutic approaches.* Paper presented at the eighth annual Birth to Three Institute, Baltimore, MD.

Munoz-Millan, R. J., & Herbert, N. J. (1998). Therapeutic nursery. In H. S. Ghuman & R. M. Sarles (Eds.), *Handbook of child and adolescent outpatient, day treatment and community psychiatry* (pp. 369–376). Castleton, NY: Hamilton Printing.

National Institute on Drug Abuse. (1996). *National pregnancy and health survey: Drug use among women delivering live births: 1992* (NIH Publication No. 96-3819). Rockville, MD: U.S. Department of Health and Human Services.

National Institute of Child Health and Human Development Early Child Care Research Network. (1996). Characteristics of infant child care: Factors contributing to positive caregiving. *Early Childhood Research Quarterly, 11*(3), 269–306.

National Institute of Child Health and Human Development Early Child Care Research Network. (1997). Child care experiences during the first year of life. *Merrill-Palmer Quarterly, 43,* 340–360.

Osofsky, J. D. (1998). On the outside: Interventions with infants and families at risk. *Infant Mental Health Journal, 19,* 101–110.

Peckham, V. C. (1999). Family school. In J. Silver, B. Amster, & T. Haecker (Eds.), *Young Children and Foster Care* (pp. 399–410). Baltimore: Brookes.

Phillips, D., & Adams, G. (2001). Caring for our youngest children. *Future of Children, 11*(1), 35–51.

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385–401.

Raikes, H. (1993). Relationship duration in infant care: Time with a high-ability teacher and infant teacher attachment. *Early Childhood Research Quarterly, 8,* 309–325.

Raikes, H. (1996). A secure base for babies: Applying attachment concepts to the infant care setting. *Young Children, 51*(5), 59–67.

Raver, C., & Knitzer, J. (2002). *Ready to enter: What research tells policy makers about strategies to promote social and emotional school readiness among three and four year old children. Promoting the emotional well-being of children and families policy paper.* New York: National Center for Children in Poverty.

Scarr, S. (1998). American child care today. *American Psychologist, 53,* 95–108.

Shanok, R. S., Gilkerson, L., Eggbeer, L., & Fenichel, E. (1995). *Reflective supervision: A relationship for learning.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Shure, M., & Spivack, G. (1982). Interpersonal social problem solving in young children: A cognitive approach to prevention. *American Journal of Community Psychology, 10,* 341–356.

Solchany, J., Sligar, K., & Barnard, K. E. (2002). Promoting maternal role attainment and attachment during pregnancy. In J. Martin-Maldonado (Ed.), *Infant and toddler mental health: Models of clinical intervention with infants and their families* (pp. 77–103). Washington, DC: American Psychiatric Publishing.

Squires, J., Bricker, D., & Twombly, E. (2003). *Ages and Stages Questionnaire: Social-Emotional (ASQ: SE).* Baltimore: Brookes.

Turnbull, A., Patterson, J., Behr, S., Murphy, D., Marquis, J., & Blue-Banning, M. (1993). *Cognitive coping, families, and disability.* Baltimore: Brookes.

U.S. Department of Health and Human Services. (1997). *Head Start Program Performance Standards.* Washington, DC: Author.

Uziel-Miller, N., Lyons, J., Kissiel, C., & Love, S. (1998). Treatment needs and initial outcomes of a residential recovery program for African-American women and their children. *American Journal of Addiction, 7*(1), 43–50.

Walker, H., Kavanaugh, K., Stiller, B., Golly, A., Severson, H., & Feil, E. (1998). First step to success: An early intervention approach for preventing school antisocial behavior. *Journal of Emotional and Behavioral Disorders, 6*(3), 66–80.

Wasik, B., & Bryant, D. (2001). *Home visiting: Procedures for helping families.* Thousand Oaks, CA: Sage.

Weatherston, D. (2000). The infant mental health specialist. *Zero to Three, 21*(2), 3–10.

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65*(1), 93–109.

Webster-Stratton, C., & Hammond, M. (1998). Conduct problems and level of social competence in Head Start children: Prevalence, pervasiveness, and associated risk factors. *Clinical Child and Family Psychology Review, 1*(2), 101–124.

Weston, D., Ivins, B., Heffron, M., & Sweet, N. (1997). Formulating the centrality of relationships in early intervention: An organizational perspective. *Infants and Young Children, 9*(3), 1–12.

Wieder, S., & Greenspan, S. I. (2001). The DIR (developmental, individual-difference, relationship-based) approach to assessment and intervention planning. *Zero to Three, 21*(4), 1–19.

Wobie, K., Eyler, F., Conlon, M., Clarke, L., & Behnke, M. (1997). Women and children in residential treatment: Outcomes for mothers and their infants. *Journal of Drug Issues, 27*(3), 585–606.

Wolfe, D., & Wekerle, C. (1993). Treatment strategies for child physical abuse and neglect: A critical progress report. *Clinical Psychology Review, 13,* 473–500.

Wulczyn, F., Hislop, K., & Harden, B. J. (2002). The placements of infants in foster care. *Infant Mental Health Journal, 23*(5), 454–475.

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs.* New York: National Center for Children in Poverty, Columbia University School of Public Health, and American Orthopsychiatric Association.

Zeanah, C., & Boris, N. (2000). Disturbances and disorders of attachment in early childhood. In C. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 353–368). New York: Guilford Press.

Zeanah, C., & Zeanah, P. (2001). Towards a definition of infant mental health. *Zero to Three, 22*(1), 13–20.

Zeanah, C. H., Larrieu, J. A., Heller, S. S., Zalliere, J., Hinshaw-Fusfuselier, S., Aoki, Y., & Drilling, M. (2001). Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 214–221.

CHAPTER THIRTEEN

Delivering Infant and Preschool Mental Health Services in Rural and Remote Areas

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Infant and preschool mental health practitioners working in rural areas and those working in urban areas deal with similar populations and similar issues. That said, however, highlighting some unique features of mental health provision in rural areas can aid infant and preschool mental health practitioners working in remote locations.

SPECIAL CHALLENGES IN RURAL AREAS

Although rural areas present infant and preschool practitioners with many special challenges, an equal number of creative responses to these challenges can be developed. At the same time, families who have young children with behavioral health problems face specific barriers to services in rural places. Perhaps the most onerous ones are a lack of specialty providers and difficulty in accessing the few professionals who do serve remote areas.

Challenges for Rural Residents

Rural and urban families may face a number of similar issues regarding infant, toddler, and preschool mental health care. But according to a national survey commissioned by the Pew Partnership for Civic Change (2002), rural and urban groups address the issue of behavioral health quite differently. Geography, economics, culture, and social norms contrast the rural-remote experience from that of urban residents. One area of difference concerns basic economic issues.

Many families in rural America no longer experience lives of economic independence. According to the U.S. Census for 2000, 6.8 million Americans in rural communities live in poverty. A significant portion of the rural population lives without basic conveniences, such as plumbing, running water, heat, telephones, passable roads, and transportation, either public or personal. Rural residents adapt with fewer resources and additional physical hard work, although Running (1998) notes that they often do so with a feeling of satisfaction and unity with the land.

Other attributes of people raised in rural places noted by researchers include independence, innovativeness, strong character, and a primary reliance on self, family, and friends, rather than on agencies and organizations. Additional characteristics found in rural residents include high work ethics, determination, traditional morals and values (compared with urban dwellers), hardiness, a general acceptance of life's challenges, and stronger belief in spirituality, religion, or a higher power (Craft, Grasser, Johnson, & Ortega, 2001).

However, it is important to remember that in spite of these general characteristics there is no "rural norm." The characteristics are not meant to stereotype rural dwellers. Remote and rural communities vary widely, and they constitute very different experiences for their inhabitants. Similarities with urban families include concerns about lack of living-wage jobs, drug and alcohol abuse, teenage pregnancies, and unaffordable child care.

Surveys have found that the majority of rural families do yearn for economic opportunity and bemoan the lack of training and education available to them. They express a desire to create a better life for their children as well as for themselves. At the same time, however, most say they want to remain in rural areas and would not trade places with city folk. As many have noted, this sense of place and identity is strong and a valuable asset for strengthening families (Pew Partnership for Civic Change, 2002; Las Cumbres Learning Services, 2001).

Pregnant women, infants, and young children constitute one of the most vulnerable groups living in remote areas. This population is at even greater risk in many rural areas because of the high level of poverty, lack of resources, and lack of public transportation to existing services. Equally as crippling is the epidemic level of drug abuse and violence, in particular domestic violence, in many rural areas. The sequela of substance abuse greatly affects young children. In addition to the chronic physical health risks of in utero exposure, abuse, neglect, poor nutrition, delays, disabilities, and chronic mental and behavioral problems are common.

The cumulative impact of poverty, a lack of basic social services, and the long distances required to obtain services place the children of these regions at risk for a number of physical and behavioral health problems. The prevalence of poverty puts additional stress on families, often leading to child abuse and domestic violence (Harris-Usner, 1995). Overall the most challenging issue for rural residents when compared with residents in urban and suburban communities is access to affordable health care (Pew Partnership for Civic Change, 2002).

In addition to a lack of availability, the barriers to mental health care as a whole include an inability to pay and the stigma that many feel when they access public services. However, individuals experiencing mental health problems living in rural and frontier areas encounter numerous additional problems in accessing services. These problems include limited numbers of mental health specialists who are knowledgeable about and sensitive to local culture and few practitioners with specialty knowledge about early childhood mental health

The many challenges and barriers can present practitioners with regions in turmoil, where the social fabric of many traditional and rural communities is unraveling at an alarming rate. The strands of a once tightly woven rug—living off the land, self-sufficiency, and reliable support provided by extended family—are breaking and being replaced by hard drugs, alcohol, poverty, abuse, depression, violence, and suicide (Harris-Usner, 1995).

As these factors have increased, so has unemployment in rural areas. The lack of jobs and fewer opportunities for education have led to an exodus of young people from remote areas, further weakening the abilities of families and communities to support themselves. The well-recognized and long-standing access barriers to mental health care for a more culturally diverse rural and frontier population remain formidable, but far from impenetrable.

Challenges for Rural Practitioners

Rural and frontier counties (that is, those with population densities of between 2 and 6.9 persons per square mile) are typically extremely underserved with respect to mental health professionals. Only 43.1 percent of frontier counties have any psychologists, fewer than 10 percent have psychiatrists, and only 23.4 percent have any master's level social workers (Holzer, Goldsmith, & Ciario, 2000).

In a study by the Rural Mental Health Association ("Rural Mental Health Practitioners Speak Out," 2001), rural mental health practitioners expressed their opinions on a number of salient issues. Some key findings emerged. Many perceived their roles as multifaceted, as they practiced as both generalists and preventionists. These practitioners report challenges such as a prevalence of major mental health problems (primarily affective disorders), substance abuse co-occurring with other problems, trauma and crisis management, family problems (including a high degree of domestic violence), and personality disorders. In particular, many practitioners mentioned high rates of drug use.

Mental health providers encounter a number of special challenges when delivering services to families with infants and preschoolers in rural areas. These include basic cultural and linguistic differences, challenges posed by long travel distances as well as poor roads (or no roads at all in places such as Alaska, which may require travel by aircraft), inclement weather conditions, and on occasion family hesitancy to engage with service systems. Additional barriers include lack of telephones and other communication technology (for example, cell phone access, Internet) and a lack of support services in the community.

Most rural areas do not have multilevel mental health professionals that include a psychiatrist, psychologist, or social worker. Coupled with this scarcity are the relatively small numbers of mental health practitioners who are knowledgeable about infant and preschool mental health issues. This places a heavy burden on the few isolated mental health professionals attempting to provide such specialized care in remote areas.

Other impediments noted by rural mental health practitioners include lack of resources and professional colleagues and overly complex government regulations that are not sensitive to the difficulties faced by rural communities. Professional isolation makes it difficult for clinicians to keep in touch with mainstream literature

and practices. In addition, there are limited models of service delivery for rural areas.

Despite the many benefits of living and working in rural areas, attracting new practitioners is difficult. The specialized training required for rural settings is not readily or widely available, and salaries in rural areas are generally lower than those in urban areas.

Consequently, there is a great need for trained infant and preschool mental health practitioners in rural and isolated areas. Despite the challenges, providing services to families and young children in these places reaps the practitioner huge rewards. Work with infants, toddlers, and preschool-age children in remote, rural, and underserved areas brings with it a sense of hope, resiliency, and a positive vision for the future.

ASSETS OF RURAL COMMUNITIES

Rural communities have strengths and inherent assets that can be used to the advantage of infant and preschool mental health providers. Many rural families have deep historical roots, including the prevalence of extended families and a strong spiritual life. Many have developed adaptations and very creative solutions to the difficulties and problems they encounter. The existence of these informal supports for families has been found to be a predictor of more positive outcomes for those clients who can access and use them (McWilliam & Scott, 2001).

Traditions of family care and a commitment to the community also strengthen informal networks. Long-established relationships and familial ties can be counted on for support even in changing times. Creativity and autonomy are valued and supported in rural areas. This allows the practitioner to think outside the box, to utilize natural supports, and to become creative in problem solving.

Innovative services can often be provided more quickly in rural programs than in urban centers. At smaller agencies with less programmatic bureaucracy, it is often easier to initiate and to coordinate programs. In addition, the relationships with and access to other providers can be less formal. Consequently, responses may be more expedient than in a large urban area. Trusting relationships that are carefully built in and among programs that reach out to the underserved build a solid foundation for coordination of, and increased access to, infant and preschool mental health services.

BASIC KNOWLEDGE AND NATURAL ASSETS IMPORTANT FOR PRACTITIONERS IN RURAL AREAS

Regardless of the location, effective infant and preschool mental health practitioners must have a specific knowledge base and competencies relevant to their level of practice. In the last few years, there have been efforts in a number of states, such as California (see Chapter Fourteen, this volume), Michigan (see Weatherston & Tableman, 2002), and Washington (in the Department of Nursing at the University of Washington), to develop specific competency profiles and certificate or endorsement programs. The following discussion will focus on competency areas that are particularly or uniquely relevant to work in remote regions.

Basic Knowledge

Paramount to the basic knowledge needed by infant and preschool mental health practitioners in rural areas is an understanding of the people, culture, and history of the places and communities in which they are working. Equally important is a basic knowledge of infant and child development, as well as an understanding of relationships and reflective practice and principles (Fenichel, 1992).

In tandem with interpersonal sensitivity (Lieberman, 1990) must come an understanding of specific cultures and their particular experiences in the region. A reflective awareness of self in this specific context guides the practitioner in working with local residents. An awareness of oneself in the context of the community and relationships includes clarity of personal values.

Rural infant mental health providers must be aware of their own culture, values, and assumptions, as well as the values and traditions of the culture where they are working. A relevant example comes from one of the southwestern states, where a young woman from a Native American tribe was describing her dilemma in a workshop on reflective supervision. She had recently been made a supervisor of the staff at the child development center on her reservation.

This woman expressed discomfort and conflict in her role as supervisor to child-care workers who had been at the center longer than she had. To further complicate the situation, the workers were her elders, whom she had been taught to respect and not question. It was important for this new supervisor to have her own place to reflect on this

clashing of tradition with her new role. She needed to find support and a venue in which to discuss how to blend her cultural training with her new role as guide and mentor.

In some parts of the world, including the United States, *rural* is equated with *traditional.* This is particularly true if the area is home to a specific cultural group, such as the Native American tribes of the southwestern United States and Alaska or the Maori of New Zealand. In these situations, it is the practitioners (especially if they are not part of the local culture) who must gain acceptance and an understanding of the local traditions, while developing ways to deliver infant and preschool mental health services that are acceptable to the particular culture and time.

Equivalently important to rural practitioners is the ability to work both independently and as part of an integrated, multidisciplinary team. These practitioners must strike a balance between being the "lone ranger" on the frontier and participating fully as a member of a multidisciplinary team. If no team exists, they must create one from the various agency staff that interact around or with children and families, including child-care providers, Head Start sites, early intervention teams, public assistance offices, and others.

Many practitioners in rural areas find themselves playing the role of generalist, acting as resource developers and family advocates as well as clinicians. This is necessary because of limited resources. Although this may frustrate those wanting to specialize, a generalist role fits well with the current infant mental health field, where best practice requires that the provider be concerned with relationships and not just discipline-specific interventions. The practitioner must join with the family (and often the entire community), with the approach and attitude that she will learn as much as she will help or teach. It is necessary to be able to help families access resources, including transportation, housing, and food, in addition to providing intervention and mental health treatment services for infants and young children.

Practitioners and advocates in rural and remote regions who are providing infant and preschool mental health services need to appreciate the important roles they play. These roles include educating and increasing awareness of infant mental health issues in the families with whom they work and among other providers, educators, institutions, and the general public. Awareness building should emphasize the importance of development in the context of relationships during the early years of childhood and the impact of these relationships on the developing child.

Public awareness and education take place continually on both formal and informal bases. It is essential that practitioners in remote areas have access to the latest research on development, education, mental health, and best practices in the field of infancy and early childhood. Also requisite is knowledge of legal issues regarding special needs, foster care, permanency planning, reimbursement and entitlement services, and other areas that affect infants and preschool children of at-risk populations.

The ability to perform multiple roles with clients expands the responsibility of the infant mental health practitioner. It is critical to have an understanding of and an ability to address boundary issues as they arise in unexpected situations because of the nature of rural communities and the frequent lack of anonymity. This is not to imply that boundaries should not or do not exist. To the contrary, failing to set limits and presenting oneself as everything to everyone is not appropriate. Nor is sharing too much about one's own life. Every action and interaction must be considered in the context of what is therapeutic and safe (Harris-Usner, 1995).

In short, the rural infant and preschool mental health practitioner needs to wear many hats. Experience and observation indicate that families accept and expect this. It seems to be in sync with the way people in many small communities share roles and perform multiple tasks themselves.

Natural Assets

The rural practitioner must understand the essential elements of relationship-based work and reflective supervision. As staff members develop trusting and consistent relationships with the community, services for infants, young children, and families can increase. As relationships positively affect other relationships, local community assets develop and grow.

If the practitioner is part of the local culture and a native of the area, she has her own experiences and intimate knowledge that will influence and guide her interpersonal style with families. In such cases, the practitioner must also be aware of her multiple roles in the community as neighbor, relative, and helper. Having a safe place to discuss role confusion and conflicting agendas or needs is important. Personal and professional priorities can clash when working with relatives and other people with whom there are multiple levels of relationships other than the "professional" one.

A commitment to living, or at least working, for an extended period of time in the area goes a long way toward inspiring confidence in coworkers, families, and community agencies. This *parallel process* of relationships affecting relationships is the practice of being genuine, consistent, and collaborative. It demonstrates a commitment not only to the individual but also to the community at large, as well as to funders and policymakers familiar with the region.

CLINICAL SKILLS NEEDED TO WORK IN RURAL AREAS

Bridging the gap, making connections, and building trust with families can be daunting anywhere. It is further complicated when the culture or experiences of the practitioner and clients vary significantly, which is often the case in rural areas.

An individual working in remote or rural settings must demonstrate the ability to apply knowledge and experience to the relationships she has developed with both families and professionals. Although this is also true for urban practitioners, relationships are often much more intimate in rural and traditional communities. Finding ways to deliver infant and early childhood mental health services in traditional and rural areas takes an extra dose of awareness, sensitivity, and patience. Tolerating frustration and ambivalence and maintaining (or practicing) self-regulation are key concepts of the parallel process that must work in reverse for practitioners. Mental health service providers will find themselves depending on their own abilities with little outside support to sustain them as they work in rural areas.

Building relationships in a new community and finding local resources are parallel processes, as multiple levels of relationships with families, communities, and providers are—out of necessity—built simultaneously. Establishing rapport, building collaborative alliances, and providing reliability and consistency in relationships will establish the foundation for acceptance in a rural or remote area. At the same time, maintaining confidentiality is of utmost importance.

In a rural area, it is not unusual for the mental health therapist to be providing assessment or ongoing services to neighbors, relatives, and coworkers. Although this may make "by-the-book" psychoanalysts uncomfortable, there is often no choice for local practitioners in remote areas. Most often, there is no other referral source. The question therefore is not "do we provide services?" but rather "how do we provide services?" given the complexity of relationships. This makes

team support and supervision essential and vital to the clinician-practitioner on all levels.

Familiarity with the locale helps the practitioner develop the skills needed to form a therapeutic alliance. Providing consistent contact, maintaining confidentiality, and developing an awareness of how the "party line" works in small, rural areas are part of building relationships with families and the community. Learning how to develop and maintain a therapeutic working alliance when distance and weather may determine the frequency of contact, usually less then ideal, requires extra attention to the details of "being held in another's mind" (Pawl, 1995, p. 5).

Self-reflection is essential, as are teamwork and support. This work cannot be done alone. All of these practices will assist the mental health practitioner in remaining helpful while working in rural and remote places, in nontraditional mental health roles and in multirole relationships, which sometimes occur in emotionally laden and traumatic situations.

An example from one small village where I worked illustrates this point. The tragic murder of two teenaged sweethearts left their families and neighbors totally devastated. Nearly everyone was affected in the small, close-knit community. The news, including specific horrific details, was unavoidable, even for the local preschoolers.

The rural child development center director asked me to come and talk to the children and staff. According to the director, everyone was having a very hard time dealing with this traumatic event. She requested help, not only for the children in her program but for the center's staff as well. The children were feeling very vulnerable, as they suddenly perceived their immediate world as unsafe for all kids. They also were experiencing the absence of their favorite lead teacher, who was the mother of one of the slain teens.

The staff members were devastated by all of the events and unable to respond to the children's increased emotional needs, fears, and acting-out behaviors. Although my staff were also affected by this tragic event, we were able to team up and assist the child-care center in several ways. We provided the children with safe circle time to discuss their fears, offered follow-up play therapy for individual children as needed, and supported the director and staff in their own grief process. We also tended to the practical matters of helping the director to address scheduling during the prolonged leave taken by the lead teacher.

Another example of the need for taking on dual roles took place during a local Child Find, which is a developmental health fair and screening for children from birth-to-five years of age. In rural areas of New Mexico, Child Finds are held in local health clinics, Head Start sites, school gyms, and community centers on Indian pueblos and reservations. The individuals who administer the screening tools are drawn from the staffs of local programs and clinics. Most often, these individuals are also local residents, and many have their own young children. I was the screener for the social-emotional category, which included referrals for mental health evaluation if the family was interested.

After I had worked as a social-emotional screener for the first time, it became clear to me that other people on staff needed to be appropriately and quickly trained to screen. My role as the director of the regional infant and preschool mental health program put me in the awkward role of screening children of staff, colleagues, and friends and then offering them services in the program that I directed. The only other option was for them to travel over a hundred miles one way to another city in search of more anonymous services. Unfortunately, infant mental health practitioners are few and far between, even in the more densely populated communities of New Mexico.

I wanted to provide more anonymity for parents, if possible, by not being the primary person screening. But it was also the case that direct contact with someone who was familiar was comforting for some parents who may have been reluctant to relate social-emotional concerns to an unfamiliar mental health practitioner. In such situations, one must develop a talent for on-the-spot, quick assessment of the family's preference and comfort level before proceeding with the full screening. I have been surprised on more than one occasion at the seeming ease and willingness with which caregivers who are familiar with staff share concerns about mental health and behavioral issues.

Helping staff to clarify their roles and relationships with families, as well as the sensitive nature of confidentiality in small towns, is an ongoing discussion in supervision and consultation. Of course, there must always be consideration for the practitioners' licensure and code of ethics, as well as what other resources-staff are available for a particular family.

Home visits are a critical component in offering services to families in rural areas. During such visits, families are often curious about the visitor, inquiring about where the home visitor lives, to whom the visitor is related, and what the practitioner's familiarity with their

community is. This may contrast with family expectations of urban home visitors, who may be more likely to be accepted as part of the available array of services. In urban areas, home visitors may not be seen as out of the ordinary and therefore perhaps not scrutinized on the same level.

In rural areas, certain social mores govern the exchange of personal information. The initial discussion in a family's home can open the door to acceptance as part of the community and give credence to a shared commitment to its residents. This beginning exchange can bring legitimacy and a way for locals to place an unfamiliar person in the social fabric of the region. Such an exchange seems to satisfy a need for familiarity and thereby creates an opening for addressing more sensitive subjects. These are the positive aspects of being closely associated with one's community of work (Harris-Usner, 1995).

TRAINING AND RESOURCES

The development and implementation of a training agenda that covers competencies and best practices should be part of the rural staff member's job description, professional development plan, and performance evaluation. Infant and preschool mental health staff must receive initial and ongoing training and consultation, as well as regular, supportive supervision. This must be part of the rural agency's infrastructure. To do this anywhere, let alone in rural and sometimes closed communities, takes patience and tact. Recognizing the need for more trained infant and preschool mental health clinicians and home visitors to work in rural service areas is a place to start. Educating community members about the importance of infant mental health is a first step.

Other clinical skills necessary for the rural provider of infant and preschool mental health services include but are by no means limited to the following:

- Knowledge and practice in relationship-based service delivery (Weston, Ivins, Heffron, & Sweet, 1997)
- Understanding of parallel processes
- Knowledge about maternal issues, including prenatal care, postpartum depression, and maternal mental health
- Knowledge of infant and child development, special needs children and families, sensory integration, and parent education

- Knowledge regarding caregiver issues, including addictive behaviors, alcohol and substance abuse, domestic violence, and psychopathology
- Knowledge of community resources for housing, food, transportation, financial and legal assistance
- Mental health expertise in determining eligibility for services, planning treatment, and accessing funding mechanisms for very young children and their families.

Information regarding these skills can be found throughout this volume.

APPRENTICESHIP BY THE SEAT OF THE PANTS

No amount of training can fully prepare a practitioner for work in a rural area. One must jump into the environment. There simply is no substitute for direct experience. However, there are currently more resources available to providers in a number of rural states than ever before. These resources include organizations such as Zero to Three and the Association for Rural Mental Health, as well as infant and toddler mental health coalitions. These emerging groups offer new opportunities for rural providers to access training opportunities and best practice literature. Networks are also an avenue for finding mentors and for facilitating the development of professional consultation and support. There are also a number of excellent video training packages available at reasonable costs.

Programs that invest in building their own library of resources, such as videos, professional journals, and handbooks, will have information and training tools readily available in their own settings. This helps expedite skill acquisition of new staff and interns. Community colleges and state institutions of higher learning, which are both closer to rural areas than the main campuses of universities and more affordable and accessible to rural residents, can also serve as training resources for infant mental health practitioners.

Supervision, direct observation, mentoring, teaming, and training in-house take time but are absolutely necessary for teaching and supporting infant mental health practitioners in rural areas. In the absence of a formal training program or even course curricula that focus on infant mental health, agencies and programs must rely on

both local talent and national expertise for knowledge and skill building. Sending staff to regional and national conferences, bringing in experts for workshops and consultation, and making resources readily available will all contribute to building competencies in infant mental health practitioners who work in remote areas. Pairing up new staff members with mentor staff on home visits and for consultation is a valuable use of time and can often be billable time as well.

On a larger scale, it has been important for rural states and regions around the world to collaborate and coordinate training as well as to develop a strategic plan to address infant mental health on a community and regional level. This type of organization can help remote and rural areas identify needs as well as strengths and share working program models. Creating such strategic plans or systems of coordinated care can also facilitate consultation, training, evaluation, and funding advocacy for rural programs. Participating in activities and associations that focus on rural mental health as well as early childhood education, such as the Association for Rural Mental Health and Migrant Head Start programs, can provide additional allies and resources.

DEVELOPING SERVICES IN RURAL AND REMOTE AREAS: A CASE EXAMPLE

In a demonstration of parallel process on a regional level, my colleagues and I worked on developing a rural collaborative. The collaboration resulted in the provision of infant and early childhood mental health training, consultation, and resources to two rural primary health care clinics.

Early on in my career working with young children, I found that innovation was easier in the fairly remote area in which I lived and worked than in the urban centers. After I launched the MiHijita/MiHijito Infant Mental Health Project in 1991, it quickly became evident to me that there was a need for more trained infant mental health home visitors to work in the vast rural area that was being serviced. Initially, a small foundation grant provided start-up funds to train and place one home visitor in a small rural clinic as part of primary care and social services.

The project grew, and several years later we formed a collaborative relationship. The Children's Trust Fund provided funds for training, consultation, and support and for the purchase of materials on infant and preschool mental health for two rural primary health care clinics.

The grant allowed for the introduction of infant mental health practices to these rural communities and the provision of family resource centers and ongoing training. After the initial three years, we were awarded a four-year grant to continue and expand our work with regional training and workshops.

This collaborative has helped each clinic leverage its resources for larger health grants that included prevention and intervention for infants and young children. The original group continues to meet regularly and has added new staff members. The collaborative has successfully maintained funding and expanded services over the years.

Embedded in the project are important elements of relationship-based programs and training. The budget includes mileage for the staff from the three different clinics so that they can meet together on a regular basis. Time for reflective and supportive consultation and supervision is provided, and resources are generously shared.

As the three clinic staff members and their immediate communities developed trusting and consistent relationships over time, the services for infants, young children, and families increased at each site. This collaborative continues to see relationships affecting relationships and a visible increase in community interest and support for infant and early childhood mental health practices growing as a result.

BEING, SHARING, AND GIVING ON THE FRONTIER: THE RIPPLE EFFECT

In rural and remote areas, it is necessary to seek and build opportunities for consultation with peers, with more experienced practitioners, and with national experts. It is a huge asset to have access to seasoned clinicians, supervisors, and mentors via phone, e-mail, or mail. Bringing in trainers from other states helps the staff maintain a perspective on their work and provides access to the latest research as well. I have done all of the above over the last twelve years of practicing in a rural area and cannot imagine having traveled this journey without long-distance guidance and support.

Ongoing and regular clinical reflective supervision is a core ingredient of quality programs. Clinical supervisors require the same knowledge and experience as the practitioner, in addition to training in providing supportive, reflective supervision to staff. Supervisors must be culturally aware and comfortable in the location in which they are practicing and with the people who reside there.

A strong and consistent sense of humor goes a long way out on the frontier. Possessing and maintaining a sense of optimism and joyfulness within oneself helps sustain commitment and cohesiveness in both the practitioner and those with whom she works.

DETERMINING COMPETENCE IN A RURAL WORKFORCE

There are many "competencies" that may not be on the usual interview list of questions nor listed on a professional résumé. However, these qualities may be the most significant factors in a rural practitioner's success in this field.

For an infant mental health employer in a community agency, it is important to determine why someone lives or wants to work in this particular rural area for a number of reasons. This information will inform the potential employer about the practitioner's knowledge of the area, including whether or not he is from the local culture. It is useful to know whether the practitioner has been settled in this region for a significant period of time or is a new transplant. Motivation to work in the region may be based on the individual's need to meet the requirements for an internship or residency by working in a rural area or a need to remain close to family who live in the area.

Additional interview topics that are legitimate to raise with individuals who are applying to work in rural and remote areas include professional and personal goals, the kind of vehicle they own, and whether it is equipped for rough roads and inclement weather.

VALUING THE LESS OBVIOUS

"Growing your own" has become a regional term among programs in a number of rural and remote areas. There is great value in taking the opportunity to train and mentor local and native people to become infant and preschool mental health practitioners.

The training and supervision time may be more encompassing because of the lack of training opportunities available for potential staff and students in remote areas, but the commitment to the work and the territory is inestimable. Building a cadre of well-trained infant mental health providers who are also members of the local community and committed to staying in and serving that community ensures the continuance and continuity that is vital to this field of work.

One young woman began her internship at our program when she was attending a junior college. She returned for another internship during her second year of graduate school (driving four to five hours two to three times a week to the closest university graduate program). Newly graduated but well trained in our program and infant mental health services, she was a very attractive candidate for a position in my agency. This young woman could have gone to a number of places to work, for higher pay no doubt, but when I heard her say that her heart was in her rural (and economically impoverished) community, I had no hesitation about offering her a job.

Growing your own helps to ensure that infant and preschool mental health services will continue in rural communities. Rural infant and preschool mental health practitioners identify qualities in themselves that often mirror characteristics of the families they serve: tenacity, humor, resourcefulness, creativity, and most of all, hope for a better life for the young children of the region. With an expanded and committed workforce whose hearts are in the region, infant and preschool mental health services will become better integrated and established in remote and rural regions. Ideally, in the future families will be able to access high-quality, culturally appropriate mental health services for their young children regardless of their geographical location.

References

Craft, B., Grasser, C., Johnson, D., & Ortega, S. (2001). Coping strength and the adversity of depression or alcohol use: The human spirit or ruralness? *Rural Mental Health, 26*(1), 19–26.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A source book.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Harris-Usner, D. (1995). Old threads, new patterns: Reaching out to rural families. *Zero to Three, 15*(5), 1–9.

Holzer, C. E., Goldsmith, H. F., & Ciario, J. A. (2000). The availability of health and mental health providers by population density. *Frontier Mental Health Services Resource Network, Letters to the Field, No. 11.* [www.wiche.edu/mentalhealth/frontier/index.htm].

Las Cumbres Learning Services. (2001). *Our journey with families: Service delivery in natural environments in rural areas: Training manual for early intervention practitioners.* Author. Unpublished.

Lieberman, A. F. (1990). Culturally sensitive intervention with children and families. *Child and Adolescent Social Work Journal, 7*(2), 101–119.

McWilliam, R. A., & Scott, S. (2001). A support approach to early intervention: A three part framework. *Infants and Young Children, 13*(4), 55–66.

Pawl, J. H. (1995). The therapeutic relationship as human connectedness: Being held in another's mind. *Zero to Three, 15*(4), 1–5.

Pew Partnership for Civic Change. (2002). *Rural solutions: Building family strengths in rural America. Final report.* Pew Partnership for Civic Change and the Annie E. Casey Foundation. Charlottesville, VA: Author.

Running, A. (1998). Health perceptions of rural elders: Landscapes and life. In H. J. Lee (Ed.), *Conceptual basis for rural nursing* (pp. 223–235). New York: Springer.

Rural mental health practitioners speak out. Highlights of a national institute of the National Association of Rural Mental Health. (2001). *Rural Mental Health, 26*(1), 10–12.

Weatherston, D., & Tableman, B. (2002). *Infant mental health service: Supporting competencies/reducing risks* (2nd ed.). Southgate: Michigan Association for Infant Mental Health.

Weston, D. R., Ivins, B., Heffron, M. C., & Sweet, N. (1997). Applied developmental theory: Formulating the centrality of relationships in early intervention: An organizational perspective. *Infants and Young Children, 9*(3), 1–12.

PART THREE

Training Standards, Systems, and Technology

CHAPTER FOURTEEN

Developing Standards for Training in Infant and Preschool Mental Health

Karen Moran Finello, Ph.D., and Marie Kanne Poulsen, Ph.D.

Professionals throughout the country have been working for the past decade to clarify the skills and competencies needed to provide effective infant and preschool mental health services. The impetus for such clarifications originated from professionals in community agencies who recognized gaps in their ability to provide comprehensive services to very young children and their families. Over time, individuals running university preservice training programs

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A complete report on the California Infant/Preschool/Family Training Guidelines, including Core Provider Training Tables, is available from the WestEd Center for Prevention and Early Intervention. E-mail vreynol@wested.org or go to their Web site at www.wested.org/cpei. We thank the WestEd Center for Prevention and Early Intervention and the First 5 California Children and Families Commission for allowing us to use information from the report in this chapter.

We would like to thank Virginia Reynolds of the WestEd Center for Prevention and Early Intervention, along with Barbara Marquez and other members of the First 5 California Children and Families Commission, for their thoughtful comments and critique of this chapter.

and others providing inservice training began to develop models to meet the complex needs of service providers. In an attempt to create more uniformity in the delivery of infant and preschool mental health training, professionals came together to try to forge compromises about what pattern the trainings need to take and who should be involved.

Based on state needs, existing training structures, and leadership available, regions of the United States have taken different approaches to developing standards for training and for measuring competence in professionals. These approaches range from very broad recommendations suggesting that professionals "develop competence before practicing with young children" to more specific framing of knowledge, skills, and competencies that should be included in comprehensive training programs.

Both California and Michigan have developed specific recommendations regarding training, although they have taken somewhat different approaches. This chapter will focus on the experiences of a committee of professionals in California as they attempted to develop a set of specific, yet flexible standards for training. The chapter will address problems that were encountered as the committee worked together and will provide examples of the training guidelines for infant and preschool mental health training that were developed.

ESTABLISHING A WORKING COMMITTEE

Building on a set of initial recommendations developed under a Maternal and Child Health leadership training grant to Marie Kanne Poulsen in 1991, a series of state work groups were established in California in association with the First 5 California Children and Families Commission Infant, Preschool and Family Mental Health Initiative; the California Department of Mental Health; and the WestEd Center for Prevention and Early Intervention. The interdisciplinary work groups were composed of representatives from the organizations involved, professionals from universities, hospitals, and community agencies, and private practitioners who were working with children under the age of five. The work was strongly supported by leadership from the First 5 California Children and Families Commission, with the aim of promoting the development of a quality workforce to provide quality services to young children and their families in the state.

The California work groups consulted with and gathered information from similar groups in other states and from leaders in the field as draft guidelines for training and personnel development were being developed. Field input was sought for several drafts of the guidelines as we worked to resolve problems and to ensure that we had not omitted any crucial information. The final version is based on over ten years of committee work, utilizing several different committee compositions, with a few key leaders providing continuity between committees. In California, we are still grappling with the issue of adoption of the standards because no single state agency is able or willing to take on the task of overseeing personnel standards for professionals from a wide range of disciplines. For now, the standards serve as guidelines for the development of training programs and for professionals trying to develop expertise in working with very young children.

PROBLEMS AND ISSUES ENCOUNTERED

As a committee, we struggled to produce a document that would not be viewed as elitist or insensitive to practitioners already working in the field. There was concern expressed about a tiered system in which mental health professionals were placed on top, along with the opposing concern that we could not ignore the ethical reality that the highest-level specialist should provide services within a discipline.

The debate focused on the clear need for mental health specialists to have the greatest depth and understanding in the field, with non-mental health professionals needing similar but less-intensive training. It seemed somewhat illogical to ignore the realities of mental health practice or to pretend that an individual with a bachelor's degree in speech would have the same type of practice or mental health training expertise as a licensed clinical social worker or psychologist.

However, a decision to make a training division was one of major debate, as the committee realized that mental health services to very young children and their families are provided on a spectrum from prevention to intervention. In addition, as services for birth to five-year-olds expand into a variety of arenas, including education, health, social services, and developmental services, large numbers of young children and their families are seen by professionals from non-mental health disciplines. We also realized that many families would not seek services from a mental health specialist, even if such services were needed, recommended, and discussed.

In addition, it was the committee's strong belief that all professionals working with very young children need to have interdisciplinary training to develop an understanding of the role of other disciplines and a respect for the boundaries of their own practices. The conundrum that the committee faced was how to develop minimum standards that would be appropriate for the range of services to be provided by professionals from a variety of disciplines.

Obviously, those specialists who would be conducting intensive psychotherapeutic interventions would need a different level of training and supervised clinical experience than would individuals who would be doing parent education or providing developmental guidance related to behavior in very young children. After much lively discussion and with input from pioneers in the field who had run training programs, the committee in California opted to divide training recommendations based on anticipated levels of mental health service delivery.

The compromise divided training recommendations into two categories: (1) training for *mental health professionals* and (2) training for *core providers* of services in non-mental health disciplines. We chose this approach rather than one with integrated levels (for example, *level 1*—infant mental health associate, *level 2*—infant mental health specialist, *level 3*—infant mental health mentor) to avoid the semblance of hierarchy, while respecting the need for different types of training. This allowed us to increase the recommended number of "minimal" training hours for mental health disciplines while keeping the recommendations for non-mental health disciplines within what we believed were reasonable ranges.

Mental health professionals are defined to include those individuals who want to provide mental health services to infants, toddlers, and preschoolers and their families and are eligible for licensure to provide mental health services. This group broadly includes clinical psychologists, developmental psychologists, school psychologists, marriage and family therapists, licensed clinical social workers, psychoanalysts, and psychiatrists. The training guidelines for mental health professionals are the primary focus of this chapter.

We defined *core providers* as all other individuals working with infants, toddlers, and preschoolers and their families. This group would include child-care workers, early childhood educators, early interventionists, home visitors, nurses, occupational therapists, physical therapists, speech and language therapists, special education teachers, and other professionals working with young children.

UNDERLYING PRINCIPLES USED TO DEVELOP THE CALIFORNIA TRAINING GUIDELINES

The training guidelines developed in California are based on the guiding principle that training of professionals should be designed to foster family-centered, culturally competent, and developmentally appropriate services. It is our strong belief that parent-professional partnerships are crucial to the effective delivery of services and that all early mental health services should be based on the goal of strengthening relationships between child and caregiver.

Early mental health services provided to children from birth to five-years-old must extend across a continuum of promotion, preventive intervention, and treatment services. Such a continuum requires that professionals from mental health and professionals from other disciplines provide a variety of services related to early mental health. Every individual working with very young children and their families must understand basic concepts of development. They must also be able to evaluate child and family needs in order to determine the most appropriate level of services.

All professionals working with young children and their families should feel competent and assured when providing some or all of the mental health services along the continuum. The California training guidelines focus on introducing infant-preschool mental health concepts and general principles of practice to the core provider group and on helping mental health professionals to develop practice applications of the core concepts. The guidelines reflect the necessity of training the infant and preschool mental health professional to be able to move from an understanding of basic concepts to in-depth clinical applications and interventions.

THE TRAINING TABLES

The training tables outline a framework for building a coherent foundation of knowledge and training that professionals need for working with very young children and their families. The tables are designed to guide programs and training institutions in developing course work, workshops, and special certifications. They are also intended to guide professionals as they seek specialized training in infant-family and preschool-family mental health. The tables are not intended to specify objectives of individual training curricula, but to provide an

overview of basic material critical for inclusion in training. Any training program is free to develop its own focus, objectives, and requirements.

The training tables are divided into two major age groups. The infant-toddler training table provides an overview of core knowledge, skills, and clinical experience necessary for work with birth to three-year-olds and their families. The preschool training table provides this overview for work with three- to five-year-olds and their families. For individuals and training programs interested in developing expertise across the age span of birth to five, additional training, along with overlap in curriculum, was considered in the formulation of the birth-to-five-training table.

Across age groups, there are overlaps in the basic knowledge required within the domains. Every practitioner, regardless of age group focus, will be required to obtain this basic information. More specialized infant or preschool training is also built into the domains. This is intended to ensure that professionals understand infant or preschool development (or both), typical behavior, and atypical behavior, as well as critical assessment, diagnostic, and intervention issues relevant to the specific age groups. (See Tables 14.1, 14.2, and 14.3.)

Content Knowledge and Related Training Topics

The tables are not meant to be inclusive; some training programs may include additional topics within the domain. No training aimed at preparing practitioners for the provision of infant and preschool mental health–related services should be focused solely on one topic within the domain. Instead training should include the range of topics listed for each domain.

The focus of the training of core providers is on an overview of core concepts falling within each broad domain. Training for mental health practitioners should be designed to help the practitioner learn to use basic knowledge as a building block for clinical application, including assessment and intervention. In other words, trainings should be focused on building upon the mental health professional's understanding of core concepts, with the goal of developing appropriate interventions designed to meet individual child and family needs.

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
a. Understanding Parenting, Family Functioning, and Infant-Parent Relationships	• Overview of attachment issues • Goodness of fit • Parenting as a developmental process • Family dynamics • Cultural issues • Developing family sensitivity	• Specialized training regarding impact of parenting and family issues on infant behavior and functioning • Intervention strategies to support infant-parent relationships	• 20 hours
b. Infant Development	• Typical infant-toddler development • Milestones • Cultural beliefs regarding development • Family expectations	• Understanding the role of development in infant mental health • Intervention options for atypical development • Working effectively with family and cultural belief systems to enhance child development	• 20 hours, plus • 4 hours of observation
c. Biological and Psychosocial Factors Affecting Outcomes in Infants	• Temperament • Neurodevelopment • Regulatory issues • Sensory problems • Nutrition • Brain development • Poverty • Communities • Schools • Impact of such factors on development and relationships	• Understanding and intervening with typical and atypical factors affecting development and parenting • Evaluating the role of biological and psychosocial factors on individual infants and their families	• 16 hours

Table 14.1. Training Guidelines for the Mental Health Practitioner Working with Infants, Toddlers, and Their Families.

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
d. Understanding High-Risk Influences on Early Relationships	• Atypical child and family factors • Teen parents • Chronic physical and mental illness • Developmental disabilities • Prematurity • Substance abuse • Family violence • Foster care • Institutional care	• Intervention strategies designed for high-risk families and children	• 24 hours
e. Risk and Resiliency	• Risk and resiliency factors • Factors that help insulate infants and families from risk	• How to facilitate and support factors to build resiliency	• 12 hours
f. Observation, Screening, Assessment, Diagnosis, and Intervention	• Basic observational skills • Use of observational information • Use of screening tools with infants and toddlers • How and when to refer for comprehensive assessment • Principles of reflective practice	• Specialized professional training in assessment strategies and relationship-based interventions • Report-writing skills for practice • Linking assessment to intervention • Formulating developmentally appropriate diagnoses • Integrating comprehensive child and family information to formulate appropriate, family-centered, relationship-based intervention strategies	• 40 hours observation, screening, assessment, and diagnosis, plus • 40 hours advanced diagnostic and intervention strategies

Table 14.1. Training Guidelines for the Mental Health Practitioner Working with Infants, Toddlers, and Their Families (cont.).

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
g. Interdisciplinary Collaboration	• Other professional roles • Interdisciplinary collaboration on behalf of young children and families • Respecting boundaries of practice	• Training in the development of interdisciplinary practice skills and strategies	• 8 hours
h. Ethics	• Ethics of scope of practice	• Ethical issues related to infant mental health practice	• 4 hours
Domain 2: Clinical Experience and Supervision	• Clinical work with children birth to three and their families • One-to-one supervision	• Based on direct work with children and families	• 500 hours • 50 hours
Total Hours	• 184 hours Knowledge Domain, plus • 500 hours Clinical Experience Domain		• 684 hours

Table 14.1. Training Guidelines for the Mental Health Practitioner Working with Infants, Toddlers, and Their Families (cont.).

Note: Supervision at the mental health level must be provided by a mental health professional working at a mentor level and be provided in a one-to-one setting with small groups as added value. Prerequisites for mental health practitioner training consist of having completed (or being currently enrolled in) a master's degree program in a mental health specialty, having taken a graduate-level psychopathology course, and having taken an undergraduate-level child development course or having demonstrated knowledge (Web-based exam, experiential credit). Portions of the Knowledge Domains meet requirements for both infant-toddler and preschool training.

[a]It is recommended that training address all knowledge areas and include a focus on children within the context of their families. Parent-child relationships and developmental issues should be infused in all areas of study.

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
a. Understanding Parenting, Family Functioning, and Preschooler-Parent Relationships	• Attachment issues affecting preschoolers • Goodness of fit • Parenting as a developmental process • Family dynamics • Cultural issues • Developing family sensitivity	• Specialized training regarding the role of parenting and family issues on preschool behavior and function • Intervention strategies to support preschooler-parent relationships	• 20 hours
b. Preschool Development	• Typical preschool development: cognition, social skills, behavioral issues, physical development, speech and language issues • Preschoolers in peer groups • Preschool settings	• Understanding the role of development in preschool mental health • Intervention options for atypical development • Development in peer settings: preschools, day-care programs	• 20 hours, plus • 4 hours of observation
c. Biological and Psychosocial Factors Affecting Outcomes in Preschoolers	• Temperament • Neurodevelopment • Regulatory issues • Sensory problems • Nutrition • Brain development • Poverty • Communities • Schools • Impact of such factors on development and relationships	• Understanding and intervening with typical and atypical factors affecting development and parenting • Evaluating the role of biological and psychosocial factors on individual preschoolers and their families	• 16 hours

Table 14.2. Training Guidelines for the Mental Health Practitioner Working with Preschool-Aged Children and Their Families.

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
d. Understanding High-Risk Influences on Early Relationships	• Atypical child and family factors • Teen parents • Chronic physical and mental illness • Developmental disabilities • Prematurity • Substance abuse • Family violence • Foster care • Institutional care	• Intervention strategies designed for high-risk families and children	• 24 hours
e. Risk and Resiliency	• Risk and resiliency factors • Factors that help insulate preschoolers and families from risk	• How to facilitate and support factors to build resiliency	• 12 hours
f. Observation, Screening, Assessment, Diagnosis, and Intervention	• Basic observational skills with preschoolers • Use of observational information • Use of screening tools with preschoolers and toddlers • How and when to refer for comprehensive assessment • Principles of reflective practice	• Specialized professional training in assessment strategies and relationship-based interventions • Report-writing skills for professional practice • Linking preschool assessment to intervention • Formulating developmentally appropriate diagnoses with preschoolers • Integrating comprehensive child and family information to formulate appropriate, family-centered, relationship-based intervention strategies	• 40 hours observation, screening, assessment, and diagnosis, plus • 40 hours advanced diagnostic and intervention strategies

Table 14.2. Training Guidelines for the Mental Health Practitioner Working with Preschool-Aged Children and Their Families (cont.).

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
g. Interdisciplinary Collaboration	• Other professional roles • Interdisciplinary collaboration on behalf of young children and families • Respecting boundaries of practice within communities	• Training in the development of interdisciplinary practice skills and strategies • Establishing collaborations	• 8 hours
h. Ethics	• Ethics of scope of practice mental health practice	• Ethical issues related to preschool	• 4 hours
Domain 2: Clinical Experience and Supervision	• Clinical work with children three to five and their families • One-to-one supervision	• Based on direct work with children and families	• 500 hours • 50 hours
Total Hours	• 184 hours Knowledge Domain, plus • 500 hours Clinical Experience Domain		• 684 hours

Table 14.2. Training Guidelines for the Mental Health Practitioner Working with Preschool-Aged Children and Their Families (cont.).

Note: Supervision at the mental health level must be provided by a mental health professional working at a mentor level and be provided in a one-to-one setting with small groups as added value. At least half of the critical hours must be with preschoolers for those seeking a certificate for preschool work. Prerequisites for mental health practitioner training consist of having completed (or being currently enrolled in) a master's degree program in a mental health specialty, having taken a graduate-level psychopathology course, and having taken an undergraduate-level child development course or having demonstrated knowledge (Web-based exam, experiential credit). Portions of the Knowledge Domains meet requirements for both infant-toddler and preschool training.

[a]It is recommended that training address all knowledge areas and include a focus on children within the context of their families. Parent-child relationships and developmental issues should be infused in all areas of study.

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
a. Understanding Parenting, Family Functioning, Infant-Parent, and Preschool-Parent Relationships	• Overview of attachment issues • Goodness of fit • Parenting as a developmental process • Family dynamics • Cultural issues • Developing family sensitivity	• Specialized training regarding impact of parenting and family issues on infant, toddler, and preschool behavior and functioning • Intervention strategies to support infant-parent and preschool-parent relationships	• 30 hours
b. Infant and Preschool Development	• Typical infant, toddler, and preschool development • Milestones • Preschoolers in peer groups • Cultural beliefs regarding development • Family expectations	• Understanding the role of development in infant and preschool mental health • Intervention options for atypical development • Working effectively with family and cultural belief systems to enhance child development	• 30 hours, plus • 6 hours of observation
c. Biological and Psychosocial Factors Affecting Outcomes	• Temperament • Neurodevelopment • Regulatory issues • Sensory problems • Nutrition • Brain development • Poverty • Communities • Schools • Impact of such factors on development and relationships	• Impact of such factors on development and relationships • Understanding and intervening with typical and atypical factors affecting development and parenting • Evaluating the role of biological and psychosocial factors on individual children and their families	• 24 hours

Table 14.3. Training Guidelines for the Mental Health Practitioner Working with Children Birth to Five and Their Families.

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
d. Understanding High-Risk Influences on Early Relationships	• Atypical child and family factors • Teen parents • Chronic physical and mental illness • Developmental disabilities • Prematurity • Substance abuse • Family violence • Foster care • Institutional care	• Intervention strategies designed for high-risk families and children	• 24 hours
e. Risk and Resiliency	• Risk and resiliency factors • Factors that help insulate young children and families from risk	• How to facilitate and support factors to build resiliency	• 12 hours
f. Observation, Screening, Assessment, Diagnosis, and Intervention	• Basic observational skills • Use of observational information • Use of screening tools with birth to five-year-olds • How and when to refer for comprehensive assessment • Principles of reflective practice	• Specialized professional training in assessment strategies and relationship-based interventions • Report-writing skills for practice • Linking assessment to intervention • Formulating developmentally appropriate diagnoses • Integrating comprehensive child and family information to formulate appropriate, family-centered, relationship-based intervention strategies	• 60 hours observation, screening, assessment, and diagnosis, plus • 60 hours advanced diagnostic and intervention strategies

Table 14.3. Training Guidelines for the Mental Health Practitioner Working with Children Birth to Five and Their Families (cont.).

Domain 1: Knowledge[a]	*Key Concepts*	*Training in Concept Application*	*Minimum Hours of Training*
g. Interdisciplinary Collaboration	• Other professional roles • Interdisciplinary collaboration on behalf of young children and families • Respecting boundaries of practice	• Training in the development of interdisciplinary practice skills and strategies	• 8 hours
h. Ethics	• Ethics of scope of practice	• Ethical issues related to infant, toddler, and preschool mental health practice	• 4 hours
Domain 2: Clinical Experience and Supervision	• Supervised clinical experience • Clinical work with children birth to three and their families • One-to-one supervision • Clinical work with children three to five and their families • One-to-one supervision	• Based on direct work with children and families	• 100 hours • 500 hours • 50 hours • 500 hours • 50 hours
Total Hours	• 252 hours Knowledge Domain, plus • 1,000 hours Clinical Experience Domain		• 1,252 hours

Table 14.3. Training Guidelines for the Mental Health Practitioner Working with Children Birth to Five and Their Families (cont.).

Note: Supervision at the mental health level must be provided by a mental health professional working at a mentor level and be provided in a one-to-one setting with small groups as added value. Prerequisites for mental health practitioner training consist of having completed (or being currently enrolled in) a master's degree program in a mental health specialty, having taken a graduate-level psychopathology course, and having taken an undergraduate-level child development course or having demonstrated knowledge (Web-based exam, experiential credit).

[a]It is recommended that training address all knowledge areas and include a focus on children within the context of their families. Parent-child relationships and developmental issues should be infused in all areas of study. Training within domains must encompass the entire birth-to-five age spectrum.

In addition, advanced training of the mental health professional is required in Domain F (observation, screening, assessment, diagnosis, and intervention) because these areas will be critical components of the mental health professional's practice. Therefore considerable time is required for the development of this domain for the mental health professional.

Course Work and Training Guidelines

The training guidelines were designed to guide the development of both academic course work through university training programs and applied workshops through continuing education, in-service training, and clinical practice settings. Based on recommendations from field reviewers regarding the difference in intensity between a workshop and an academic course, we decided to follow the recommendations of the Play Therapy Association, which gives one and a half hours of credit for every one hour of academic course work. The following discussion provides examples of how training might be provided across a range of different programs.

• *Academic course work on the undergraduate or graduate level.* A more in-depth approach would be allowed by designing semester- or quarter-long courses in the infant area, the preschool area, or both. For *core providers,* domains might be combined into two three-unit semester courses (90 hours total) or three three-unit quarter courses (90 hours total) to prepare the provider to work with either birth to threes or three to fives. In addition, sixty hours of supervised clinical work with birth to three-year-olds (or three- to five-year-olds) would be required.

For *mental health professionals,* the domains might be combined to create four three-unit semester courses (180 hours) or six three-unit quarter courses (180 hours). In addition, a yearlong (fifty-week) clinically supervised experience would be needed, with a commitment of ten hours per week of clinical work with birth to threes or three to fives. If a program was interested in training practitioners to work with children from birth to age five, use of the allowance of one and a half hours for every one hour of academic training would provide sufficient hours across the same number of courses.

Workshops and continuing education courses. Each domain is designed so that it can be taught in a freestanding workshop in blocks

of four to eight hours. In addition, supervised clinical experiences would need to be sought outside of the workshop format.

Supervised clinical practicums, internships, and postdocs. Clinical sites could design a one- to two-year intensive, involving a combination of seminars and clinically supervised experiences developed in a sequential style.

Combination approach. Finally, a practitioner might elect to gain training through a combination of academic course work, workshops, continuing education, and supervised clinical practicum or internship experiences. This model might be particularly useful for an individual who is retraining to work with young children.

CLINICAL EXPERIENCE AND SUPERVISION

Application of knowledge and skills cannot develop in a vacuum. Effective application of basic concepts involves the development of interventions at a variety of levels. Such application also requires supervision and feedback. This supervision may occur in the context of an academic setting for course work (for example, assessment training) or in supervised clinical settings where the application of information learned in workshops or the academic setting can be more fully developed.

The need for appropriate supervision is particularly evident as assessment, diagnostic, reporting, and intervention skills are developing. An appropriate mentor will be able to guide both core providers and mental health providers as they hone their skills in working with very young children and their families.

An emphasis on reflective supervision and practice in work with very young children and their families is seen in high-quality infant-toddler-preschool mental health programs. This type of supervision can be differentiated from the previous field emphasis on administrative supervision and supervision related to the mechanics of "case management." Reflective practices and related supervision involve a focus on relationships, qualitative improvement, and the investment of self in the intervention and treatment process.

The California training guidelines recommend that supervision be focused around principles of reflective practice. The definition we used for *reflective supervision* is "a regularly scheduled time when a staff member receives support and opportunities to develop insight and

skills about the process and content of his or her clinical work through in-depth discussion with a supervisor."

Supervision of the core provider may be done either individually or in a small group (four to six supervisees). Such supervision must be conducted by an experienced provider of infant, toddler, and preschool services. Supervisors may either be *master's level core providers* or *master's level mental health practitioners* with experience in supervision and in working with very young children.

Supervision of the mental health practitioner must be done individually by *mental health mentors.* We defined mentors as mental health professionals holding a minimum of a master's degree in a mental health field, plus fifteen hundred hours of experience in the direct provision of relationship-based services, including assessment, therapy, or intervention. Such services must encompass a range of practice specific to infants, toddlers, preschoolers, and their families.

Mentors must also have a demonstrated record of leadership and commitment to the field involving training, writing, and presentation skills in the area of infant-preschool mental health. In addition, they must have two years of postgraduate experience supervising the provision of infant-preschool mental health services within an infant-family or preschool-family program or a relationship-based therapeutic practice.

Mental health mentors providing supervision to individuals working with infants and toddlers must themselves have training and experience with infants and toddlers. Mentors who wish to supervise individuals providing services to preschoolers will be required to have training and experience with this age group.

CONTINUING ISSUES

Issues that remain under discussion revolve broadly around three areas: (1) *capacity building* for all professional disciplines involved with birth to five-year-olds, (2) *adoption and oversight* of the infant and preschool mental health training standards, and (3) *system issues* primarily related to barriers to infant mental health and preschool mental health service delivery.

Within the arena of capacity building, professionals in California are looking at logical ways to issue state certifications of training. No single state professional agency (such as the Board of Psychology) is interested in taking on the challenge of overseeing both its own and

other professional groups. We therefore are exploring the possibility of establishing a review body associated with an existing state organization or a California chapter of an international organization such as the World Association for Infant Mental Health, which would provide oversight for all professionals (that is, mental health and non-mental health) working with very young children. We believe this is an important step toward building a competent, recognized workforce.

We are also engaged in awareness-building activities to promote adoption of the standards. These activities include presentation of the training standards at meetings in order to help professionals understand the skills they need to become competent practitioners, to build our force of mentors, and to assist training programs in developing course work and workshops that will fit within the training guidelines. We believe this will lead to more rapid adoption of state standards and has already contributed to the growing national movement toward the development of recognized standards in the field.

Finally, we are concerned about barriers to effective service delivery, including reimbursement rates, diagnostic categories for reimbursement, and rigid licensure requirements that may preclude some competent practitioners from becoming paneled by insurance companies to provide mental health services to very young children and their families. We are continuing to work toward identifying these barriers and developing recommendations for reducing them. We look forward to working with professionals in other locations who are also struggling with these issues and hope to one day have state, national, and international standards for the provision of infant mental health and preschool mental health services.

CHAPTER FIFTEEN

An Interdisciplinary Training Model

The Wayne State University Graduate Certificate Program in Infant Mental Health

Deborah J. Weatherston, Ph.D.

The Graduate Certificate Program in Infant Mental Health at the Merrill-Palmer Institute of Wayne State University in Detroit, Michigan, was designed in 1988. Its primary purpose is to teach and support graduate students and professionals from multiple disciplines to provide infant mental health assessment and intervention services to infants, toddlers, and their families. Approved by the university's board of governors, the program is governed by the graduate school and housed at the institute. Created in collaboration with faculty from the Colleges of Liberal Arts, Education, Nursing, and Science, as well as the School of Social Work, the program reflects the university's commitment to interdisciplinary study, education, and research.

Graduates of the program work in a variety of settings and in different capacities (for example, frontline mental health clinicians, early intervention teaching staff, birth-to-three and family program supervisors, development officers, consultants to Head Start and Early Head Start programs, and university faculty). Graduates include social workers, developmental psychologists, pediatric nurse practitioners,

occupational therapists, and early childhood educators, among other professions. All are prepared at the master's level; some have earned their doctorates; a few have returned for postdoctoral study.

The training program reflects Selma Fraiberg's commitment to infant mental health theory and supervised clinical practice (Fraiberg, 1980). The program offers graduate students and professionals from multiple disciplines the opportunity to study infancy and early parenthood, family relationship development, approaches to assessment, developmental risks and jeopardized relationships, and strategies for effective, infant mental health intervention (Kaplan-Estrin & Weatherston, in press).

The training program provides a context for master's and postmaster's students and professionals from the fields of social work, psychology, early childhood, special education, and nursing to study theories about development and early intervention and to develop new skills in the practice of infant mental health. In addition to taking their academic course work, graduate students enroll in a yearlong clinical internship to apply theories about infancy and early relationship development to their work with infants and families through supervised observation, assessment, and clinical experiences. The clinical internship is the cornerstone of the graduate certificate program. Observation and clinical casework, individual supervision, group discussion within a biweekly seminar, and supportive relationships with new colleagues and peers contribute to each trainee's development within the clinical training year (Weatherston, 1999).

This chapter examines the clinical skills that are essential to accomplish the complex and delicate tasks of observing, assessing, and intervening with very young children and families with sensitivity to relationship growth. How do practitioners learn to observe carefully and respectfully, to identify competencies and understand risks within the context of each parent-child relationship? What experiences are needed to nurture the art of clinical questioning, careful listening, and empathic response? What is the role of supervision in infant mental health training? How do you prepare graduate students and professionals to be self-reflective in their work with infants, toddlers, and families? These are questions that all stakeholders need to ask when considering the design of training experiences and programs to prepare practitioners to work with very young children and their families.

THE TRAINING PROGRAM

The Graduate Certificate Program in Infant Mental Health is an interdisciplinary specialization designed to prepare graduate students and professionals to work with infants, toddlers, and families. The program reflects principles and practices embedded in Fraiberg's original description of infant mental health services (Fraiberg, 1980). The approach invites academic study and supervised work with parents and infant together—frequently in their own home—to observe, assess, understand, and support infants within the context of early developing relationships.

Requirements for admission to the graduate certificate program include admission to Wayne State University's graduate school as a master's or postmaster's degree student, work experiences with young children and families, professional and personal references, and an interview. The focus of the graduate program is developmental, educational, and clinical, with an emphasis on the social and emotional well-being of the infant, the parent, and the relationship. Significant attention is given to the personal and professional development of each trainee within a supervisory relationship for guidance and reflection.

The academic work includes (1) infant development, attachment relationships and early parenthood, (2) structured observation and formal assessment, (3) family studies, and (4) infant mental health practice. The clinical training year includes the observation of an infant within the context of the family, home visiting services to infants and families identified as at risk for developmental failure and significant emotional disturbances, a supervisory relationship, and a group seminar. (See Table 15.1.)

Course Work	*Title*	*Graduate Credits*
Theory and research	Infant Development	3 graduate credits
	Infancy: Assessment	3 graduate credits
	Family Studies	3 graduate credits
Infant mental health practice	Infant Mental Health	1 graduate credit
	Theory and Practice: IMH	1 graduate credit
	Special Issues: IMH	1 graduate credit
Supervised clinical practice	Internship: twelve-month, supervised observational and clinical experiences with infants and parents and a group seminar	10 graduate credits

Table 15.1. An Interdisciplinary Graduate Certificate Program.

Note: Total requirement is 22 graduate credits.

INFANT AND FAMILY OBSERVATION

The training of clinicians through the observation of infants has a distinguished history in England at the Tavistock Clinic and the Anna Freud Centre (Bick, 1964; Freud, 1975; Reid, 1997). Selma Fraiberg adapted this method of training when she assigned healthy infants and families to infant mental health staff and trainees in Ann Arbor, Michigan, for the purpose of learning about early development and relationships (Fraiberg, 1980). Important for understanding development in the first year of life, the observation experience invites discussion about the emotions aroused in the presence of a particular infant and expressed within the developing parent-infant relationship (Tuters, 1988). The observation of an infant within the context of the family provides a trainee or practitioner with remarkable opportunities to study early infancy, relationship development, and a family's unique adjustment to a baby's care (Fraiberg, 1980; Miller, Rustin, Rustin, & Shuttleworth, 1991; Baltman, 1994; Weatherston, 1999; Wightman & Weatherston, 2004).

Overview

The infant and family observation experience is a significant part of the Graduate Certificate Program in Infant Mental Health at Wayne State University (Weatherston & Baltman, 1992; Baltman, 1993). Infant mental health faculty designed the infant and family observation experience to complement work with high-risk infants and their families. The yearlong observation experience offers clinical trainees the opportunity to learn from infants and families who are at no identified risk, beginning during the pregnancy or first months of life and continuing through the baby's first year.

The experience includes a careful examination of infant behavior and development, as well as early parenting experiences. Graduate observers watch as a baby and parent enter into a relationship with each other. The experience prepares trainees to observe and to listen carefully; to notice the details of development, interaction, and relationship; and to reflect on what they see and hear. These experiences are significant to infant mental health practice with all infants and families. Infant and family observation offers a rich training ground for reflective practice.

The family's willingness to enter into a relationship with a trainee at a time when they are beginning their own relationship with their baby offers the trainee an exquisite opportunity to observe the complexities of

early development in a family's first year. The trainee has no responsibility to give the family advice or to provide an intervention. The trainee's responsibility is to watch the infant, noting the baby's weight, size, degree of activity, and responsiveness to face and voice. A trainee also notices the ways that a parent attends to the baby—cradling, picking up, or setting down. The trainee watches the parent and eagerly notices the parent's interest in the baby, the "dance," and not so eagerly recognizes the parent's fatigue, ambivalence, and uncertainty about what will happen next or how to respond.

Arrangements

Each observation lasts for about an hour in the family's home. The trainee videotapes the family for five to ten minutes once a month, capturing an early feeding sequence, playtime, the introduction of a new toy, diapering, bathing, or just "being with the baby" as the parent chooses to be. Each videotaped sequence provides a powerful record of one baby's development in interaction with the family. The videotape offers compelling examples of infants and parents at play, during bath time, or during a feeding. This leads to thoughtful comments, in supervision or within the training seminar, about the observed experience as well as attention to the practitioner's emotional response.

Each trainee prepares a written summary following each observation. In this way, the trainee records changes in the baby's development, along with information about the early relationship and parental response over the course of a year. The details of those observations are also shared in supervision or occasionally within the clinical discussion group. Written and videotaped recordings strengthen each trainee's understanding of development in multiple domains and better ensure attention to individual differences in relationship development, security of attachment, and the subjective experience of early parenthood.

The Learning Experience

Within the course of the year, each trainee concentrates on the baby's adaptive capacities, milestones reached, and relationship domains. Each trainee also observes the parent's responsiveness to the baby and watches carefully for signs of an early developing relationship, negotiation of crises, and individual resolutions within that first year. Growing more skilled at observing and listening, the trainee learns to hold the uncertainties, the wonder, the questions, and the concerns

about feeding and sleep routines, about a father's loneliness, about early separations, or about a mother's return to work.

The trainee works hard to contain the stresses, frustrations, and delights. In the process of recording observations and bringing them to supervision, the trainee finds his or her "voice." Each trainee begins to clarify what has been observed and to speak about the infant and parent's behavior and development within the context of the emerging relationship.

Self-Reflection

Self-reflection is significant to the infant and family observation experience. The training supervisor encourages each trainee to reflect on his or her own values about infancy and early parenthood and to consider personal experiences within a family, either recently or many years ago (Weatherston, 1999). "The baby is so unresponsive. I'm wondering what it is like for his dad to play with him and get so little in return?" And then, "My second baby was like that, too. I remember feeling somewhat upset because I wanted him to be more playful. It was a long time before I understood that he was just a quiet baby. I haven't thought about Jamie as a baby in a very long time."

In the presence of an observation family, many thoughts and feelings, some of them sobering, some of them not, are aroused. A trainee may bring these thoughts to supervision for further reflection where they may be shared and safely explored. For many trainees, the training experience is the first opportunity they have had to talk deeply about infancy, parenthood, and early development or to consider their more personal responses to families, relationship development, and early infant care.

Summary

Infant mental health trainees discover many unexpected rewards as they sit quietly to observe, with no responsibility for advice or care. They learn to listen more carefully and follow a parent's lead. They learn to watch the details of infant and relationship development that may have been overlooked before. They learn about the baby's contribution to a relationship and the importance of each parent's emotional response.

They experience the uniqueness of each developing relationship in the course of the training year. They grow aware of their own thoughts

and feelings in the process of playing a less active role. At the same time, trainees discover the wisdom of "sitting on one's hands" in the presence of infant and parent, wondering about early development and relationship change (Baltman, 1993).

WORK WITH CLINICAL INFANTS AND FAMILIES

In addition to learning about typically developing infants and their families, trainees learn to provide intervention services where there are concerns about the pregnancy or the baby and the parent's capacity to provide appropriate care. Infants and parents are referred to the infant mental health program and may receive services, primarily in their homes, for up to one year. Trainees work within the Fraiberg Model, offering emotional support, concrete resources, developmental guidance, advocacy, and infant-parent psychotherapy, as needed, and as described in greater detail in Chapter One.

Beginning Assignments

Each trainee is assigned one, two, three, or four infants and families for assessment and intervention services. Effort is made to assign families where the risk is moderate and the infant is under six months of age. There are many reasons for referral: the death of a previous baby to SIDS, the birth of a baby with special needs, premature birth and hospitalization for several weeks, the diagnosis of nonorganic failure to thrive, the inability of a baby to signal wants or needs, the inability of a baby to be comforted or consoled.

Other reasons include a mother's ambivalence or hostility toward her baby, lack of preparation or prenatal care, abandonment by the baby's father, postnatal depression, mother's history of placement in foster care. Still other referrals may be made due to a family's isolation, homelessness, poverty, chronic illness, or neglect. Some or all of these risk factors may be present. They place the social and emotional well-being of a baby and parents in jeopardy.

Developing Relationships

Each trainee is initially challenged to connect with the assigned family with whom she may work for the year. The initial challenges are to develop a trusting relationship with the family and to understand the

infant's and parent's developing capacities and concerns. All services are provided to the infant and parents together, weekly, for a minimum of one hour. Most services are provided in the family's home. The trainee is invited to practice what she has learned from her graduate course work about infants, parents, and relationship-based service.

Learning to Wonder

Under the watchful eyes of a trusted supervisor and in the clinical training seminar, each trainee discusses her work with an infant and family referred for infant mental health services. The trainee learns to wonder about both and to share observations and thoughts during supervision or in the context of the training group. "What about the baby?" the training supervisor might ask. "Tell me what you see." In this way, the supervisor invites the trainee to pay attention to details: the baby's age and size, his level of activity, his interest in his mother's face or his father's voice, the way in which he approaches her, his steady gaze, engaging smile or mournful cry.

Other questions may follow. "What does the baby bring to the newly developing relationship? What kind of care does he require?" Questions like these encourage each training participant to look at the infant referred for intervention and wonder about his development within the context of a particular relationship. For many, this is the first invitation they have had to observe a baby who is at risk and to think about what they see.

"What about the parent?" the training supervisor might also ask. "How old does she appear to be? What does the parent bring to the baby? How interested in or responsive does she seem to be to the baby? How able is the father to attend to the baby's immediate needs?" Questions like these ask the trainee to study the parent's appearance and behavior and to wonder about both. The training supervisor may also ask, "What do you think it is like to be this parent caring for this baby day after day?" With questions like these, the trainee may begin to be drawn into the infant and parent's worlds, but the observation does not stop there.

Enhancing the Study of Relationships

By processing a home visit together or examining moments on videotape, pleasurable or painful, the trainee has time to think about the intricacies of relationship and the uniqueness of a particular infant-parent

pair. The training supervisor may ask, "How do they interact with each other? How satisfying does their relationship seem to be? What emotions are contained within the interaction, expressed or silently shared?"

Professional and Personal Reflections

The shared observations lead to personal reflection. Training supervisors may ask practitioners questions that encourage thoughtful responses (Schafer, 1995; Goldberg, 1998; Foulds, 1997). "What do you find yourself thinking about as you watch this mother-baby pair?" Many respond with a thought about the baby's development or the mother's health. "I wonder if the baby has a delay. He doesn't babble or make the sounds other babies his age make." "I wonder if she is using again. She's so agitated."

Others may offer a story about a family with whom they are currently working that relates to the family under close observation in a similar way. "I was reminded of the Jones family as I listened to you talk about this mother-baby pair." Still others may be more introspective, remembering the care they gave to their own siblings many years ago. "I can't help but think about my sister when she was a year old and the fun we had. I loved taking care of her. That was a long time ago."

Or they may remember aspects of their own early experiences with a mother or father or grandmother. "I wondered about my own mother and how frightened she must have been when I was born." Many thoughts and feelings may wash over trainees as they begin to reflect, often for the first time, about the meaning of relationship development to them and the importance of early infant care.

Emotions Expressed

It is important to note that as most trainees begin to observe and assess infants and parents at high risk for disorders or disturbances, they often become more sensitive to their own emotional responses (Wright, 1986). They may become increasingly uncomfortable, frustrated, angry, or tense as they talk about a family or review a particular video sequence. They may feel lonely or deeply sad in response to a baby or family with whom they are working.

Some will protect themselves by detaching from the experience, shutting down, or turning away. Others may deny that they feel anything at all. Still others may express some ambivalence about the observation experience or the field of infant mental health, or they may

grow increasingly active in their attempts to solve "the problem" or develop a working plan. It is important for the training supervisor to allow these feelings to be experienced, to hold them respectfully, and to establish a place within the training relationship or the group where it feels safe for each practitioner to speak, if desired (Schafer, 1995).

CLINICAL QUESTIONING ESSENTIAL TO THE LEARNING PROCESS

Careful questioning enriches infant mental health observation, assessment, and intervention services. In addition to having the knowledge that is gathered through the use of formal infant assessment inventories or scales, the training supervisor wonders about a baby or parent, the dynamics of their relationship, and the caregiving environment (Wightman & Weatherston, 2004).

The Baby

Some initial questions may include the following: Who is the baby in need in this family? How old is the baby at the time of your visit? What are some of the unique characteristics of the baby? Does the baby smile in response to a face or a voice? Is the baby able to communicate wants or needs clearly? Is the baby active, responsive, engaging or not? Is the baby aware of and interested in people or activities? Is the baby responsive to caregivers? Does the baby brighten, gurgle, vocalize, or talk? Can the baby be comforted? What happens when the parent holds, touches, or amuses the baby?

The questions will vary according to the baby's age and ability. The trainee learns to keep the questions in mind in order to keep the focus on the baby and to continually record or note the changing developmental capacities or risks. This is introduced in the course work and reinforced through supervision and experiences throughout the internship year.

The Parent

The trainee also learns to wonder about the parent. The following questions are presented to help the trainee think deeply about the parent alone and in relationship to the infant: How old is the parent? How does the parent interact with or respond to you? Is the parent able to hold, stroke, comfort, feed, or attend to the baby's needs? Does the

parent appear agitated, depressed, tearful, angry, lonely? Is the parent's physical health or mental health a concern? Is the parent able to recognize the baby's cues and respond appropriately? Is the parent able to differentiate different cries and cues? Is the parent consistent in offering care, emotionally responsive, understanding of wants and needs, able to set limits that are appropriate to the infant's age? Is the parent able to follow the baby's lead?

The Relationship

When observing the infant and the parent together, the trainee also learns to think about the developing relationship: Are the interactions synchronous, smooth, and carefully tuned? Do parent and infant follow each other's lead, smiling, talking, reaching, or touching? Is there a sense of pleasure shared in the games they play? How would you describe the relationship that is developing between them? Does the infant appear safe with the parent, protected and secure? What factors protect the infant in the first months of life? What makes caregiving difficult, leading to abandonment, abuse, or neglect? What makes holding or feeding the baby almost impossible for a parent? What explains the disturbance in the development of relationship between parent and child? What enables the infant or parent to progress?

These, and questions like these, invite trainees or practitioners new to the field to think deeply about the details of early development as they are observed within a relationship context and to incorporate those details into the clinical work with infants and families (Weatherston & Tableman, 2002; Hirshberg, 1996).

The Context for Development

Finally, the trainee also learns to organize observations about the environment in which an infant and parent live. What is life like for this baby and this parent every day? A sample of questions includes these: Where does the baby reside (home, hospital, or foster care)? Who provides for the baby's daily care? Who else lives there? How safe does the baby appear to be? What is the level of activity in the home? Where does the baby sleep? Are basic needs for food, clothing, and protection met? Are there family members or friends to offer guidance and support?

Answers to these questions and others may come slowly. They are most important as guides to the infant mental health assessment and intervention process.

A Safe Base

The trainee is challenged to create a context in which families feel safe enough to talk. Attentive, respectful, and genuinely concerned, the trainee or practitioner learns to follow the parent's lead and listen without interruption, to approach with consideration and warmth, and to behave in a nonjudgmental way. Sensitive to each parent's successes and to each infant's strengths, the trainee learns to identify what is going well.

Training supervisors help trainees pay attention to vulnerabilities, clarify a parent's wants and needs, and permit the expression of worry or despair. Within the context of a secure and stable working relationship, parents begin to share their own observations about the baby, their adjustments, developmental questions, and, as appropriate, the details of the pregnancy and the baby's early care.

The trainee is prepared with an array of questions: When did you first know that you were pregnant? What was your reaction to the news? How did you feel during your pregnancy? Did you expect a baby girl or boy? Was someone with you during the baby's birth? Did your labor and delivery go as you expected? Were there any complications or changes in your plans? Did the baby leave the hospital with you? What were the first weeks at home like? How did the early feedings go? Did you have any help from your family? Was the baby's father able to be around? Does he share in the baby's care?

These, and questions like these, lead to a shared understanding of the baby's early development and relationship history and the family's needs for support and continuing care (Trout, 1987). Throughout the training experience, participants learn to ask these questions directly or indirectly, inviting parents to talk about the baby and demonstrating a willingness to listen.

Parental Histories

Finally, parental histories may also explain caregiving difficulties and relationship risks. Trainees learn about the importance of personal history as it affects caregiving capacity and parental response. Dynamics related to family relationships and early infant care are vital to the assessment and intervention process.

Questions that trainees wonder about are those related to abandonment, abrupt and extended separations from parents who provided primary care, histories of physical abuse or neglect, interruptions in relationships, removal to foster care, sexual abuse, exposure to trauma,

and unresolved losses. The trainee is instructed throughout the program to gather historical information carefully and slowly, within the context of a working alliance that is comfortable.

THE SUPERVISORY RELATIONSHIP

Selma Fraiberg was clear in her belief that individual supervision is fundamental to infant mental health training and professional development within the field (Fraiberg, 1980). Reflective supervision is at the center of the training experience at Wayne State University's graduate certificate program, too.

A Relationship for Learning

The supervisory relationship provides a relationship for learning about infants and their families, a place for clinical questioning and for individual growth. A trainee learns to bring the details of his or her work to a supervisor for careful consideration. Each supervisor gives time and attention to a trainee, offering the experience of consistency, respectful listening, and guided support.

In the course of weekly supervision, each trainee learns to observe babies carefully, to nurture vulnerable parents, to invite and listen intently to stories offered by parents, and to respond with empathy to the stories told. Trainees learn to watch infants in interaction with their parents and to respect the courage each family displays.

They watch for developmental milestones and speak about emerging capabilities and needs. They learn to hold parental disappointments and failures, grief and unresolved losses. They experience parental ambivalence, rejection, and despair. They learn to address painful experiences that make the care of a baby difficult and to offer hopefulness for change (Fraiberg, 1980; Lieberman & Pawl, 1993; Weatherston & Tableman, 2002).

Thoughtful Questioning and Wondering

Careful observation of the infant and parents together, the use of formal or informal scales or tools, gentle questioning, and thoughtful listening are requirements for successful infant mental health practice. These are important clinical competencies that are addressed throughout the academic program and during the training year. The trainee

learns to organize an abundance of information about a baby, the family, developing relationships, and the caregiving environment.

In the best of circumstances, the trainee brings the details of his or her visits into individual meetings with a training supervisor. Together they will consider the infant's developing competencies, contributions to the parent-infant relationship, disturbances, and risks. They will think about the parents, their capacities to nurture and respond to the infant, their worries, and their hopes.

Supervisor and trainee will review the details of developmental observations and clinical interviews. They will wonder what might explain disturbances or delays or an inappropriate caregiving response. Later, as their trust in each other grows, supervisor and trainee will look more closely at the feelings awakened in the presence of a particular parent and infant as they relate to the assessment process and to the trainee herself. At its best, the relationship between supervisor and trainee offers a place for reflection, questioning, shared understanding, guidance, and support (Bertacchi & Coplon, 1992; Shahmoon-Shanok, 1992).

A Holding Environment

As relationship-based services to infants and families have increased, practitioners and supervisors have written about the importance of the supervisory relationship to effective service designs. Shahmoon-Shanok (1992) writes, "When it is going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences" (p. 37).

Within the supervisory relationship, so much growth is possible for a trainee. Safely held, the trainee grows more resourceful and confident, informed about the observations she makes, and more emotionally available to the families that she serves. At the same time, she may begin to consider personal responses to the clinical relationships that she has entered (Bertacchi & Coplon, 1992; Schafer, 1996). The trainee flourishes within this encouraging and trusting teaching relationship.

Relationship Development

The trainee's interpersonal skills are important factors to successful relationship building. How a trainee approaches a parent, the tone of voice used, and the nonverbal gestures are critical to the process. As a

parent experiences sensitive care and empathic response, she grows increasingly trusting of the practitioner. They enter into a therapeutic relationship that permits talking about the baby's care and development. Within this trusting relationship, a parent may explore thoughts and feelings that are crucial to the infant's mental health and to the parent's capacity to provide more appropriate care.

Stories that have never been shared with anyone before may now be talked about with the infant mental health trainee, who is emotionally available and responsive to what the parent has to say. The stories may be about an abusive father, a neglectful mother, the birth of a baby with special needs, the death of a sibling, or the loss of a child. Overwhelmed by a variety of feelings surrounding the abuse or neglect or unresolved loss, the parent has little emotional reserve for the care of a baby, placing them both at risk. The opportunity to share stories and feelings with the infant mental health trainee may relieve the parent's emotional distress and open the possibility for relationship with the baby. The supportive relationship with the infant mental health trainee offers a model for relationship and an opportunity for change. It is significant to emotional awakening within an infant mental health intervention.

In summary, the Graduate Certificate Program in Infant Mental Health offers an interdisciplinary specialization in infancy and early intervention for graduate students and professionals interested in working with infants, toddlers, and families.

The field of infant mental health is devoted to nurturing and supporting the development of relationships between parents and infants. The understanding of relationship development and its significance to social and emotional health is a "treasure that should be returned to babies and their families as a gift from science" (Fraiberg, 1980, p. 3).

The Graduate Certificate Program in Infant Mental Health is designed to integrate theory and research about early relationship growth and health with supervised, practical experiences. Relationship development is reflected in all components of the program—the academic course work, the infant and family observation experience, intervention experiences with infants and families at risk for disturbances or disorders, supervisory relationships, and in the seminar. The overarching goal is to prepare graduate students and professionals from multiple disciplines to respect the importance of relationship for human growth and development.

References

Baltman, K. (1993, October–December). Training professionals to look into space. *The Infant Crier* (pp. 6–8). East Lansing: Michigan Association for Infant Mental Health.

Baltman, K. (1994). *Clinical training seminar, graduate certificate program in infant mental health.* Detroit: Merrill-Palmer Institute, Wayne State University.

Bertacchi, J., & Coplon, J. (1992). The professional use of self in prevention. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook* (pp. 84–90). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Bick, E. (1964). Notes on infant observation in psychoanalytic training. *International Journal of Psychoanalysis, 45,* 558–566.

Foulds, B. (1997). *Personal training materials, in-service training in infant mental health.* Detroit: Merrill-Palmer Institute, Wayne State University.

Fraiberg, S. (Ed.). (1980). *Clinical studies in infant mental health.* New York: Basic Books.

Freud, W. E. (1975). Infant observation. *Psychoanalytic study of the child.* (Vol. 30, pp. 75–94). New Haven: Yale University Press.

Goldberg, S. (1998). *Personal training materials, in-service training in infant mental health.* Detroit: Merrill-Palmer Institute, Wayne State University.

Hirshberg, L. (1996). History-making, not history-taking. In S. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 84–124). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Kaplan-Estrin, M., & Weatherston, D. (in press). Training in the seven languages of infant mental health: The graduate certificate program at Wayne State University's Merrill-Palmer Institute. *Infants and Young Children.*

Lieberman, A. F., & Pawl, J. H. (1993). Infant-parent psychotherapy. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 427–443). New York: Guilford Press.

Miller, L., Rustin, M., Rustin, M., & Shuttleworth, J. (Eds.). (1991). *Closely observed infants.* London: Duckworth.

Reid, S. (Ed.). (1997). *Developments in infant observation: The Tavistock model.* London: Routledge.

Schafer, W. (1995). *Clinical training seminar, graduate certificate program in infant mental health.* Detroit: Merrill-Palmer Institute, Wayne State University.

Schafer, W. (1996). Clinical supervision is a necessity for infant specialists. *The Infant Crier* (pp. 6–7). East Lansing: Michigan Association for Infant Mental Health.

Shahmoon-Shanok, R. (1992). The supervisory relationship: Integrator, resource and guide. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A source book* (pp. 37–41). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Trout, M. (1987). *Working papers on process in infant mental health assessment and intervention.* Champaign, IL: The Infant-Parent Institute.

Tuters, E. (1988). The relevance of infant observation to clinical training and practice: An interpretation. *Infant Mental Health Journal, 9*(1), 93–104.

Weatherston, D. (1999). Infant mental health assessment through careful observation and listening: Unique training approaches. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *World Association for Infant Mental Health handbook of infant mental health, Vol. 2: Early intervention, evaluation, and assessment* (pp. 119–155). New York: Wiley.

Weatherston, D., & Baltman, K. (1992, September). *The training of infant mental health practitioners.* Paper presented at the World Association for Infant Mental Health Conference, Chicago, IL.

Weatherston, D., & Tableman, B. (2002). *Infant mental health services: Supporting competencies/reducing risks* (2nd ed.). Southgate: Michigan Association for Infant Mental Health.

Wightman, B., & Weatherston, D. (2004). The awakening of relationships as a baby joins a family: Observations and reflections. *Bulletin for Zero to Three, 24*(3), 30–37.

Wright, B. (1986). An approach to infant-parent psychotherapy. *Infant Mental Health Journal, 7*(4), 247–263.

CHAPTER SIXTEEN

The DIR™ Certificate Program

A Case-Based Competency Training Model

Serena Wieder, Ph.D.

This chapter will describe the DIR™ Institute Certificate Program as a model for training in infant mental health and other developmental disorders. The overall certificate program is

The DIR Institute Certificate Program was initiated by Stanley Greenspan, M.D., and Serena Wieder, Ph.D., founders of the Interdisciplinary Council on Developmental and Learning Disorders. The current program has developed thanks to the dedicated efforts of its founding faculty. I would like to express special appreciation to Barbara Kalmanson, Ph.D., and Ruby Salazar, M.S.W., senior faculty who serve on the steering committee, as well as Judy Ahrano, M.D., Ron Balamuth, Ph.D., Lois Black, Ph.D., Danakae Bonahoom, M.A., Jeanetta Burpee, OTR, Sherri Cawn, SLP, Milli Cordero, Ed.D., Gerry Costa, Ph.D., Griff Doyle, Ph.D., Barbara Dunbar, Ph.D., Paula Erdelyi, M.S.W., Gil Foley, Ph.D., Sima Gerber, Ph.D., Ira Glovinsky, Ph.D., Cindy Harrison, SLP, Sharon Lowery, M.A., Monica Osgood, B.A., Beth Osten, OTR, Stephanie Pass, Ph.D., Lori Jeanne Peloquin, Ph.D., Ricki Robinson, M.D., Diane Selinger, Ph.D., Chris Seminaro, M.A., Rebecca Shahmoon-Shanok, M.S.W., Ph.D., Moshe Shtuhl, Ph.D., Rick Solomon, M.D., Rosemary White, OTR, Kelli Wilms, SLP, and Molly Romer Witten, Ph.D.

designed for experienced interdisciplinary clinicians who are already credentialed in their fields and have some background education in DIR theory and practice. It is one of several educational and training programs developed by the Interdisciplinary Council on Developmental and Learning Disorders (ICDL). These various programs provide a range of learning opportunities to multidisciplinary professionals and parents including introductory and advanced-level conferences, workshops, training and consultation to service programs, academic courses at universities, mentorship and self-study programs, a forthcoming distance learning program, and parent education programs (see Figure 16.1). Several avenues lead to the DIR certificate. The purpose of this chapter is to present the current DIR Institute Certificate Program as a model for national training in infant mental health, developmental disorders, and learning disorders.

The DIR Model of Infant Mental Health (IMH) is described at length in Chapter Eighteen. The training we provide is part of the DIR

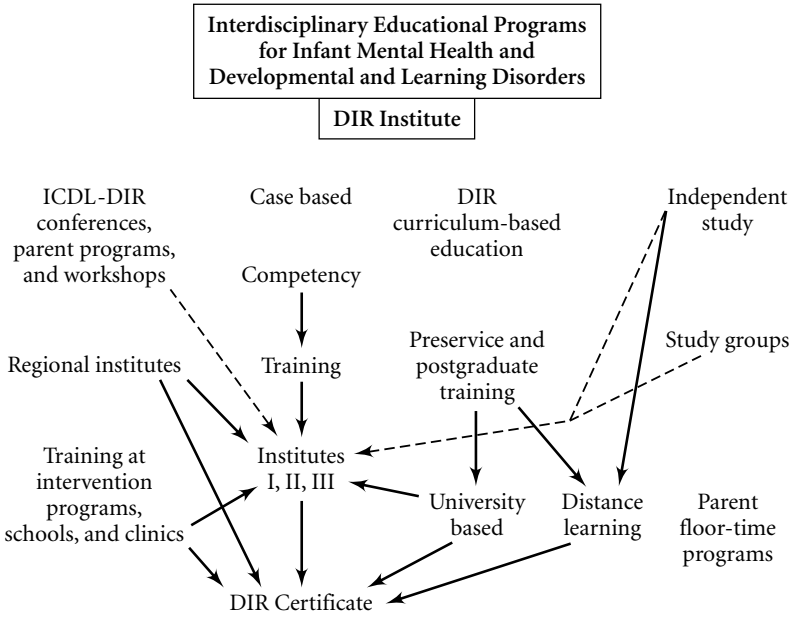

Figure 16.1. ICDL DIR™.

Certificate Program (DIRC). The goal of DIRC is to educate professionals from all disciplines related to children and families with a range of training experiences suited to their professions. Infant mental health professionals most often enter the program with some prior training and experience in this field, and they want to develop further DIR expertise in working with children with special developmental or learning needs. Other mental health practitioners are just starting their training in infant mental health and require training in the wider range of IMH studies, including parenting, family functioning, multiproblem and high-risk challenges. The majority of the DIRC faculty are IMH specialists with broad clinical, research, and administrative experience. The primary objective of the DIRC is to integrate a developmental perspective represented by the functional emotional developmental capacities along with an understanding of individual differences and relationships in families and the broader culture. This developmental perspective provides the foundation for infant and child mental health, including relating, communicating, thinking, and learning.

Like the families with whom we work, professionals come from a wide range of cultures. In addition, there are various "cultures" of training and practice among disciplines. The DIRC attempts to respect the cultures and approaches of each discipline but also attempts to open the borders between us. This is accomplished by looking at how the basic building blocks of development come together to support functioning. Thus the DIRC demonstrates how the principles of intervention can cross borders but still respect the boundaries important for families and professionals alike.

The DIR model can be applied to every avenue that reaches children and families, including prevention, early intervention, assessment, and treatment. These avenues cut across the disciplines of infant mental health, pediatrics, social and protective services, speech and language services, sensory-motor processing, and education or special education services. Whatever crossroad a family reaches or whatever needs are identified, an understanding of functional emotional development, individual differences, relationships, culture, and environment is essential. The DIR training model must integrate different knowledge bases, different models of intervention, varied cultures, and a wide range of professional experience in order to be most effective. It is only then that the DIR will achieve its full promise in the work with families.

HISTORICAL BACKGROUND

The DIR model originated in a six-year longitudinal study of infant development in multiproblem families called the Clinical Infant Development Program (CIDP). The CIDP was directed by Stanley Greenspan at the National Institutes of Mental Health. Program objectives included the provision of preventive intervention to support the development of infants in families in which other siblings and parents were already having trouble. Intervention staff included social workers and psychologists experienced in infant mental health, as well as nurses, teachers, and assistants. The research staff included psychologists and child psychiatrists who provided supervision and implemented the research protocol.

The clinical and research staff met more often than planned because of the crisis nature of the daily experience for many of the families. Reflective supervision was an essential element for sustaining the staff and the program, given the high risk and complex nature of the families served. Through reflective supervision, we strove to understand the impact of multiple dynamic factors. These included the experiences parents brought to their new infants from the past and present, the stressors of an insecure and unstable environment, and the widely varied constitutional makeup and individual needs of the infants. Mismatches between infants and their distressed parents were also examined.

The staff, in turn, was affected by worries of survival and abuse and exhilarated by the moments of helping mothers and infants to bond and experience the joy of falling in love with a new life and new possibilities. These issues, too, were addressed through reflective supervision.

Several things became evident as we worked with these families. As infant development proceeded, we needed to learn more from other disciplines about the individual differences and underlying sensory processing that we observed in self-regulation, interaction, and communication, as well as in motor execution, language, and cognition. To understand the full contribution of the infant to attachment and relationship formation, we also had to understand the match with the parent's constitutional tendencies and the impact on caregiving capacities. We also learned that the parts did not add up to the whole and that assessment of each particular aspect of development, such as language or motor milestones, did not convey how the child actually functioned.

For this, we had to develop a framework that would guide what we expected of functioning as the infant developed and relate it to the caregiving patterns and environment. How would we assess whether the infant, given his or her individual differences, was reaching the functional emotional developmental milestones needed to establish the building blocks for later functioning and mental health? In dealing with infants, we had to go beyond recognizing behaviors and symptoms that signaled difficulties, especially because typical early symptoms such as feeding and sleep disorders could be attributed to so many causes.

Instead the goals would be to develop a framework that would define the structure needed for the developing child to have the capacities to cope with whatever life would bring (in other words, the structure of the stage for the play). This framework would be linked to the parents' capacities to support their infants and would take into account what had previously been learned in infant mental health. (See Chapter Eighteen, which describes the foundations of infant mental health.)

This model was an enormous breakthrough in integrating all the components of development. It challenged all professionals working with infants and families to integrate their expertise and perspectives to best understand the functional capacities of each child. It also required professionals to determine how to provide intervention to strengthen these capacities when the child, the parents, and the environment indicated the need.

This required a framework for observing functioning, including what to look for in functioning and what elements might be impeding or derailing these critical developmental capacities. Such elements might derive from the infant's individual differences, from the parents' individual capacities to support their infant given their past and present experience, or from the impact of the environment and life's circumstances.

The formulation of this model had very specific implications for the concept of infant mental health. First, it infused development into IMH with regard to very specific aspects of emotional development and relationships. Second, it prioritized the observation of spontaneous interactions as the most important evidence of functional capacities. Functioning must be observed through interactions with others, including parents, caregivers, teachers, or peers. Evaluation of functioning must also go beyond asking parents about their children

or testing children individually. Parent interviews and formal assessment of children may provide useful information; however, it is only the observation of actual interaction that can reflect just how the child functions, utilizing all his developmental and emotional and regulatory capacities, and how the parent facilitates the child's functioning through continuous interactions.

Third, the model specified how the infant's individual characteristics might be contributing to the parents' perceptions, fantasies, and interpretation of their infant's behaviors. Fourth, and related to the last, is an emphasis on understanding the match between the parent and child as they present their individual differences within the context of interactions. For example, we may see a mismatch in the interactions between a highly underreactive baby and an overreactive parent.

There is an inherent conflict between the training within individual disciplines and this integrated view of infant mental health and functional developmental capacities. Although each discipline provides information and knowledge regarding these related components, the process of assessment and treatment has been fragmented. It is common for each professional to work within his or her own discipline and to occasionally meet to discuss infants and families. Transdisciplinary models attempt to plan for a more consistent process for individual team members to share information and intervention approaches with the whole team. The DIR model, however, is uniquely interdisciplinary in its attempts to train professionals across disciplines to integrate all relevant aspects of functioning in order to promote the development of functional emotional capacities and parent-child relationships and interaction.

THE CHALLENGE: TRAINING ACROSS DISCIPLINES

The DIRC model of training was first implemented in 1999. It was preceded by clinical case conferences at interdisciplinary senior clinician meetings during the previous decade. These interdisciplinary meetings were first held annually and then twice each year, following our national training conferences (the Infancy & Early Childhood Training Course and the annual ICDL International Conference). Initially, the clinicians attending the case conferences were psychologists

and psychiatrists, many practicing infant mental health, later joined by other disciplines. From the group, we recruited the faculty for the first DIR Certificate Program in 1999. The first two summers were used to advance invited senior clinicians to the certificate training level. They became our faculty once the program opened to the field.

We had defined the relevant issues for training and practice through the DIR model. We then needed to address the following issues: Whom would we train? What knowledge base and experience would be needed? How would we offer our training, as we were neither a clinical nor educational site and had only offered brief large-scale national-level training conferences until then? Could we expect to gather candidates from across the nation and the world for training? How often could we meet? How would we offer clinical mentorship? How would we determine the level of competence? Could we use new technology such as distance learning and teleconferencing while protecting the nature and intimacy of clinical training? How would we develop the faculty to provide training and mentorship given the expected demands in the future?

Each of these issues presented a subset of questions and challenges. We were bringing together different professional cultures and perspectives. We were bringing together different levels of training and experience. We were bringing together different populations to be studied and treated. Where to begin?

Phase I

Phase I involved a top-down approach in that we invited the most experienced clinicians to get their certificates. They would then become the faculty that we would rely on to open our program to others. At the same time, we opened the door to future candidates who could begin preparing for the certificate program through the following paths:

- Large-scale introductory-level programs open to professionals and parents with lecture-type presentations, extensive videotaped illustrations, and opportunities for questions. Participants were also offered readings, handouts, reference lists, and audio or video training materials that could be further studied independently.

- The formation of study groups, often organized by our senior clinicians, to discuss materials and look at training tapes or tapes of children, while guided by DIR profiles. Parents also initiated parent-to-parent groups in an effort to support and learn from one another.
- Mentorship and consultation were available first through senior clinicians and then through DIRC faculty, supervisors, and faculty in training.

Phase II

Phase II involved launching the DIR Summer Institute for clinicians and educators who had participated in Phase I. The goal was for this group to present their own clinical work in small case-based discussion groups as well as to participate in the mini-courses offered during the Summer Institute. Phase II also included the development of special tracks within the DIR Institute for specific groups such as IMH practitioners, educators, administrators, and parents. These institutes, as well as conferences, are also held regionally. (A detailed description of the DIR Summer Institute is provided in the Appendix.)

Phases III and IV

Phase III involves developing preservice education programs for academic institutions at the undergraduate and graduate levels. Currently, most academic training is provided within specific departments divided by discipline. Each is concerned with development and professional training using curricula, observations, and training prescribed by the discipline. Widely varied approaches are seen in assessment, intervention, and evaluation between disciplines. The goal of the DIRC is to develop certificate and graduate degrees in DIR as well as to integrate DIR into existing degree-granting and postgraduate IMH and other programs.

The goal of Phase IV, which is developing simultaneously with Phase III, is to offer a distance-learning program. This program would offer introductory- and advanced-level training that would be integrated into the DIR Certificate Program.

THE STRUCTURE OF THE DIR CERTIFICATE PROGRAM

The DIRC program was designed with several needs in mind:

- Candidates would be coming from different areas of the United States and the world.
- Candidates would already be working and would need to come for a concentrated program at a convenient time (for example, during the summer months).
- Candidates would undertake self-study or other courses to fill in gaps in their knowledge base between DIR Institutes.
- Candidates would need some form of mentoring and consultation while in the program. This would be aided by the formation of regional networks and attendance at ICDL and related conferences and workshops.
- Candidates would enter with varied experiences and readiness to complete the program. That being the case, the program would need to be paced according to individual needs to allow for varied rates of progression through it.
- Candidates would need to complete the individually determined hours of assessment, intervention, and mentorship.
- Candidates would need to demonstrate competencies through video and oral presentations, small-group discussions, and written products.
- Candidates would have opportunities to receive training to become mentors and faculty-in-training. This would lead to faculty positions, permitting the expansion of the DIRC programs.

The DIR Institute would also need to develop a parallel structure to nurture and support faculty and clinicians who have completed the certificate program and are becoming the leaders in their communities. These faculty and clinicians would be able to offer a range of DIR-based services, as well as regional institutes, academic courses at universities, and other training opportunities in their own communities.

An appreciation for the need for ongoing learning, mentorship, and consultation to one another emerged from our development as a group. Participants were eager to enhance their work by meeting to discuss cases, share experiences and readings, and tackle challenges through an on-call system. In addition, faculty would need to be mentored to conduct case-based presentations, in groups and through course work, as well as to provide workshops for others.

We would enhance our collaboration through periodic faculty retreats, which would focus on issues that we wanted to discuss in greater depth. Periodic conference calls to discuss diagnostic and treatment challenges would allow mentors to discuss mentorship issues. Additional opportunities for growth would occur through work with other faculty on specific committees related to the DIRC process, through participation in research, through the development of classification systems, and through other professional activities.

THE PROCESS OF THE DIR CERTIFICATE PROGRAM

The DIR Institute predicates training on the process of preparation, presentation, and reflective discussion of clinical case material during the institutes and during the year through mentorship. It is a competency-based approach. Candidates are expected to demonstrate specific competencies during participation at a minimum of two Summer Institutes as well as through a final written study.

During Institute I, participants present a short-term case to a small multidisciplinary group that includes two faculty members. The intent is to demonstrate the application of the DIR profiles. Participants spend two days with the same group, composed of candidates from Institutes I and II and the same faculty. Each group includes professionals from a variety of fields to enrich the discussion of challenging cases from the perspective of different disciplines.

Faculties guide the discussions to address all aspects of the case material, along with reflection on the experience and relationships of the presenter. The faculties also focus on the group process and the challenges of the responses of group members to one another. The groups are kept small (usually six to eight participants) in order to provide the safety and confidentiality of a small group, as well as to permit sufficient time for in-depth discussions.

Another feature of the group organization is mixing different levels of experience in the groups for the first two days. Beginners benefit from the more experienced clinicians from Institute II, who act as role models and actively guide the discussions and reflection in the group. This paves the way for identification of candidates who may become future faculty or trainers.

During the second two days, beginning participants work in groups composed of other participants from Institute I and new faculty members. In addition to the group process, faculties provide individual and group feedback. At the end of the institute, faculty meet to discuss evaluations and to make recommendations to each participant. These may include suggestions about how participants might further develop their knowledge base, recommendations about the types and ranges of clinical cases to pursue, and ideas about how to advance to the next institute. A plan for supervision and mentorship is also discussed. Monthly phone conferences are also available to candidates for case discussion.

Many candidates elect or are encouraged to return to gain further training at the level most appropriate to meet their training needs, either I or II. It is also possible for an applicant to request advanced placement to Institute II if they have extensive long-term experience. During Institute II, candidates present a long-term case with whom they have worked for at least eighteen months, as well as a clinically challenging case. The group may also be provided with clinical challenges by the faculty to assess responses to common case material.

We created Institute III at the request of candidates who wanted to return to work with advanced peers. The forums of Institute III are used for advanced discussions and special courses to prepare candidates to provide mentorship, to conduct training, or to teach DIR courses.

While participating in the DIRC, candidates are expected to carry a specific number of cases to ensure the development of clinical experience. Similarly, the renewal of the certificate requires ongoing clinical work and continuing education.

DETERMINING COMPETENCY

Because DIR is a competency-based program, we developed guidelines for presentations at each level with specific criteria demonstrating competencies. Evaluation forms are used to assess these presentations in

terms of the work being done and the level of integration and reflection of the candidate. Feedback is provided within the group as well as during individual miniconferences with the faculty.

In addition, each candidate is contacted after a joint faculty review that follows the institute. This is usually accomplished by a phone conference in which the faculty's evaluation and recommendations are shared. We also developed specific guidelines for use in the case-based discussion groups to evaluate the overall intervention as well as the quality (competency) of the interactions that the clinician demonstrated on videotapes while working with children and families. This could be while working directly with the child or while coaching a parent to interact with her child. These two specific components are considered in the context of the conceptualization and presentation of the overall case (including history, presenting problems, parents' history, and so forth), the therapeutic process, and reflection. Candidates are encouraged to work with a range of families in different contexts or with different challenges. The key elements of competency revolve around the application of the DIR model and its principles. Recommendations of mentors are also taken into account as candidates are advanced toward completion of the program. The requirement of four presentations over a three-year period provides multiple opportunities for evaluation of competencies in assessment and short- and long-term interventions with a range of clinical cases. Detailed formats have been developed for the evaluation of competency in candidates.

The DIR Institute provides a unique certificate model of interdisciplinary training in infant mental health and developmental and learning disorders. The model is based on case-based discussions presented by credentialed candidates, model presentations, and mini-courses at Summer Institutes. Candidates follow individualized programs between the institutes including individual and group mentorship, as well as self-study or courses to complete the knowledge base necessary for their work.

The DIR Institute prepared the foundation for this training model by recruiting highly experienced clinicians from across the United States. These clinicians were the first to complete the training and become the original faculty for the institutes. The intensive Summer Institutes and the mentorship of clinical or educational work done by candidates between the institutes provide an intensive in-depth training model. The model allows candidates to develop expertise that can be applied in a wide range of settings.

Appendix: DIR Institute Certificate Program

The DIR Certificate Program provides in-depth advanced levels of education to ensure the quality and recognition of DIR competencies. The five days at the Summer Institute are quite intense from morning to night, with some afternoon breaks. The program features the following:

- Model case presentations from professionals of different disciplines integrating DIR interventions in educational, group, and clinical practice.
- Case-based workshops with presentations by candidates in small groups with two faculty members.
- Group and individual feedback and consultation during the institute.
- Follow-up consultation, planning, and mentorship with faculty during the year.
- Mini-courses focusing on the integration of DIR principles in various interventions, work with families, work in schools, supervision and training.

Sample topics covered by the mini-courses are listed here. Some of them have an infant mental health focus.

Sample Mini-Course Offerings

A. Reflective mentorship (required of candidates in Institutes I and II)

Demonstration.

Small-Group Discussions, according to discipline when possible: two faculty members are identified to coordinate each group. Advanced candidates who have both received and provided reflective supervisory experience may indicate preference for specific II and III groups. (School Settings and

Working Across Disciplines are two of the topics included in some groups.)

B. Parent and Peer Coaching "on the floor" (home, classroom, therapy)

C. Challenges in Working with Families (Long-Term Work is one of the topics covered in some groups.)

D. The Developmental Social-Pragmatic Model

E. Developmental Language Models Informed by DIR

F. Purposeful Communication: Systematic Instruction, Augmentative Communication, and Oral Motor Treatment

G. Functional Emotional Assessment Scale (FEAS) and Individual Differences (This course focuses on scoring the FEAS. Participants should have prior experience and bring text with them.)

H. Developing Self-Regulation and Motor Planning (Cotreatment Strategies is one of the topics covered in some groups.)

I. Neurodevelopmental Groups: Implications for Intervention

J. DIR in the Community: Home-Based Programs and Transitions to School

K. Overview of Use of Medications and Related Interventions, Recognition of Seizure Disorders and Implications

L. Floor Time: Advanced Symbolic Functioning

M. Integrating DIR in the Classroom and School Consultation

N. Augmentative Facilitated Communication

O. How to Maintain Relationships with Families and Not Get into Trouble! Self-Reflection: Boundaries and Transference Issues

P. Neuropsychological Assessment and Its Application to DIR

Q. Attachment Theory, Relationships, and DIR

R. Infant Mental Health and DIR

S. Dynamic Formulation—Importance for DIR Work

T. Border Between DIR and Interpretive Psychotherapy with Neurotic Formation

U. Developmental Pathways to Symptom Formation: Diagnosis and Treatment of Anxiety, Mood, Obsessive-Compulsive, and Impulse Disorders

V. New Developments (with Stanley Greenspan)

CHAPTER SEVENTEEN

Using Technology as a Training, Supervision, and Consultation Aid

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The field of infant mental health is growing, but the centers for training are still outnumbered by the number of people who need and request training in this subspecialty field. Many graduate programs in psychology, psychiatry, nursing, education, and social work that have child and adolescent tracks do not include the treatment of infants. The factors that negatively influence the mental health of infants and children, such as poverty, domestic violence, substance abuse, and maternal depression, are widespread. Babies are born everywhere, in spite of whether or not their parents will have access to infant mental health professionals. The onus is therefore on supervisors and consultants to develop innovative methods for training and supervising professionals by remote means in such a way that services can be provided to infants and their families regardless of their geographical locations.

This chapter briefly will discuss why distance training, supervision, and consultation are appropriate and needed in the field of infant mental health specifically. More important, it will detail our experiences

with providing distance training, supervision, and consultation in two projects: the International Research Project and the Tulane University Infant Mental Health Training Program. We also propose guidelines that may be useful to individuals and programs that will participate in distance training, supervision, and consultation, either as the providers or recipients of the services.

THE NEED FOR DISTANCE TECHNOLOGY

Issues regarding infant mental health have been considered by developmental psychologists, clinical psychologists, social workers, child psychiatrists, nurses, and pediatricians for decades. Over the years, specific associations for the advancement of infant health and mental health have been established. Zero to Three was established in 1977 and holds annual training conferences. The World Association for Infant Mental Health was founded in 1980 and conducts biannual world conferences. The International Society on Infant Studies holds biennial meetings to disseminate research findings related to infants and their families. In addition to national and international organizations, there are many state associations for infant mental health, such as the Louisiana Infant Mental Health Association, the Michigan Infant Mental Health Association, and the Texas Infant Mental Health Association.

The development of these organizations and associations reflects the fact that infants and young children have unique emotional and developmental needs that frequently require unique interventions. Workshops sponsored by local, state, national, and international organizations are designed to provide information and trainings related to the unique needs of infants and very young children. However, a thorough understanding of and proficiency in infant assessment and treatment techniques cannot be fully achieved through participation in convention workshops alone.

The uniqueness of the skills required to be an infant mental health practitioner, coupled with the wide-reaching demand for infant mental health services, has required practitioners to develop innovative means of providing training, consultation, and supervision. Such methods must be designed to reach the maximum possible number of clinicians and students, using the most time-efficient and location-efficient means available.

The development of technology, such as videoconferencing using the Internet, has aided in this pursuit. However, it is important to remember that other "low-tech" means of consultation and supervision are also available, including the telephone. Training in mental health techniques, although possible via videoconferencing, is more difficult to provide, and skill proficiency is even more difficult to assess without being on-site. Training, consultation, and supervision bring with them different requirements for both the provider and the recipient, and the differences are important to consider.

In a training scenario, the trainer must provide adequate theoretical knowledge and the skill demonstration necessary for the student to become proficient at the technique being taught. The trainer must assess the student's abilities after the training is completed and provide feedback on the student's proficiency. Then it is best if the student can incorporate the feedback and make necessary changes, as evidenced by demonstration of the newly acquired skill.

In a supervision scenario, the supervisor assumes responsibility for the supervisee's actions, and the supervisee is obligated to follow the direction of the supervisor. There is an assumption that the supervisee has a knowledge and skill base that is adequate for practice but not yet adequate for *independent* practice.

In a consultation scenario, the consultant may provide a child-specific or an agency-specific consultation. In either case, skilled professionals who are able to practice independently present the consultant with a dilemma, difficult situation, or particular problem for which they require or desire outside assistance. The consultant is seen as having a particular area of expertise that the consultee does not possess. The consultant makes suggestions for a plan or plans of action, and the consultee may or may not follow those suggestions (Cohen & Kaufmann, 2000).

It is important to be clear about which type of relationship is being entered into at the outset of any arrangement. This standard is even more important when the relationship will be conducted long distance. If the relationship will be a supervisory one, the legal and licensure regulations of the state or states in which the supervision will take place must also be examined, particularly if the supervision is going to be used to fulfill licensure requirements. If regulations are not in place, advice should be sought from the licensure boards that would have jurisdiction.

METHODS OF DISTANCE SUPERVISION

All methods of distance supervision have advantages and limitations that can be evaluated to determine which is best in a given supervisory situation. There are limited means by which distance supervision can be conducted. We will review the use of the telephone and videoconferencing as methods of distance supervision. It is also possible to use electronic mail (that is, e-mail) for consultation regarding challenging cases, but it is unlikely that one could conduct ongoing supervision via e-mail.

Telephone

Supervision by telephone has the advantage of being easily accessible to both parties. All that is required is readily available telephone equipment, including a headset or a speakerphone, so that both individuals are comfortable during the supervisory session. In addition, a quiet, private room for each party is essential both so that the participants can hear each other and so that they can share information that is confidential.

If the supervisor has previously established a relationship with the supervisee, and if they both have a good command of the shared language of the discipline, then telephone supervision may be feasible. The supervisor and supervisee should make an effort to find a regular time to talk unless it is impossible to do so. Telephone supervision, because of its ease of access, can suggest a "casualness" of interaction that is inappropriate. It may also invite frequent rescheduling. The supervisor and supervisee should make an effort to meet in person on a regular basis, possibly quarterly, to enhance their relationship as well as their supervisory interaction.

Telephone supervision is much more challenging than face-to-face meetings due to several circumstances. Telephone supervision may be quite difficult when the supervisor and supervisee do not share command of the same native language, or while the supervisee is acquiring the technical language of the discipline. When the supervisee is attempting to "find the right word" or is worried about his language proficiency, his ability to participate fully is compromised. In the same vein, the ability of the supervisor to "read" the supervisee is constrained.

However, the distance created by the use of the telephone can have the advantage of the supervisee admitting perceived vulnerabilities in her skill, attitude, or confidence to the supervisor that may be more difficult to discuss in a more intimate face-to-face supervision meeting.

When telephone supervision is used in a group setting, an individual may be asking someone else for assistance in communicating a thought, and the supervisor is unable to "see" this communication.

In sum, telephone supervision has the following advantages: ease of contact, relatively low cost when used domestically (cost is a disadvantage for international supervision), the possibility of calling from a variety of locations that are not restricted by access to the Internet, and the ability to discuss more easily perceived limitations in the supervisee's skills with the supervisor. Disadvantages include reduction in basic communication, particularly when there are language differences, and inability to note the reactions—emotional, nonverbal, or otherwise—of the supervisee. Inability to see a supervisee conducting a therapeutic intervention, and being dependent on his description of the technique and its application, are drawbacks as well. The supervisor must work especially hard, such as asking about the supervisee's emotional reactions, to best utilize all the information typically important to achieving full understanding of the therapeutic dilemma.

Videoconferencing

There are a number of configurations for videoconferencing, encompassing a wide range of quality and price. The advantages of using a Webcam or of videoconferencing are found primarily in the fact that this method allows the supervisor and the supervisee to hear and to see each other. This technology is particularly valuable as they grapple with the supervisee's emotional reactions to challenging work. We find that it is almost always better to have visual as well as auditory interaction.

Having both types of information allows for the development of a more cohesive relationship between supervisor and supervisee and often enhances the quality of their supervisory interactions. This format is useful regardless of the language proficiency of the participants but is particularly essential when there are language differences between the supervisor and the supervisee or when there is group supervision.

The constraints with regard to Webcam or videoconferencing concern financial, technical, and accessibility issues. Webcams vary in price and in quality. Those of greater quality and with more extensive features can be expected to cost more. As stated earlier, it is essential to have both audio and video connections that are clear. Webcams

work by sending a signal through the Internet. They are therefore dependent on the Internet service available in both the supervisor's and the supervisee's site.

In addition, such issues as firewalls and specific computer configurations that support videoconferencing can be daunting but can be overcome. It is possible to use an inexpensive Webcam (for video) with the Internet while talking on the telephone (for audio), although this can be a frustrating experience when there is an echo on the line. In addition, of course, one must have high-speed Internet access to consider this option. Because the signal leaves one computer, travels into and through the Internet, and then is delivered elsewhere, issues of privacy may be of concern.

It also is possible to use an integrated services digital network (ISDN) line. Although the expense with this approach is usually higher both for the ISDN line and for the required equipment, it is possible to show training videotapes when ISDN is an option. Although this may be less important with a one-to-one supervisory situation, it can be quite useful in a distance-training setting.

Interface Between the Culture of Supervision and the Culture of Technology

Individuals engaged in supervision value one-to-one interaction and strive to develop an understanding of the other's experience. This is the heart of the supervisory relationship. Because this is so, having the ability to have both audio and video contact with a supervisee in a distance setting is valued and appreciated by both the supervisor and the supervisee. Those individuals engaged in the design and setup of such technology may have less of an understanding of (and sometimes less of an ability to appreciate) the need for quality of interactive capability. It is, therefore, important that the supervising site fully describe what is needed to the technician in order to ensure that the technology is in place to optimize the distance supervisory relationship.

SUPERVISION AND CONSULTATION CASE VIGNETTES

The following are two examples of programs in which the authors have been involved that use distance technology for supervision and case consultation. The first vignette describes a research project that took place in Europe but was managed both in Europe and the United

States. The supervision and case consultation were provided by professionals in the United States via telephone and Webcam. Despite the fact that the project spanned two continents, the project was "in-house," which made technical arrangements and decisions more streamlined than they would have been had the communication been among unrelated entities. The supervision and case consultation took place over a period of years, but the locations in each country for the Webcam meetings were consistent. In addition, the staff for the supervision and consultation remained remarkably consistent, which was helpful because everyone became acclimated to the technology in the same time frame.

The second vignette details a program that uses telephone supervision. The supervisees change approximately every six months, although the same supervisors have been working with the program for several years. This training program is attended by individuals from various parts of Louisiana, as well as from other states and countries. Telephone supervision is used because it is accessible to all parties and does not require a significant additional investment beyond paying for the training. Attempts were made and are ongoing to expand the training by having didactics broadcast via Webcam, but the different entities involved have not yet been able to identify and incorporate the necessary technology that will make the expansion feasible. What follows is a detailed description of our experiences with technology and distance learning and supervision in these two unique programs involving infant mental health.

Vignette One: An International Research Project

Funding was obtained for an international research project aimed at studying the development of institutionalized infants and toddlers who were randomly assigned to foster family environments or continued institutionalization. In addition, a comparison group of children from the community was recruited. All children were assessed at baseline and then at regular intervals over the next three years. On average, children were twenty-one months of age when the study began.

The study staff consisted of psychologists and social workers who were recruited in the country where the study took place. Our project manager was from the country where the study took place, and he was also an American citizen who was particularly adept at understanding and addressing the cross-cultural issues that were inevitable with such an innovative effort.

A wide variety of measures were used in the study, including measures of cognitive abilities, attachment, and behavior problems. These measures were, by and large, new to the country. Particular care was taken with questionnaire measures that needed to be translated. The research staff all spoke English, with varying levels of skill and comfort, and American researchers began to understand some of the native language. Training in administration of the measures took place in the study country. The training was provided by American personnel who were on-site during much of the feasibility phase of the project, during the first few weeks of data collection, and during quarterly visits thereafter.

DEVELOPMENT OF A SYSTEM OF FOSTER CARE. Institutionalization can have profound effects on the cognitive, socioemotional, and behavioral abilities of young children (Goldfarb, 1945; Tizard & Rees, 1975; Zeanah et al., 2003), particularly when the environment is one of severe social deprivation. In addition, such children frequently have marked speech and language delays (Glennen, 2002). Transitions into family care after institutionalization, even for young toddlers, can be very challenging for the children and for their caregivers (Chisholm, 1998).

Our goal was to provide a family care experience that was supportive to young postinstitutionalized children and a foster care network that could be duplicated throughout the country. We did not want to generate foster care that was outside the financial or practical reach of the local child protection system. We did, however, want to demonstrate a foster care network based soundly in attachment theory. Foster care was quite new to the country, and it seemed sensible to avoid some of the aspects of foster care that have given it a poor reputation in the United States and other countries.

DISTANCE SUPERVISION FOR STUDY STAFF. Distance supervision, in the form of weekly telephone calls, began very soon after data collection began. At first, discussions focused on the measures and other administrative aspects of the project. Shortly after the placement of the first toddlers into foster care, it became clear that the social workers who were administering the foster care network would need assistance as they attempted to support foster parents in their care of these very challenging, postinstitutionalized children. Supervision was increased to twice weekly telephone calls, one hour for the research assistants and one hour for the social workers. One of the authors had extensive experience in working with young foster children and their foster

families in the United States (Heller, Smyke, & Boris, 2002) and undertook the supervision of the research assistant and social work teams.

Although some foster parents had come to our network after fostering children for later international adoption, many had not been foster parents before and were confused, frustrated, and unsure of how to manage their foster child's extreme behavior. Our team decided that we would offer several simple interventions to address these behaviors. Having noted in our practice in the United States that language problems and behavior problems often co-occur (Heller et al., 2002), we decided to offer the Toddler Talk Group (Academic Communication Associates, 1999) for selected foster parents and their children. In addition, a social worker and either a psychologist or research assistant typically were teamed up to provide in-home interventions.

Our supervisory model was firmly based in attachment theory. Our goal was to implement a parallel process that included respectful interactions between supervisors and supervisees that would in turn transfer to foster parents, with the hope that the foster parent would act in a similar way toward her foster child. There were obstacles to this model, though, that we had not anticipated.

A model of clinical, rather than administrative, supervision did not exist in the country where the study took place. Workers were familiar with being criticized for failing to complete a project, but they were unfamiliar with a spontaneous flow of ideas that strengthened the clinical acumen of the psychologist or social worker. An essential component to the supervisory relationship, as we construed it, was trust. It took a long time, in fact over a year, for trust to develop. Americans, even post-9-11, are used to being taken seriously, to coming and going as they please internationally, and to being listened to and respected. It soon became clear that this was not the expectation that our supervisees brought to the supervisory relationship.

The project took place in a formerly Communist nation whose citizens had been encouraged to inform on one another. Although the Communist regime had fallen, the feeling that one was unsafe in voicing one's opinion and that information that was shared might appear to place one in a vulnerable light was quite evident in the early days of supervision. Of course, this proved a barrier to the development of the supervisory relationship. In addition, we met for group supervision due to constraints created by the large difference between the time zones of the two countries. This may have contributed to the sense that it was not safe to share vulnerable feelings.

Initial supervision occurred via speakerphone. Although team members generally spoke and understood English, they often seemed embarrassed about their English proficiency. This was complicated by the fact that we were talking on the telephone, and the speakerphone at that, thus reducing visual cues. Further, when we used the phone, it was not always possible to tell if the group had fully understood a particular point or indeed if they had heard a given comment. When it rained, the connection was often poor.

At one point, in an effort to engage playfully in a discussion about the supervisees' feelings regarding the difficult cases that they were managing, we asked that they rate their feelings, such as happiness, on a scale of one to ten, with one being quite unhappy and ten being blissfully happy. They were very uncertain about the assignment and were immediately suspicious of our intent. Would they be fired if they were unhappy? Should they act as if they were very happy in this challenging work and not admit that it was sometimes difficult? Sufficient trust had yet to be developed for them to ask for clarification or to challenge this request.

The introduction of a Web camera seemed to ameliorate the situation in both simple and profound ways. First, and quite important, the ability for both the supervisor and the supervisee group to see and hear one another made for improved communication and increased sensitivity. For example, in the past, if a supervisee had difficulty understanding a concept, her quizzical expression would not be apparent, nor would the body language of a shrug, signaling withdrawal or pulling back from the discussion, be visible. The Web camera allowed the supervisor to query the supervisee further, if she seemed confused or uncertain, and to add further clarification as needed.

The addition of visual cues also allowed the supervisor to note when the supervisees were uncertain of a word and when they would begin a discussion among themselves as to the appropriate word for the situation. Often, if the supervisee would say the word, it would be similar to either an English or French word and the supervisor could double-check that she understood the meaning that was being communicated.

Even with the introduction of the Web camera, some cross-cultural issues remained, as one might expect. There seemed to be an abiding fear that admission of mistakes or some other inadvertent comment would have serious repercussions. This was very difficult to understand for the supervisor, who did not live in fear of such an occurrence. However, this was clearly of concern to the supervisees. Continued reassurance that this was not the goal of supervision eventually contributed to the development of trust.

PROBLEMS WITH INTERVENTION. The idea of intervening with infants and very young children was a new one for the country, and although the team members were generally open to supervision, there were challenges for both the supervisees and the supervisor. For example, it was difficult for study staff to ask personal questions related to the caregivers' own feelings about the situation. This made sense, given the aforementioned fear of revealing personal information, but made it difficult to have a good understanding of the reasons that interventions seemed, at times, to fail to progress.

As an example, a common theme among foster parents was that they could not discipline one of their young foster children because the child had "suffered enough" in the institutional setting. This attitude, which we sometimes see in foster parents working with young, maltreated children in the United States (Heller et al., 2002), accounted for some of the foster parents' inability to provide structure for their young foster children, despite the clear evidence that the young child did not want to be in charge of the situation and was becoming anxious at the lack of boundaries.

Study staff sometimes were frustrated when caregivers seemed unwilling to cooperate or, worse yet, said that they would cooperate but then did not. They were encouraged to return to the foster parent and determine whether there were other factors, such as the foster parent's early childhood experiences or experiences of a recent loss regarding another foster child, which might be occurring.

On one occasion, the staff reluctantly returned to a foster mother who was having difficulty with an intervention. They did not want to "pry" and were well aware of the general hesitation for individuals to share their own personal thoughts. When they asked the foster mother about her early experiences of being parented, she revealed that she had been institutionalized at the age of six and remembered well how difficult it was for her and her brother during their stay in the institution. Her sympathy (and transference) in the situation made it difficult for her to set clear, consistent limits with her foster son. Once the team members were aware of her difficulties, they were able to educate her regarding her foster son's strong need to be guided by her and to support her as she made attempts to do so.

When it became more and more apparent that some of the children warranted interventions that were both clinically and developmentally grounded, the decision was made to divide the supervision responsibilities. A clinical psychologist was assigned to provide supervision and consultation for the psychologists. The developmental

psychologist, who was director of the foster care services program in the United States, would continue to advise the social work team. Supervisees were asked whether the new arrangement met their needs. Much cross-referencing still takes place as staff familiar with the cases work in teams to carry out interventions.

As we plan for the future and think about ways to disseminate this attachment-based model of foster care for deinstitutionalized children, as well as an attachment-based model of supervision and consultation, trust between the supervisors and supervisees has grown enormously. Gone are the supervisees' concerns about whether their English is good enough and much of their reluctance to share feelings about these complex cases and the ever-changing demands of their jobs. In their place is a solid sense that working together in mutual respect and trust is good for the team, good for the foster parents, and most of all, good for young postinstitutionalized children.

Vignette Two: Infant Mental Health Training Program

The Tulane University Institute of Infant and Early Childhood Mental Health offers an intensive yearlong training in infant mental health. There are two parts to the training: six months of on-site experience at a Tulane clinic that treats children under the age of five, and six months of case consultation. The training is attended by mental health clinicians who want to become infant mental health service providers.

ON-SITE TRAINING. Trainees spend two and a half days per week at a Tulane clinic for approximately six months. The clinic provides assessment and treatment for infants and children who are under five-years-old and who are in foster care due to abuse or neglect. Assessment and treatment is also conducted with the families of these young children. Trainees learn to complete a relationship assessment that includes but is not limited to a parent-child interaction procedure (Heller et al., 1998) and the Working Model of the Child Interview (Zeanah & Benoit, 1995). In addition, didactics are held once per week and address infant mental health topics ranging from normal child development to maternal depression.

The trainees' performance conducting interviews and interaction procedures is monitored and critiqued, along with their ability to

interpret the information from assessment measures. In addition, they observe and sometimes participate in dyadic therapy and play therapy sessions. The trainees complete written examinations after the completion of the on-site training. The trainees spend the rest of the week at their home sites, in addition to traveling to and from the Tulane clinic. At the end of the on-site experience, the trainees are assigned a mental health clinician, who serves as a consultant to them for an additional six months.

CASE CONSULTATION. For the six months following on-site training, trainees receive telephone consultation that is both child-specific and agency-specific. The child-specific consultation is aimed at assisting the trainees in integrating the on-site training that they received into work at their own clinics, and in honing the skills they had begun to develop. The agency-specific consultation is aimed at assisting the trainees in integrating the new information into their clinics' existing culture, as they are often the only clinicians in their areas who have received infant mental health training.

Telephone consultation usually is done on a weekly basis at consistent appointment times. Consultations usually last about one hour. The ways in which the trainees use the consultation varies according to the trainees' investment in infant mental health, their preexisting skills, and the nature of their caseloads at their clinics.

In addition, different consultants conduct the sessions in different ways. Some consultants have their trainees send videotapes for review prior to the consultation session. This allows the consultant to actually see what the trainee says and does in assessment and therapy without being on-site. Other consultants have telephone conversations and make visits to the trainees' clinics. Still other consultants have telephone conversations exclusively.

Using videotapes to augment telephone supervision can be extremely helpful. However, there are some issues to keep in mind. Clients must give their consent to be videotaped and for that videotape to be seen by people other than their clinician. In addition, there is an element of risk when mailing a videotape that the videotape will not reach its destination. In our program, videotapes have been hand carried by clinicians who are in the on-site phase of the training for trainees who are in the supervision phase. The videotape also has to be returned to the clinician, and the same considerations must be understood.

Advantages and Challenges of Using Distance Technology in the Two Programs

For both of these projects, the use of distance technology was an integral part of the programs' success. In the international project, it is hard to imagine having to provide case consultation or supervision via "snail mail," which takes weeks or even longer to be delivered, or having to relocate to the country for several years in order to maintain and ensure the quality of the services provided. The international project had the advantage of having the Webcam system in place, as it provided the parties with visual information and enhanced the rapport between the parties.

However, due to the time difference, this required an earlier than normal workday, with video conferencing beginning at six or seven o'clock in the morning for the supervisors and consultants in the United States. In addition, there were often problems with the Internet and telephone due to weather, the equipment in the rest of the country, or computer problems in the offices. Because of the time difference, parties could not simply call back in an hour or two when the problem had been addressed or the weather had changed. There were many mornings when the supervisors in the United States were exasperated because they had arrived at the office at dawn only to spend a frustrating hour *not* making a connection.

The training program had the advantage of providing hands-on preparation before the distance case consultation began. This allowed the supervisors and trainees to develop rapport, to varying degrees, prior to the distance consultation. In addition, they developed a shared professional vocabulary during the on-site training. When the distance consultation began, the trainees were able to mentally put a face with a voice, which was very helpful. In addition, even though they had to adjust to conducting consultation by telephone, using the telephone itself was a familiar task, and the adjustment was primarily to the setting for a supervisory and consultation experience.

What follows are our guidelines and recommendations for conducting distance training, supervision, and consultation. These guidelines will require modifications to meet the unique needs of different training programs and situations. We nevertheless hope that they provide a starting point for the considerations that one must make when instituting and maintaining a technology-based distance training, supervising, or consultation process.

GUIDELINES AND RECOMMENDATIONS FOR DISTANCE TRAINING, SUPERVISION, AND CONSULTATION

The following guidelines and recommendations have been gleaned from the experiences of the authors and their colleagues in conducting distance supervision, training, and consultation.

1. It is essential to have good, reliable equipment for distance supervision. This is particularly true when one party is using a language that is not his or her first or primary language. If the supervision or consultation will be by telephone with a group, a high-quality speakerphone is well worth the investment.
2. It is imperative to have backup plans for times when the normally reliable equipment fails. For instance, there should be an agreement that if the preferred Webcam technology is not working, a specified party will call by telephone. If they cannot make contact by telephone, electronic mail messages will be sent in order to identify the problem or reschedule the time. Finally, questions and responses can be sent via electronic mail to substitute for speaking together as an interim plan.
3. When supervision or consultation is done by telephone, it is helpful to have a stated agreement that the appointment will be treated as if the parties are meeting in person. Telephone calls can be perceived as more casual than in-person appointments, by both the caller and the caller's coworkers. For this reason, reserving a time and allowing others in the office to know that a meeting is being held will increase the chances that both the trainee and the coworkers will be respectful of the telephone call.
4. The method of communication should be chosen based on the type and length of relationship that will exist. It may not be necessary to buy computers and Webcams for a one-time consultation that can easily be done by telephone. However, visual cues almost always augment the experience rather than detract from it, and an investment in Webcam equipment is usually justifiable in long-term and long-distance relationships.
5. We have found that it is better to have face-to-face contact prior to beginning a distance supervisory or consultative relationship. It is much easier to build rapport in person than over the telephone, and a strong rapport is crucial when both parties will have to work

together in the unfamiliar territory of the high-tech world. At a minimum, both parties have to at least trust that the other party is not engaged in other activities, such as reading the mail or playing computer games while consulting on the telephone!

6. It is helpful to remember that using a Webcam or the telephone for supervision is often awkward for most people at first. The awkwardness fades over time, and the parties soon forget that they are "on camera," as they get deeper into clinical issues. In addition, it is not possible for two people in different places to speak at the same time using a Webcam—one speaker's words will cut off the other person's words. Until the parties fall into a rhythm of speaking, there may be a great deal of starting and stopping sentences, which leads to disjointed communication. It is also often the case that looking into a camera means that one cannot watch the party on the computer screen, and watching the computer screen requires that one is not looking at the other party through the camera. This can be disconcerting at times, but again, with time, a rhythm develops and both parties typically feel more at ease.

7. It is imperative to keep cultural and regional differences in mind when doing distance supervision, consultation, and training. It is more difficult to do so when one is sitting in her own office in her own world where her viewpoint makes perfect sense. It is useful to amass and consult resources concerning what is culturally acceptable in the areas where the clients are, especially around infant care. For instance, the concept of what constitutes spoiling a child may differ in different areas of the country and between countries.

8. In order to conduct training exclusively over a long distance, flawless equipment and connections are needed. It is difficult to conduct trainings that last more than an hour or two by video only. Instead it may be beneficial to spread a daylong training into several meetings rather than to attempt to cover all the material in one sitting. We do not recommend intensive, skills-based trainings that are held for multiple days, such as learning to code procedures for research, to be held via the Internet or telephone.

9. It is imperative that each site have its own technical support and that the individuals providing technical support are willing to have conversations with one another. It is extremely helpful if the technical-support person has an understanding, even a basic one, of what happens in therapy and what the parties' needs are. For example, one technical adviser stressed to the authors that headphones should be used in order to get the best sound quality and decrease audio

feedback. However, because we conduct group supervision, this method was not feasible. Another technical adviser stated that better sound quality could be obtained through use of another system that did not include video, and he could not be persuaded that the video aspect of the supervision was of the utmost importance to us. A third individual was able to listen to what we wanted and about what we were willing to compromise, and he assisted us in choosing an appropriate system. Finally, an ongoing positive relationship with a technical-support person is necessary for times when the technology fails or when the humans involved fail the technology. Adding new computers or servers or software may have bigger ramifications than expected at first sight!

10. Security on the Internet is always an issue. All parties should be aware that information is being transmitted through cyberspace, and they should discuss how confidentiality and security will be safeguarded. This can be done with software and firewalls, and by the parties deciding on details such as whether clients' names, initials, or some type of code will be used to identify them.

11. Especially when supervision is being done in order to fulfill licensure requirements, the state or states' governing entities should be consulted about the acceptability of and requirements for distance supervision. For example, if the supervision is being done between states, must the supervisor be licensed in both states?

In summary, technical tools, from the telephone to the Internet, can be used to promote training and supervision in the field of infant mental health. As with any new skill, the use of distance supervision, consultation, and training requires careful consideration of how and why the tools will be used. There is usually an adjustment period, during which time using the technology may feel awkward. In addition, technology is not perfect, and it will fail on occasion, leading to frustration for everyone involved.

However, having the ability to provide or receive supervision, consultation, or training from someone who is half a world away is a tremendous experience and well worth the initial awkwardness and intermittent frustration. In addition, technology for distance training and supervision is improving and becoming increasingly accessible to groups and individuals. This technology has the potential to meet several of the training, supervision, and consultation needs of individuals who choose to become infant mental health practitioners. Such

practitioners will be important additions to the infant mental health community as they perform the essential work of providing services to infants and their families throughout the world.

References

Academic Communication Associates. (1999). *Toddler talk: A family-centered intervention program for young children.* Oceanside, CA: Author.

Chisholm, K. (1998). A three-year follow-up of attachment and indiscriminate friendliness in children adopted from Romanian orphanages. *Child Development, 69,* 1092–1106.

Cohen, E., & Kaufmann, R. (2000). *Early childhood mental health consultation.* Washington, DC: Center for Mental Health Services, Substance Abuse Mental Health Services Administration.

Glennen, S. (2002). Language development and delay in internationally adopted infants and toddlers: A review. *American Journal of Speech Pathology, 11,* 333–339.

Goldfarb, W. (1945). Psychological privation in infancy and subsequent adjustment. *American Journal of Orthopsychiatry, 14,* 247–255.

Heller, S., Aoki, Y., Crowell, J., Chase-Lansdale, L., Brooks-Gunn, J., & Schoffner, K. (1998). *Parent child interaction procedure: Coding manual.* Unpublished manuscript.

Heller, S. S., Smyke, A. T., & Boris, N. W. (2002). Challenges facing foster children and foster families: Issues, obstacles, and interventions. *Infant Mental Health Journal, 23,* 555–575.

Tizard, B., & Rees, J. (1975). The effect of early institutional rearing on the behavior problems and affectional relationships of four-year-old children. *Journal of Child Psychology, Psychiatry, and Allied Disciplines, 27,* 61–73.

Zeanah, C. H., & Benoit, D. (1995). Clinical applications of a parent perception interview in infant mental health. *Child and Adolescent Psychiatric Clinics of North America: Infant Psychiatry, 4*(3), 539–554.

Zeanah, C. H., Nelson, C. A., Fox, N. A., Smyke, A. T., Marshall, P., Parker, S. W., & Koga, S.F.M. (2003). Designing research to study the effects of institutionalization on brain and behavioral development: The Bucharest Early Intervention Project. *Development and Psychopathology, 15,* 885–907.

PART FOUR

Innovative Models of Training and Service Delivery

CHAPTER EIGHTEEN

Developmental Pathways to Mental Health

The DIR™ Model for Comprehensive Approaches to Assessment and Intervention

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The impact of infancy and early childhood experience has long been of historical, theoretical, and clinical interest. As clinicians were called upon to address the challenges of development going awry or even being at risk, the need to identify the critical interactive experiences essential for healthy emotional development during the rapid growth of infancy and early childhood became essential. How could we be helpful during this critical period of development without a model specifying the developmental expectations for establishing the foundation for mental health?

Filling in the missing pieces of the developmental road map required constructing a truly comprehensive, developmental approach that needed to take into account all aspects of the infant's life, such as individual "processing" differences, developmental abilities, and interactive patterns, as well as caregiver, family, cultural, and community dynamics. A comprehensive developmental framework that integrates these complex components—called the Developmental, Individual-Difference, Relationship-Based (DIR™) model—is presented in this chapter to guide the assessment and intervention process in infants and young children with mental health challenges.

This model builds on the foundation for understanding infant mental health and emotional development accumulated through numerous studies and clinical experience. This includes studies on *early emotional development* by pioneers such as Spitz, Bowlby, Winnicott, Murphy, Anna Freud, and Erikson; *individual differences* by pioneers such as Brazelton, Ayres, Murphy, and Escalona; and *caregiver and family dynamics* and *early intervention* by pioneers such as Provence and Fraiberg (Spitz, 1945; Bowlby, 1951; Winnicott, 1965; Murphy, 1974; Freud, 1965; Erikson, 1959; Brazelton, Koslowski, & Main, 1974; Ayres, 1964; Escalona, 1968; Provence, 1983; Fraiberg, 1980). It also includes relatively modern literature on *normative emotional development, psychopathology in infants and young children,* and *preventive and early intervention* by individuals such as Ainsworth, Emde, Sroufe, Stern, Greenspan, Lourie, and Wieder (Ainsworth, Bell, & Stayton, 1974; Emde, Gaensbauer, & Harmon, 1976; Sroufe, Waters, & Matas, 1974; Stern, 1974; Greenspan & Lourie, 1981; Greenspan, 1992; Greenspan et al., 1987).

The formulation of the DIR model began with the Clinical Infant Development Program (CIDP) at the National Institutes of Mental Health (NIMH) from 1977 to 1983 (Greenspan et al., 1987). The CIDP was a comprehensive assessment and preventive intervention program for infants and families at risk for and with a variety of developmental and emotional challenges. It started with the challenge of reaching out and engaging mothers who still needed to be mothered themselves and struggled with their ability to nurture their children, haunted by their own past and present needs. It led to a recognition of the enormous impact of the constitutional makeup of the child on caregiving interactions and development. By observing and charting early healthy and pathologic emotional milestones, motor and sensory processing differences, and infant-caregiver and family interaction patterns, we constructed a comprehensive approach to assessment, diagnosis, and intervention.

Over time, we refined this model with further clinical experience with a wider range of challenges, including children with special needs. The DIR model for infant and early childhood mental health can be applied to a wide range of clinical challenges. These can be divided into (1) interactive disorders, such as problems with attachment, anxiety and fear, and depression; (2) regulatory disorders, where significant processing differences, such as sensory over- or underreactivity, motor planning problems, or visual-spatial processing problems, contribute to attentional, sleep, impulse control, language, or

learning problems; and (3) disorders of relating and communicating, where multiple processing challenges derail the core functional emotional developmental capacities, such as engaging and relating, reciprocal emotional gesturing, and symbol formation. This last category includes syndromes such as autistic spectrum disorders, multisystem developmental disorders, and severe deprivation reactions, as seen in children from poorly run orphanages or severe multiproblem families. (For a further description of these categories and a discussion of assessment and therapeutic approaches, see *Diagnostic Classification: 0–3;* Greenspan, 1992; Greenspan & Wieder, 1998; Greenspan et al., 1987).

THE DIR MODEL

To chart the developmental pathways to mental health and various disorders, as well as identify problems early and intervene to help an infant back on an adaptive developmental pathway before problems become chronic, it is necessary to understand the three dynamic components that work together to direct human development. The first is what the child brings into the world by way of his biological and genetic makeup. For example, relative strengths or weaknesses in processing capacities in the areas of auditory processing and language, visual-spatial processing, motor planning and sequencing, and sensory and affective modulation, as well as other cognitive, motor, or sensory processes, all play a mediating role in the way a child interacts with those around him. The second component, which includes cultural, environmental, and family factors, influences the thoughts, behaviors, and ideas that the child's caregivers or others in his environment bring to the interactions with him. These two components contribute to the third component, the child-caregiver interaction patterns.

As mentioned previously, we have termed our approach to assessing and understanding the role of all of these components in the development of infants and young children the Developmental, Individual-Difference, Relationship-Based (DIR) model. In this model, the *D* stands for the functional, emotional developmental capacities the child needs to master; the *I* refers to the individual differences, which are the expression of the child's unique biology (genetic, constitutional, and maturational components); and the *R* describes the relationship with caregivers, family members, and the larger culture.

The goal of the assessment is to understand as much as possible about the *D,* the *I,* and the *R.* These set the stage for the intervention program, where the goal is to tailor interactions with the child, including

therapeutic ones, to her individual processing differences (that is, her unique biology). The ultimate goal is to facilitate mastery of each of the core functional emotional developmental capacities (for example, engagement, affect signaling, and symbol formation). This model can help a clinician work with children and families to deal with and overcome emotional and cognitive lags, constrictions, and deficits, as well as associated symptoms, and to foster adaptive development (Greenspan, 1979, 1989, 1992, 1997; Greenspan, DeGangi, & Wieder, 2001; Wieder & Greenspan, 2001).

THE ASSESSMENT PROCESS USING THE DIR MODEL

The DIR model examines the developmental capacities of children in the context of their unique, biologically based processing profiles and their family relationships and interactive patterns. Assessments must begin with discussions and observations. They include (1) two or more clinical observations, of forty-five minutes each, of child-caregiver or clinician-child interactions; (2) developmental history and review of current functioning in terms of the functional emotional developmental levels to be achieved; (3) review of family and caregiver functioning; (4) review of current programs and patterns of interaction; (5) consultation with speech pathologists, occupational and physical therapists, educators, and mental health colleagues, including the use of structured tests on an as-needed, rather than routine, basis; and (6) biomedical evaluation.

Using these tools, the clinician can begin to uncover a unique profile of functioning in many areas that can reveal and inform a developmentally appropriate intervention plan. The comprehensive, developmental model (DIR) assesses the functional emotional *D*evelopmental levels, *I*ndividual differences in sensory and sensory-affective processing, and *R*elationships and interactions.

The D: Functional Emotional Developmental Levels

The functional emotional developmental levels provide a way of characterizing emotional functioning and at the same time a way of looking at how all of the components of development (cognition, language, and motor skills) work together in a functional manner (as a mental team), organized by the designated emotional goals at each

level. For example, when we describe an eight-month-old's capacity for two-way interactive emotional communication (reciprocal affect cueing), we take into account the cognitive component (cause-and-effect interaction), the motor component (reaching), the language component (exchanging vocalizations that convey affect), and the sensory component (using sight, touch, and perception of sound as part of a coregulated reciprocal emotional interaction). We not only look for what the infant or toddler is evidencing (for example, specific emotions or symptoms) but also for what the child is not evidencing. The eight-month-old who is calm, alert, and enjoyable, but who has no capacity for discrimination or reciprocal social interchanges, may be of more concern than an irritable, negativistic, food-refusing, night-awakening eight-month-old with age-appropriate capacities for differentiation and reciprocal social interchanges.

Each developmental level involves different tasks or goals. The relative effects of the constitutional-maturational, environmental, or interactive variables will, therefore, depend on and can only be understood in the context of the developmental levels to which they relate. For example, as a child negotiates the formation of a relationship (engaging), his mother's tendency to prefer talking over holding may make it harder for the child to become deeply engaged in emotional terms. If he has low muscle tone and is hyposensitive to touch and sound, his mother's intellectual style may be doubly difficult, as neither she nor the child is able to take the initiative in engaging the other. He may be able to negotiate this early phase of development with the support of others (for example, father "wooing" him). Then at age three, when the developmental phase and task is different, he may have an easier time, even though his mother has not changed. She is highly creative and enjoys pretend play as well as give-and-take logical discussions. The task is no longer forming a relationship but learning to represent (or symbolize) experience. His mother's verbal style is now quite helpful to him.

There are six early organizational levels of experience. Each will be described in this section with expected emotional functioning and examples of challenges. It is important to note that all levels embrace a widening range of emotions as the child develops.

I. SELF-REGULATION, INTEREST IN THE WORLD, AND SHARED ATTENTION—HOMEOSTASIS: BIRTH TO THREE MONTHS. The first level of development involves self-regulation and shared attention—that is, the capacity to attend to multisensory affective experience and at the same

time organize a calm, regulated state (for example, looking at, listening to, and following movement of a caregiver). In the early stages of development, the caregiver normally provides sensory input through play and caretaking experiences such as dressing and bathing and soothes the young infant when distressed to facilitate state organization. It is an interactive process of mutual coregulation whereby the infant uses the parent's physical and emotional state to organize himself. The early regulation of arousal and physiological states is critical for successful adaptation to the environment and for learning self-calming, attention, and emotional responsivity. The optimal level varies considerably and depends on the infant's threshold for arousal, tolerance for stimulation, and ability to control arousal.

The baby who calms down is learning the means for obtaining dependency and comfort. The baby who is interested in the world can—with a certain posture or glance—let his primary caregiver know that he is interested in visual, auditory, and tactile sensations. Infants who have difficulty calming are uncomfortable and may not be able to organize the affective domains of joy, pleasure, and exploration as well as goal-directed movement or social behaviors. Even when the infant is quite competent from a regulatory standpoint, a depressed or self-absorbed caregiver might fail to draw a baby into a regulating relationship. A caregiver who is impatient with dysregulation, or one who reacts with abuse or withdrawal, may encourage ineffective patterns of behavior.

II. FORMING RELATIONSHIPS—ENGAGEMENT: TWO TO SEVEN MONTHS. Once the infant has achieved some capacity for regulation and interest in the world (typically between two and four months of age), she becomes more engaged in social and emotional interactions. There is greater ability to respond to the external environment and to form a special relationship with primary caregivers. Engagement is supported by early maturational abilities for selectively focusing on the human face and voice and for processing and organizing information from senses. A type of synchrony of relating is evident in the way that the infant and parent use their senses, motor systems, and affects to resonate with each other in order to orchestrate highly pleasurable affect in their relationship.

Clinically, some infants are not able to employ their senses to form an affective relationship with the human world, such as when sounds, touch, or scents are avoided with chronic gaze aversion, recoiling, flat affect, or random or nonsynchronous patterns of brightening and alerting.

Functional relationships organize a widening range of emerging affects as development unfolds from positive affects such as joy and pleasure to assertiveness, curiosity, protest, and anger. Major limitations are evidenced by flat or shallow affect or when the infant is under stress.

III. TWO-WAY, PURPOSEFUL COMMUNICATION—SOMATOPSYCHOLOGICAL DIFFERENTIATION: FOUR TO TEN MONTHS. The next stage involves purposeful communication consisting of intentional, preverbal communications or gestures. These gestures convey affective communication seen in facial expressions, arm and leg movements, pointing, vocalizations, and postures or movement patterns. This stage indicates processes occurring at the somatic (sensorimotor) and emerging psychological levels once the infant is able to discriminate primary caregivers and differentiate her own actions from their consequences. One can see cause-and-effect signaling with the full range of expected emotions. For example, the eight-month-old shows pleasure with smiles and love of touching when cuddling, shows curiosity and assertiveness when reaching for a rattle, shows anger and protest as she throws her food on the floor in an intentional manner and looks at her caregiver as if to say, "What are you gonna do now?" and may protest and even bite as an expression of anger. With the lack of reciprocal responses from her caregiver, the infant may evidence affective dampening and despondency or sadness even after earlier joyfulness and adaptive attachment.

The child demonstrates mastery of this stage by using purposeful gestures, such as facial expressions, motor gestures (showing you something), or vocalizations in a reciprocal back-and-forth manner. It is important to note whether the infant or toddler initiates such gestures *(opens the circle of communication)* and if she, in turn, responds to the parents' countergesturing with a further gesture of her own *(closes the circle of communication)*. Aimless behavior, misreading of the other person's cues, fragmented islands of purposeful interaction, and self-absorbed behavior indicate challenges at this level. In addition, the ability to be purposeful around some affects, but not others (that is, around love, but not assertiveness), also indicates limitations.

IV. BEHAVIORAL ORGANIZATION, PROBLEM SOLVING, AND INTERNALIZATION—A COMPLEX SENSE OF SELF: NINE TO EIGHTEEN MONTHS. This capacity is evidenced by engagement in a continuous flow of complex, organized, problem-solving, affective interactions (for example, the fourteen-month-old who can take mother's hand, walk her to

the refrigerator, bang on the door, and when the door is opened point to the desired food). The toddler now sequences many cause-and-effect units related to wishes and intentions into a chain or organized pattern and takes a more active role in developing and maintaining the reciprocal relationship with his parent interactions. He can now use and respond to social cues to achieve a sense of competence and autonomy (sense of self).

The piecing together of many smaller cause-and-effect units of experience involves a widening range of experience, such as pleasure, assertiveness, curiosity, and dependency, into an organized pattern. For instance, a toddler may start out cuddling with parents, shift to a pleasurable, giggly interchange with them, imitate a little hand game, and then get off their laps and invite them to engage in an assertive chase game in which he runs to a room that is off-limits and turns to look at the parent. When the parent says, "No, you can't go in there," protest and negativism may emerge.

The toddler uses emotional signals to figure out if behaviors related to exploration, aggression, and limits are acceptable or not. The toddler runs back to the playroom, picks up the play phone to call mommy (indicating functional understanding of objects, used in a semirealistic way but not yet in imaginary play, guided by mental representations or ideas), and then sits on his parent's lap, pleasurably exploring pictures in his favorite book. Had someone unfamiliar come into the room, he might be wary or fearful, discriminating his affiliations. He is then able to regain security in proximity to his parent, who responsively signals that everything is OK. Had the child been across the room feeding the doll babies, distal emotional signals from his parent (for example, smiling and talking in a friendly voice) would allay his concerns. Here the child has gone full circle, suggesting that he has connected the many affective-thematic areas in multiple circles of communication.

The different gestures reveal the range and type of affects from assertive, competitive, and mildly aggressive behavior to explosive and uncontrolled rage, or from promiscuous emotional hunger to mild affection and a sincere sense of warmth and compassion. Basic emotional messages of safety and security versus danger, acceptance versus rejection, approval versus disapproval, can all be communicated through facial expressions, body posture, movement patterns, and vocal tones and rhythm. Words enhance these more basic communications, but gestures convey emotional messages even before the conversation gets started and may discount the words.

Gestural communication also relays what aspects of our own emotions are being accepted, ignored, or rejected. The raised eyebrows and head nods that we perceive quickly tell us whether the person hearing our message is reacting with excitement, anger, curiosity, or detachment. The nonverbal, gestural communication system is therefore a part of every dialogue contributing to our sense of who we are and what we perceive. In the second year of life, toddlers can make their intentions known and are learning to comprehend the intentions of others through opening and closing many circles in a row (thirty or forty emerge).

The importance of the presymbolic gestural level of communication cannot be overestimated. The clinician who only focuses on a person's words may miss an underlying, critical lack of organized gestural communication. Our gestures, in part, help us define our feelings (for example, muscle tension and anger) and also are a form of expression of feelings. Even when children move onto symbolic levels, the lack of gestural variation removes the early warning system. Children may have difficulty learning to modulate their behavior because there is no graded gestural feedback or internal signaling system. Instead they may receive only all-or-nothing punishments, much like the all-or-nothing quality of their own behavior.

A child may not establish this distal-communication capacity because a parent is overanxious, overprotective, or overly symbiotic. The child may not have optimal use of the distal modes because of a unique maturational pattern or processing problem. He may not decode the emotional intent or tone of mother's "that's a good boy." He may have difficulty reading facial gestures or interpersonal distance. He may have to be held to feel secure.

Most worrisome is the toddler who pulls away entirely from emotional relationships or becomes constricted (for example, the child who never asserts himself or is always negative) or has difficulties with affiliative behavior or does not form the intermediary warning and delay capacities for which complex internal affects are used. Such a child may tend to see people only as fulfilling his hunger for physical touch or for candy, cake, or other concrete satisfactions. Problems at this stage of behavioral organization include chronic temper tantrums, inability to initiate even some self-control, lack of motor or emotional coordination, chronic negativism, sleep disturbances, hyperirritability, withdrawal, delayed language development, and relationships characterized by chronic aggressive behavior.

V. REPRESENTATIONAL CAPACITY: EIGHTEEN TO THIRTY MONTHS. The next level involves the creation, elaboration, and sharing of meanings. This may be seen in the toddler's ability to represent experience in pretend play, the verbal labeling of feelings ("I feel happy"), and the functional use of language to express and interpret feelings rather than simply act them out ("me mad"). Pretend play is perhaps an even more reliable indicator than language of the child's ability to interpret and label, especially when the child may have language delays. Infants progress from engaging in actions with themselves (for example, feeding self) to using themselves as the agents to act upon others (for example, toddler uses a doll to feed another doll).

The elaboration of ideas or representations gradually becomes more complex as does the sense of self, which now involves symbols, not just behaviors. Initially, the elements in the complex drama may not be logically connected but may expand to include a range of themes, including dependency, pleasure, assertiveness, curiosity, aggression, self-limit-setting, and eventually empathy and love. If for any reason the child is not getting practice through interactive pretend play or functional language use, deficits or constrictions may occur, because mother or father becomes anxious in using ideas in emotionally relevant contexts.

For example, the child may be afraid of emotional fantasy, especially specific themes such as separation or rejection, aggression, or assertiveness. Parental anxiety often leads to intrusive, overcontrolling, undermining, hyperstimulating, withdrawn, or concrete behavioral patterns (such as, "Let's not talk or play about your fears or anger; instead, I will feed you because that's more comfortable"). As a result, the child may not use ideas to reason, instead regressing to the concrete prerepresentational behavioral action pattern of acting out. If parents do not permit the child to elevate aggression to the representational plane, they are leaving aggression to the behavioral discharge mode. Some children may never learn to use the representational mode to show impulsive or withdrawn behavior or may limit symbolic modes to dominance and aggression and show little elaboration in the pleasurable or intimate domain. Others may represent these dependency domains but avoid anger and aggression.

VI. REPRESENTATIONAL DIFFERENTIATION—BUILDING LOGICAL BRIDGES BETWEEN IDEAS AND EMOTIONAL THINKING: THIRTY TO FORTY-EIGHT MONTHS. The next level involves *creating logical bridges* between ideas and feelings and differentiating those feelings, thoughts, and events

that emanate from within and those that emanate from others through pretend play and reality-based conversations. As logical bridges between ideas are established, reasoning and appreciation of reality grow. The child learns to distinguish what is pretend from what is believed to be real, what is right from what is wrong, and to deal with conflicts and find prosocial outcomes. As children become capable of emotional thinking, they begin to understand relationships between their own and others' experiences and feelings ("I am mad because you took my toy"). As they develop, children balance fantasy and reality, taking time and space into account.

Pretend play often begins with feeding or hugging scenes, suggesting nurturance and dependency. Over time, however, the dramas the child may initiate (with parental interactive support) will expand to include scenes of separation (one doll going off on a trip and leaving the other behind), competition, assertiveness, aggression, injury, death, recovery (the doctor doll fixes the wounded soldier because good guys never die), and so forth. At the same time, the structure of the fantasy or drama becomes more and more logical and causally related. The He-Man doll is hurt by the "bad guys" and therefore "gets them" by riding his super rocket ship that can go on land, sea, and outer space!

It is at this stage that the young child develops the capacity to share differentiated meanings. The child not only can communicate his own ideas but also can build on the ideas and comments of the other person, thereby exploring a wider range of feelings. Parents who confuse their own feelings with the child's feelings or who cannot set limits may compromise the formation of a reality orientation. Children at this stage also begin to negotiate the terms of their relationship with others in more reality-based conversations (for example, "Can I do this?" or "Can I do that?" "What will you do if I kick the ball into the wall?"). They begin to engage in debates, opinion-oriented conversations, and elaborate, planned, pretend dramas.

The I: Individual Differences in Sensory and Sensory-Affective Processing

These biologically based individual differences in the way sensory information is processed (that is, received, interpreted, or discriminated) and used to motor-plan or sequence actions to act on intent are the result of genetic, prenatal, perinatal, and maturational variations or deficits. They can be characterized by different patterns of sensory modulation and the ability to regulate the response to sensory

input (including touch, sound, smell, vision, and movement in space). Also included are sensory overresponsivity (hyperreactivity), underresponsivity (under- or hyporeactivity), and sensory craving for sensory input in each sensory modality. Sensory processing involves interpreting the similarities and differences among stimuli (for example, recognizing specific sounds or different patterns of sound, discriminating the visual spatial field, knowing what is being touched, being aware of moving the body in space), along with postural responses (that is, balance, bilateral movement, muscle tone, and muscle control) that are necessary for motor planning and sequencing new actions.

There are also individual differences in the ability to process and react to affect, including the capacity to connect "intent" or affect to motor planning and sequencing, language, and symbols. This is based on the hypothesis that sensory information may be coupled with affective processing in each modality and gives meaning to the sensation or sensory information. Sequencing involves the capacity to sequence actions (motor planning), behaviors (executing intent), and symbols, including symbols in the form of thoughts, words, visual images, and spatial concepts. This processing capacity may be especially relevant for autistic spectrum disorders (Greenspan & Wieder, 1998).

The R: Relationships and Interactions

Using the DIR model, one observes the interaction patterns between the child, caregivers, and other family members. These interactions can bring the child's biology into the larger developmental progression and can contribute to the negotiation of the child's functional developmental capacities. Developmentally appropriate interactions mobilize the child's intentions and affects and enable the child to broaden her range of experience at each level of development, moving from one functional developmental level to the next.

In contrast, interactions that do not deal with the child's functional developmental level or individual differences can undermine progress. For example, a caregiver who is aloof may not be able to engage an infant who is underreactive and self-absorbed. In addition to the relationship between parent, child, and family members, it is important to consider the provider's own experience and expectations as she navigates known and unknown pathways in trying to help the infant and family.

THE FUNCTIONAL DEVELOPMENTAL PROFILE

The DIR assessment leads to an individualized functional profile that captures each child's unique developmental features and serves as a basis for creating individually tailored intervention programs (that is, tailoring the program to the child rather than fitting the child to a general program). The profile describes the child's functional developmental capacities, including biological processing differences and environmental interactive patterns (that is, different interaction patterns available to the child at home, at school, with peers, and in other settings). The profile should include all areas of challenge, not simply the ones that are more obviously associated with symptoms of specific syndromes or diseases. For example, the preschooler's lack of ability to symbolize a broad range of emotional interests and themes in pretend play or talk is just as important, if not more important, as that same preschooler's tendency to be perseverative or self-stimulatory. Clinically, we have often seen that as the child's range of symbolic expression broadens, perseverative and self-stimulatory tendencies decrease.

The functional approach to creating a profile enables the clinician to consider each functional challenge separately, explore different explanations for it, and resist the temptation to assume that difficulties are necessarily tied together as part of a syndrome (unless all alternative explanations have been ruled out). For example, aggression may be related to sensory underreactivity and sensory craving, coupled with punitive, unavailable caregiving. Hand flapping may be related to motor problems and is frequently seen when children with a variety of motor problems become excited or overloaded.

A special feature of the DIR profile is its focus on early presymbolic levels of functioning. Whereas higher levels of functioning are often explored through an elaboration of the content of the patient's mental life, presymbolic levels often involve basic structure-building, affective interactions, such as those involving the capacities to relate and reciprocate emotional gestures. In considering different types of problems and personalities, one is often tempted to go where the action is, getting caught up in the conflict of the moment (the family drama or—understandably—the patient's anguish). However, a full developmental profile includes early presymbolic structures as well as dynamic contents.

In each area of the profile, one looks for competencies as well as deficits (where the ability is not attained at all). One also looks for constrictions (where the ability is there but not at its full, robust, and stable form). Constrictions may involve a narrowing of the thematic or affective range (only pleasure, no anger), a lack of stability (the child can engage but loses this capacity and becomes self-absorbed whenever anxious), or a lack of motor, sensory, cognitive, or language support for that capacity (for example, the child can be assertive with words, but not with motor patterns).

A DEVELOPMENTAL MODEL FOR INTERVENTION

A number of pioneering intervention models established vital foundations for a comprehensive developmental approach. These included Selma Fraiberg's work on caregiver perceptions and misperceptions of their infants, Sally Provence's work on family support and social development, and a number of projects showing the impact of early educational enrichment programs (for example, the Carolina Abecedarian Project, the Syracuse University Family Development Research Program, the Ypsilanti Project, and the Elmira Prenatal/Early Infancy Project).

Building on these foundations, which focused on one or a few areas of development, we created a model for intervention that would include all of the facets of the child's developmental processes. This model was initially implemented in our NIMH Clinical Infant Development Program and has been extended to clinical work with children with autistic spectrum and other emotional, developmental, and learning disorders through regional networks and councils of the Interdisciplinary Council on Developmental and Learning Disorders in most major American cities. The principles of this model include the following:

1. Opportunities to enable the child to master the basic functional emotional developmental capacities described earlier.
2. Support for stable and broad-ranging mastery of these capacities. For example, the child may have mastered two-way communication in terms of dependency but not assertiveness, curiosity, or aggression. Similarly, the child may master a developmental capacity in a stable way, so that it tends to survive even under stress, such as a mild physical ailment, a brief separation from a parent, or a strong feeling.

3. Work with contributing factors, including the constitutional and maturational aspects of the child's development (that is, processing differences) and the interactive and family aspects of the child's experience.
4. Ongoing relationships (including caregivers, therapists, and educators) that foster each of the capacities described previously.

Consider, for example, problems with attachment. In the DIR model, the problem would be approached not only from the perspective of the caregiver-infant relationship and caregiver and family dynamics but also from the perspective of the infant's individual processing differences, such as sensory underreactivity and motor planning problems. Infants with attachment difficulties may be sensorially underreactive and evidence low muscle tone and motor planning challenges in addition to the challenges in the caregiver-infant interaction patterns and the overall family functioning. All of the factors may work together to intensify one another, such as a caregiver's feelings of failure because her underreactive infant is hard to engage, which then leads her to withdraw and become more and more depressed. In such a context, it is often very helpful to work directly on strengthening the infant's sensory modulation and motor capacities while working with the interactive, caregiver, and family dynamics. Similarly, challenges that are often thought to be predominantly physical in nature, such as a motor delay, require attention to the caregiver's feelings and the family patterns. Autistic spectrum disorders require attention to all of these factors.

The DIR model is a way of systematizing a comprehensive approach that harnesses all of the elements in an integrated manner. We have been able to use it to facilitate development in children with a variety of problems, ranging from autistic spectrum disorders to circumscribed regulatory and emotional challenges (Greenspan, 1992; Greenspan & Wieder, 1998, 1999; see also www.ICDL.com).

A Developmental Approach to Direct Work

Traditionally, direct work with very young children has included imaginative play, putting feelings into words, attempting to resolve conflicts, and the use of behavioral principles, as well as advice for parents to behave in certain ways with their children. These approaches often do not sufficiently deal with all of the functional emotional developmental levels, including the child's preverbal levels of interaction or the child's individual motor and sensory processing differences.

The DIR model (sometimes referred to as *Floor Time*) uses a developmental approach to working directly with the child. The approach harnesses the infant's or young child's core functional emotional developmental competencies, including capacities for attention and engagement, for two-way communication, for representing experience (if the child is eighteen months or older), and for differentiating experience (if the child is over two and a half or three years). This is accomplished by literally getting down on the floor with the youngster and engaging him by following his lead in what interests him. This is done in order to mobilize the different functional emotional developmental levels. In the case of a preverbal infant or very young child, it involves wooing him into a rhythm of reciprocal interaction, using facial expressions and gestures to pull the child in. A comprehensive, developmental DIR intervention program may involve parents, educators, and therapists in engaging the child in this way.

The parents' involvement is one of the first and certainly one of the most important goals. In general, we recommend that the parents engage their child for twenty- to thirty-minute sessions or longer for the unstructured playful side of Floor Time (that is, interactive or pretend play) a number of times each day, depending on the child's developmental needs. For three-year-olds and older children, an additional session should be devoted to the more reality-based, logical, or problem-solving aspects of Floor Time. This involves helping the child to learn to engage in cause-and-effect and anticipatory thinking. For example, the child is helped to anticipate situations and feelings and to consider alternative behaviors for problem areas (either using words, pretend play, or both).

Often the diagnostic workup may indicate that in addition to the parents' time with the child, direct one-on-one therapy is needed. The therapist should build his specific and traditional psychotherapeutic efforts on the *D* (functional, emotional, developmental level), *I* (individual differences), and *R* (relating and relationships) of the DIR model discussed earlier, incorporating the principles of Floor Time. It is important to note that direct work with the child should not supplant the Floor Time that the parents do with their child.

The clinician can help the parents figure out how to engage the child at each of the functional developmental levels and deal with the child's individual processing differences. In addition, the therapist helps the parents assist the child to apply each of these developmental capacities to a broad range of human emotions—pleasure, dependency,

excitement, assertiveness, aggression, self-limit-setting, empathy, and more mature types of love.

In the therapist's direct work with a child, through their emotional interactions, there is an attempt to facilitate the functional emotional developmental capacities up to the highest one the child has achieved, to broaden the child's emotional range, and to strengthen processing capacities. This enables the therapist to help the child who is avoidant, is overly reactive, has difficulty remaining focused, becomes easily agitated, tends to withdraw, becomes paralyzed with anxiety, has overwhelming fears, or becomes fragmented and lost in fantasy. As the clinician works with the child's individual processing differences, for example, he will be especially soothing and regulating with the hypersensitive child, energizing with the sensory underreactive child, and supportive of the child's motor and visual-spatial worlds with the child who has motor planning and visual-spatial processing challenges.

The therapist will want to coach himself in much the same way that he coaches the parents, paying attention to his own tactics. For example, "How am I trying to simplify my gestures or words for this child with an auditory processing difficulty?" He will also want to pay attention to his own emotional reactions: "Why do I get so bored and avoidant when Johnny tunes me out or becomes repetitive in his play?" The therapist may conduct his direct work either with the parents present, with the child alone, or in both ways, depending on the clinical needs of the case.

The ongoing intervention is also an ongoing assessment. The clinician who initially observes the parents' and his own interactions with the infant or child to formulate his initial diagnostic impression should continually revise these (as well as his goals) through his therapeutic experiences.

Work with Parents and Caregivers

Work with the parents and caregivers can be divided into two broad categories. The first involves a more active coaching role for the Floor Time activities with the child. The therapist may suggest that the parents try this or the other approach or actually go through the motions of Floor Time with them. Alternatively, the clinician may model Floor Time techniques with the child for the parents.

We have found that one of the best ways of coaching is to get down on the floor with the parents, sometimes whispering suggestions into

their ears, sometimes wondering aloud why they are trying something one way rather than another, and sometimes providing a few ideas that the parents can use to discover how it feels to engage their child in a new way. In general, when working with parents, the key is to capture the parents' attention, engage them, interact with gestures and expressions, and help them think about how and why they interact with their child in a certain way.

A second facet of consulting involves working with the parents' or caregivers' own difficulties in interacting with their children. One might assume that most parents would have an intuitive ability to interact with their children in the ways described earlier. This is not always the case. When this ability is not naturally occurring, however, there is usually a good reason. Perhaps the parents were unengaged in this way as children and so did not have a chance to learn these techniques; the parents may have conflicts with one or more of the developmental processes or about applying them to the different emotional realms; or there may be family challenges. The clinician will discover over time which, if any, of these factors are operating.

So in addition to the educational, coaching role, which needs to be handled with respect for the parents' need for active mastery and discovery, the clinician needs to be aware of the parents' underlying feelings and challenges. Part of the clinician's job, in this regard, is to clarify for the parents how these feelings influence their interaction with the child. Such clarification may be achieved on the floor or in sessions alone with the parents, when they can feel freer to discuss their reactions to the child's Floor Time.

It should be expected that the parents' conflicts and anxieties have to play themselves out with the child. A parent who is anxious about aggression is less likely to be able to help a child with aggression than a parent who is comfortable with it. However, parents who are motivated by warmth and concern and have the potential for growth can be mobilized by their desire to assist their children. In this way, parents can grow alongside their children.

Work with Caregiver and Family Patterns

In order to help parents utilize the Floor Time processes, the clinician must observe how family patterns have contributed to the child's current functioning (along with the other factors). For example, in a certain family, does the father's avoidance and the mother's making nice-nice with regard to the child's aggression interfere with their own

relationship? Is the mother frustrated with the father's avoidance? Is the father frustrated with her tendency to make nice-nice? How does this process affect the other children in the family?

The therapist's goal is not to become fragmented or lost in the family's patterns but to help the parents understand and work with those patterns. For example, when individual differences in the child, like sensitivities to sound or touch or tendencies toward motor discharge, have made it difficult for the parents or caregivers to engage the child, parent consultation sessions can often help the family deal with the reality of the child's sensitivities or motor difficulties without distortions or projections. Depending on the degree of family difficulties, short-term work or work over a longer period of time will be needed.

There are many disorganized families that one may wish to discount in order to work with the child alone. It may be easier to see the parents only for support or to give specific advice regarding not overstimulating or being overly punitive with a child. Even in a very dysfunctional family, where one or both parents may have a borderline personality organization or a severe character disorder or where there are serious marital problems, progress is possible. One may spend the first year simply getting consistent engagement and two-way communication among family members, without much progress in symbolizing complicated affects or seeing connections between affects. But even this accomplishment provides a strong foundation, especially if the child does not have the rug pulled out from under him by disengagement or random and chaotic communication patterns. Over time, as a foundation of engagement and simple two-way communication is established, the family's ability to symbolize and categorize complex affects will gradually grow (Greenspan et al., 1987).

Supporting the therapist through reflective supervision in this developmental process is essential. Therapeutic relationships embody the same developmental course as that described for the functional developmental course of the infant. This process ranges from establishing the regularity of meetings to developing trust in the relationship to communicating feelings and fears in the course of understanding the infant and the parent, as well as differentiating past experiences and projections. The same developmental framework can be used to guide the therapist in the dual function of supporting infants and parents simultaneously.

As Winnicott (1965, p. 39) said, "There is no such thing as an infant," in the absence of sustaining caregiving relationships, and infant mental health cannot be considered outside the context of the family.

In DIR, infant mental health cannot be considered without understanding the specific functional developmental capacities that need to be attained and the specific capacities that guide the work in the context of individual and family relationships.

The relationship with the therapist develops in synchrony with the development of the infant or young child and the family, and this can present the therapist with various challenges. These may involve learning more about development, learning more about individual differences, and appreciating complex transference and countertransference feelings. Such feelings might derive from the compelling urgency of the infant's needs that are not being met and from reactions to a parent who cannot meet them. Sometimes these feelings relate to the parent's depression or inadequacy, which may cause a shift to occur to help the parent. During such times, the therapist may lose sight of the infant. Sometimes balancing listening and working through projections of the past while also coaching the parent in direct ways to interact with her baby can be complex and confusing. The meaning of the child and the meaning of the parent are compelling influences on the therapist's ability to use herself to facilitate healthy emotional development. Reflective supervision provides the facilitation to the therapist to do this work.

CASE ILLUSTRATIONS

Consider the case of an eight-month-old, who is very fearful. She avoids assertive behavior, crying insistently until her mother picks her up. This infant has no constitutional or maturational problems. As one watches the mother and the child interact, one sees that every time the baby makes a sound, the mother assumes it is a sound of distress, rather than just a sound of "Hey, what a wonderful world this is!" or a sound of assertiveness. The mother moves in right away to find out what is wrong. As a result, the baby never seems to have an opportunity to flex her muscles, to try things out, or to initiate interaction. Talking to the mother reveals that she is a person who feels "empty" inside. She wants to make sure her baby feels "filled up." The father is also overprotective, and mother feels distressed when he competes with her.

This baby has some capacity for two-way interaction—she can gesture and signal. However, she is unable to use gestures to deal with assertiveness, aggression, or separation, because the mother intervenes too quickly. One sees the early beginnings of a very passive, fearful character structure.

What therapeutic approach is appropriate here? One wants to encourage the baby to be more assertive, but not at the cost of putting the mother aside. Mother needs to help her baby negotiate the stage of two-way intentional interaction. (The abilities to be calm and attend and to engage well are already in place.)

The goal then is to help the mother read the baby's signals better in order to understand the baby's natural assertiveness. As mother learns to slow down her response a bit and observe more before she moves in, she can foster not only the baby's dependency needs but also the baby's assertiveness needs.

Another case involves a two-and-a-half-year-old boy who has nightmares, wakes up, and comes into his mother's bed. He is competent constitutionally and maturationally. When the baby interacts with the mother during play, he vacillates between being very aggressive and very fearful. He has the dolls hitting one another and then becomes overexcited and almost shaky. The father does a lot of roughhousing, because he wants the child to be "tough," but he doesn't help the child represent emotions in his pretend play. Mother is a very cautious person. She is sincere and not overprotective, but when the baby begins playing or talking, the mother seems to be a step behind. The baby will say, "Truck crash." Instead of saying, "Oh, yes, the trucks are crashing. What are they going to do next?" the mother may watch silently for a few seconds, then look perplexed, and then make an indirect comment, such as, "Do you want this truck, too?" Her pauses interrupt the rhythm of the interaction.

Many depressed caregivers seem to be a step slow in their interactions. These "empty holes" (as they might be described) in the expected rhythm of communication may create in the child a feeling of grabbing at empty space. We have seen children respond with agitation and increased activity, feelings of uncertainty, distractibility, and dysphoric affects including sadness and emptiness. Both the pattern of early reciprocity and the formation of representational abilities may be affected.

Based on these clues, what does one do to help this child get over his nightmares? One sees that the child is not getting support from either parent for symbolizing or representing affect. His mother is cautious and somewhat depressed, and the rhythm of her voice, instead of helping him to represent his feelings by confirming them in a representational form, tends to leave the child feeling disconnected. She lacks the ability to cue affects and represent experience with him.

The father pulls in the opposite direction. He pushes the child to "Go out and be John Wayne," while the mother is saying, "I'm not sure I can offer you all that much security." The father is giving the child support for assertiveness but only in prerepresentational forms. In so doing, he is also overexciting and overwhelming the child.

As a result of these conflicting experiences, the child cannot harness and integrate his emerging ability to symbolize experience and to accommodate his security needs with this assertiveness. Neither parent helps him elevate experiences to representational levels. It is not surprising that he would have scary dreams. The clash of his experiences worries him at night. The fact that he can have nightmares is in part a positive sign, because it means that he can at least partially symbolize experiences and use images, although he is not yet able to symbolize them enough to work them through.

The therapeutic approach appropriate for this child calls for sessions for both child and parents. The therapist can help the mother be a little quicker to respond (just the opposite of the previous case) and empathize with her child's feelings. Also the therapist will need to find out more about her depression (which may cause her rhythm to be so slow). The therapist can help the father be more sensitive to the child's dependency needs and help him modulate his approach to his child's assertiveness. Both parents can work to facilitate the child's emerging representational abilities in daily Floor Time, so that he can fully represent feelings of both dependency and assertiveness.

A group of children who might be described as having impulse control difficulties illustrates the role of preverbal interactive patterns. A number of bright, verbal two- to five-year-olds (with excellent motor and language abilities) had a common problem with either hitting peers or parents or exhibiting unpredictable, provocative behavior, which was quite resistant to routine parental limits. In observing these children over a period of time, we noticed that neither they nor their parents used anticipatory gestural communication, including facial gestures, vocal gestures, affect gestures, or motor gestures.

It occurred to us that perhaps these families, who seemed to include a high degree of "poker-faced" individuals, had failed to negotiate an important aspect of gestural communication in the second year of the child's life. During this time, it is likely that gestures serve a number of functions for the child with regard to self-limit-setting. Gestures may help the child identify his own feelings and intentions. Adults, in part, know their feelings through the feedback from their own facial expressions, clenched fists, or angry voices, and it seems as

though affects are in part defined by their somatic manifestations. In addition, the parents' gestures, such as an angry look, a stern grimace, or a firm finger-pointing may help warn the child of his parents' reaction before a parental sanction is necessary. Finally, the child's gestures may also help the parents anticipate what the child is about to do, allowing them to intervene in a warning way before the child misbehaves. This system of gestural communication is highly developed in the animal kingdom. Two animals will posture and gesture to one another, seeing who will back down so they can avoid a fight. Similarly, this gestural communication appears to play a significant role in the safe handling of interpersonal aggression in humans. It should not be surprising that in cases where this system has not developed properly for a variety of reasons, psychosocial as well as constitutional, one might see impulsive behavior.

We have shown that the Developmental, Individual-Difference, Relationship-Based (DIR) model builds on a considerable foundation of work in infant and early childhood mental health. Filling in the developmental road map and integrating different contributing developmental processes, it considers all of the elements of a comprehensive, developmental approach, including the mastery or nonmastery of the child's functional emotional *D*evelopmental milestones; the child's biologically based *I*ndividual differences; and the child's *R*elationships with his parents and caregivers, as well as the larger context of his family and culture. It guides both assessment and intervention and enables parents to be totally involved in the care of their infants and young children, even when there are significant problems. In this model, the goal is for the child not just to overcome problems but also to get back on an adaptive developmental pathway.

References

Ainsworth, M.D.S., Bell, S. M., & Stayton, D. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In M. Richards (Ed.), *The integration of the child into a social world* (pp. 99–135). Cambridge, England: Cambridge University Press.

Ayres, J. A. (1964). Tactile functions: Their relation to hyperactive and perceptual motor behavior. *American Journal of Occupational Therapy, 18,* 6–11.

Bowlby, J. (1951). *Maternal care and mental health* (World Health Organization Monograph No. 2). Geneva: World Health Organization.

Brazelton, T. B., Koslowski, B., & Main, M. (1974). The origins of reciprocity: The early mother-infant interaction. In M. Lewis & L. Rosenblum (Eds.), *The effect of the infant on its caregiver* (pp. 49–76). New York: Wiley.

Diagnostic classification: 0–3. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (1994). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Emde, R. N., Gaensbauer, T. J., & Harmon, R. J. (1976). Emotional expression in infancy: A biobehavioral study. *Psychological Issues Monograph No. 37.* Madison, CT: International Universities Press.

Erikson, E. (1959). *Identity and the life cycle: Selected papers, with a historical introduction by David Rapaport.* Madison, CT: International Universities Press.

Escalona, S. (1968). *The roots of individuality.* Hawthorne, NY: Aldine de Gruyter.

Fraiberg, S. (Ed.). (1980). *Clinical studies in infant mental health: The first year of life.* New York: Basic Books.

Freud, A. (1965). *Normality and pathology in childhood: Assessments of development.* Madison, CT: International Universities Press.

Greenspan, S. I. (1979). Intelligence and adaptation: An integration of psychoanalytic and Piagetian developmental psychology. *Psychological Issues. Monograph No. 47/48.* Madison, CT: International Universities Press.

Greenspan, S. I. (1989). *Development of the ego: Implications for personality theory, psychopathology, and the psychotherapeutic process.* Madison, CT: International Universities Press.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International Universities Press.

Greenspan, S. I. (1997). *The growth of the mind and the endangered origins of intelligence.* Reading, MA: Addison Wesley.

Greenspan, S. I., DeGangi, G. A., & Wieder, S. (2001). *The Functional Emotional Assessment Scale (FEAS) for infancy and early childhood: Clinical & research applications.* Bethesda, MD: Interdisciplinary Council on Developmental and Learning Disorders.

Greenspan, S. I., & Lourie, R. S. (1981). Developmental structuralist approach to the classification of adaptive and pathologic personality organizations: Application to infancy and early childhood. *American Journal of Psychiatry, 138*(6), 725–735.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth.* Reading, MA: Perseus Books.

Greenspan, S. I., & Wieder, S. (1999). A functional developmental approach to autism spectrum disorders. *Journal of the Association for Persons with Severe Handicaps, 24*(3), 147–161.

Greenspan, S. I., Wieder, S., Lieberman, A. F., Nover, R., Lourie, R., & Robinson, M. (1987). Infants in multirisk families: Case studies in preventive intervention. *Clinical Infant Reports: No. 3.* Madison, CT: International Universities Press.

Murphy, L. (1974). *The individual child.* (Department of Health, Education, and Welfare publication no. OCD 74–1032.) Washington, DC: U.S. Government Printing Office.

Provence, S. (Ed.). (1983). Infants and parents: Clinical case reports. *Clinical Infant Reports: No 2.* Madison, CT: International Universities Press.

Spitz, R. A. (1945). Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child, 1,* 53–74.

Sroufe, L., Waters, E., & Matas, L. (1974). Contextual determinants of infant affective response. In M. Lewis & L. Rosenblum (Eds.), *The origins of fear* (pp. 49–72). New York: Wiley.

Stern, D. (1974). Mother and infant at play: The dyadic interaction involving facial, vocal, and gaze behaviors. In M. Lewis & L. Rosenblum (Eds.), *The effect of the infant on its caregiver.* New York: Wiley.

Wieder, S., & Greenspan, S. I. (2001). The DIR (developmental, individual-difference, relationship-based) approach to assessment and intervention planning. *Zero to Three, 21*(4), 1–19.

Winnicott, D. W. (1965). The theory of the parent-infant relationship. In D. W. Winnicott, *The maturational processes and the facilitating environment* (pp. 37–55). Madison, CT: International Universities Press.

CHAPTER NINETEEN

The *Relationships for Growth* Project

A Transformational Collaboration Between Head Start, Mental Health, and University Systems

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This chapter describes the *Relationships for Growth* (*RfG*) Project—an intense, four-year pilot aimed at seamlessly interweaving mental health services and approaches within Head Start, in large part by training Head Start staff.[1] We include an evaluation of child outcomes as well as preliminary reflections from participants on the process of training, supervision, and partnership collected through ethnographic methods to illuminate systemic change. We call this change *the ripple effect* of this *transformational enterprise.*

The *RfG* Project is a school-based, innovative, strength-centered, and comprehensive model of child mental health assessment and intervention as well as staff training. Developed as a pilot five years ago, it is based on the service and training program for mental health professionals, educators, and others provided by the Early Childhood Group Therapy (ECGT) Program of New York's Jewish Board of Family and Children's Services' (JBFCS) Institute for Infants, Children & Families (JBFCS-Institute). JBFCS-Institute holds over three and a half decades of continuous experience in integrating mental health approaches within preschools of all kinds. Although the conceptual

and descriptive underpinnings of ECGT (Brusiloff & Merkin, 1981; Brusiloff & Witenberg, 1973/1983; Shahmoon-Shanok, 2000; Shanok, Welton, & Lapidus, 1989) form the theoretical foundation of the *RfG,* the focus in this chapter is on the systemic impact of the *RfG* on the overall service capacity of the community agencies that it serves.

HISTORICAL ROOTS

When JBFCS-Institute and the Administration for Children's Services (ACS)-Head Start formed a partnership in 1999 to develop the *RfG,* both had a long-time interest in the social-emotional, cognitive, and linguistic well-being of preschoolers. Although conceived and launched with very similar goals, at virtually the same moment over thirty-five years before, each organization followed distinctly different growth patterns.[2]

Opening in 1965 as a six-week summer program, Head Start quickly became the largest national intervention for low-income families with young children (Zigler & Valentine, 1997). The ECGT program of JBFCS-Institute remained small, working with about thirty-five children a year within a few host preschool sites over many consecutive years.[3] The ECGT Program is a peer play psychotherapy modality offered to children with social, emotional, cognitive, linguistic, or behavioral challenge within preschool settings of all kinds, serving the spectrum of diverse New Yorkers and other families nationally. Implemented in schools, it encourages collaborations with school staff in identifying children in need and in reaching out to their parents. The ECGT Training Program, in turn, prepares practitioners from all disciplines to carry out this work.

From its inception in 1966 and 1967, ECGT aspired to ready children to succeed in school with all of the capabilities that this mission implies. It was solidly rooted in the mental health disciplines of psychoanalysis and psychodynamic psychotherapy, social work, clinical psychology, psychiatry, and community psychiatry and in the principles and practice of progressive early childhood education, itself a blend of education and mental health.

The ECGT Training Program began in 1974.[4] It soon brought together both experienced and new educators, mental health workers, and professionals from other disciplines for its two-year half-time fellowship program. The training program consists of two intensive weekly content seminars, a clinical staff meeting, a continuous group

conference focused on one playgroup's evolution over time, and weekly individual and group supervision. Seminar topics include typical and atypical early childhood development; play; psychoanalytic-psychodynamic theory; and ECGT-specific approaches to assessment, to peer play psychotherapy, to working in host settings, and to outreach and intervention with parents. Over the last fifteen years, the program has integrated screening and intervention approaches from applied speech and language therapy, occupational therapy and sensory integration, and the arts therapies.

By the mid-1980s, ECGT leadership had recognized its ability to reach children, families, and staff alike and was seeking resources to expand its services and training within a research-demonstration frame. ECGT seemed to be uniquely well suited to Head Start—a large, stable, national, multigenerational intervention—as it espoused similar goals for children: school readiness through a focus on the "whole" child, and for families: strength-based support and education. Both envisioned the possibility of supporting vulnerable children without requiring labels or emphasizing diagnoses. Clearly, Head Start was fertile soil for ECGT expression.

In the mid-1990s, ACS-Head Start became motivated to increase the number of children assisted by mental health services because, both nationally and in New York City, Head Start was actively seeking ways to respond to the mental health needs of children. The ACS-Head Start leadership, long committed to staff training and professional development, also recognized that something more was needed to support teachers and other staff who often felt ill equipped to respond to the large numbers of children with social-emotional, cognitive, linguistic, and behavioral concerns. After initial discussions between the parties, ACS-Head Start invited six agencies to learn about the ECGT Training Program; of those, three elected to become involved with what became the *Relationships for Growth* Project. Since 1999, the *RfG* Project has been operating as a pilot in the three Head Start agencies in New York City.

PRINCIPLES OF THE *RELATIONSHIPS FOR GROWTH* PROJECT

RfG integrates ECGT-tailored mental health principles and assessment strategies into a comprehensive training program that includes the delivery of on-site screening, assessment, treatment, supervision, and other mental health services to children, staff, and parents. To achieve

the project's goals, staffs of the three Head Start agencies were trained to reach children and parents of very diverse ethnic backgrounds. This initiated the process through which the partners would learn to confront a wide variety of challenges.

To the mental health consultation model often used in Head Start and other preschools, *RfG* added a commitment to an ongoing relationship between experienced clinicians and Head Start staff and subtracted referrals for off-site mental health services. Case planning for all children and specialized intervention services for at-risk, diagnosable, or already-diagnosed children was implemented on-site. It was organized around intensive, long-term Head Start staff training and development.

At least two staff members from each Head Start agency participated in ECGT's formal training program and acted as co-leaders of *playgroups,* a specialized therapeutic modality. These staff received training, mentoring, reflective supervision, and role modeling from experienced ECGT mental health professionals employed by the JBFCS-Institute. Much of the training, supervision, consultation, and support have been provided on-site at the three Head Start agencies by JBFCS-Institute staff.

Built from this base, the *RfG* has become an early childhood community-based, prevention, and intervention model that promotes relational, emotional, developmental, regulatory, cognitive, and language development and improves children's readiness for school. By beginning with a joint project among partners with a common mission—that of identifying and intervening with at-risk and diagnosable children to help them "make it" in school and in life—the *RfG* is having a generative effect on the entire Head Start environment of the three agencies.

In building on the strengths and expertise of Head Start staff, who become engaged in intensive, collaborative training, *RfG* has had a systemic impact while it also successfully delivered integrated mental health services to a wide range of children on-site: exposure to long-term professional development in a variety of individual and group forums (such as team meetings and case conferences), in connection with mission, appears to enable staff to use reflective practices to improve the quality and direction of their work with all children and families, and with one another.

Partnership and Shared Decision Making

The *RfG* Project is a partnership with three New York City Head Start agencies, the JBFCS-Institute, and university-based researchers who have particular experience in using a partnership model for conducting

community-based research and evaluation. The partnership came together with twin goals of identifying and strengthening vulnerable young children while simultaneously improving classroom practice for all children.

From the beginning, the partnership was established with certain foundational principles—namely, shared decision making, decision by consensus, and respect for differing values, priorities, approaches, and theories of change. Each of the partners has representation on the *RfG* Steering Committee. This committee met monthly throughout each year of the four years of the pilot and during the fifth year of data analysis. Researchers from Columbia University-Mailman School of Public Health were members of the steering committee at the outset and have been active participants, particularly in developing the evaluation of *RfG*.[5]

The partnership model for community-based research and evaluation was empirically examined in a survey of Head Start and university partnerships. Lamb-Parker and her colleagues (Lamb-Parker, Greenfield, Fantuzzo, Clark, & Coolahan, 2002) explored the kinds of activities and principles that support well-functioning partnerships. They uncovered the importance of shared decision making in ensuring successful joint research projects. Community-university partnerships reporting high levels of shared decision making devoted more time to discussing specific research issues; dealing with trust, values, and goals; and discussing diverse priorities and practices. By contrast, partnerships with low levels of shared decision making spent more time dealing with problems that were impeding their progress toward their goals. The *RfG* began with the premise that shared power in decision making would be crucial to the success of the project.

As the steering committee met over time, contributions moved beyond the representative role, such that all members participated in "trans-role" ways. As we became more knowledgeable about one another's roles and responsibilities, we became more involved in one another's specific aims. The commitment to the *RfG* partnership at the management and administrative levels, with the go-ahead from Head Start parent advisory boards, got the ball rolling, but it was the people on the ground who, through an incremental process, developed the trusting relationships with one another that would make this commitment result in real growth for children, staff, and families.

From the beginning, a foundation for partnership was laid with the development of parallel threads of relationship: Head Start directors with the ECGT director and the clinical coordinators, Head

Start-ECGT trainees with the ECGT clinical coordinators and staff therapists, and clinical coordinators and staff therapists with classroom and family service staff. In the Head Start centers, weaving the cloth of partnership, which becomes the agency's *RfG* tapestry, starts when the clinical coordinator (a seasoned ECGT supervisor and member of the JBFCS-Institute senior team) and the staff therapist (a recent ECGT graduate) begin going to the Head Start agency for several hours each week. Their initial relationships naturally are established with ECGT trainees in the *RfG* Project and other Head Start staff assisting in the running of groups. They also endeavor to build relationships with the director and other staff.

Aware that they communicate by their behavior and interests even more than by what they say, those on the ECGT team try to see through the eyes of Head Start staff. For example, asking questions, joining in or promoting discussions about a child, family, or teaching team at lunch or break are informal ways of entering the system. Another good example of this occurred in the first year when a clinical coordinator initially felt defeated by the fact that the Head Start teachers in ECGT training did not show up for scheduled supervision. After discussions at the ECGT senior team meeting, she began to see how to build relationships by reflecting about *their* perceived roles, responsibilities, and interests. A situation that had been in danger of reaching a stalemate improved when she began spending time in the teachers' classrooms instead. She offered to assist in filling out forms and performing the observations required by that Head Start agency.

Through cycles of misconnection, reflection, and reconnection such as this, mental health professionals, accustomed to focusing on individual relationships out of the context of ongoing action, bring themselves into the site of activity. In so doing, they partake in the lived experience of the teacher-trainee rather than hearing about it secondhand. Through such experience, the mental health professional comes to participate in relationships with teacher-trainees that not only involve the responsibilities and knowledge of the traditional supervisory relationship but also profoundly respects the mission and expertise of the teacher in the classroom environment.

Likewise the teacher participates in this relationship with the clinician-supervisor by opening her workplace to be experienced firsthand by the supervisor as she opens herself to consider new ways of seeing. The supervisor, engaging side by side in the most unpopular of tasks—paperwork—reflects a desire and a willingness to "know" the grinding realities that the classroom teacher faces, providing

evidence to the teacher that this is someone ready to work with her constructively and nonjudgmentally.

Clinical coordinators provide and model support for the staff and director at the agencies and reflective supervision for ECGT-Head Start staff trainees and staff therapists. The director of ECGT at the JBFC-Institute is simultaneously the service and training director of *RfG.* She joins the senior team, sharing her vision of energizing systemic parallels both top down and bottom up, and manages the meta-level of the program.

People involved with *RfG* at all levels reported the experience of being heard. Linkages happen when one is listened to "with generosity" (Toomey, 2004): child with adult, adult with children, children with children, parents with staff, staff with parents and one another. One director commented, "It takes a lot of time. We have to set aside time for meetings and more meetings. But it becomes the way to do our work. It made us rethink and refocus our procedures." Earlier in the partnership, this particular director had resisted offering the time that would need to be involved, seeing it as a demand coming from the ECGT staff, rather than as a reflective opportunity that weaves meaning and learning for everyone engaged. This transition—from seeing meetings, classroom visits, supervision, seminars, and the like as time-and-energy-consuming demands from the outside to experiencing *RfG* as their own potentially more rewarding and energizing way to work—is a theme that was replayed in many ways, big and small, throughout the years of the project.

To support those children that everyone worries about became our collaborative venture, a way of making relationship that united us. Over time, teachers felt the affection and loving concern that the clinical coordinators and staff therapists had for the children in their (teachers') care. They saw the level of interest and involvement that these mental health professionals applied toward understanding each and every child's needs and strengths through their (the clinicians') engagement with the teachers and family workers around creating nourishing relationships and experiences for each child.

A teacher said, "All of a sudden, teachers spoke to family workers, family workers to teachers." Circles of communication (Greenspan & Wieder, 1998; see also Chapter Twenty-One, this volume) became "ripples"—circles that communicate. As we observed the children succeeding, we became bonded together through shared satisfaction and pride. Over time, the ripples seemed to synergize, yielding waves that lifted individuals and then each agency to a more relationally attuned level.

Effective teams at the workplace formed around the daily work to be done, with respectful, democratic facilitation energized by shared mission. In *RfG,* teams are generated and fostered on several levels, each with a different but complementary set of goals. The JBFCS-Institute senior team that organizes the ECGT Training Program, for example, sets policy regarding requirements, admissions, and placements. It also plans and teaches seminars and provides peer supervision for one another in weekly meetings.

Staff Training and Development

The foundation of *RfG*'s systemic staff training approach is collaborative relationship development. This means that Head Start staff participates in intensive training, mentoring, and supervision from child mental health professionals who work side by side with them over several years.

In the context of this in-service, advanced training approach, staff benefit from many opportunities to apply what they are learning with the children and families with whom they work on a daily basis. By learning to observe children in vivo, in a trusting and open atmosphere of acceptance, they are assisted in reflecting on their experiences, whether challenging or successful. A quality of relationship as transformational space is created, a "safe haven from the ordinary demand that we must know what we are doing or who we are . . . [in this approach we are] allowed and even encouraged to have a 'don't know mind.'" Trainees (and trainers) are "encouraged to empty [them]selves of posturing, of being the 'one who knows,' so that we can fill up with a new kind of knowing" (Cope, 2000, p. 27). Trainees are helped to increase their capacities to focus on individual strengths, needs, and goals—not only their own goals but also the goals of their peers, the families, and the children. Engagement in open, reflective, relationship-based practice promotes problem-solving, planning, and goal-setting skills, as well as self-awareness.

The fact that Head Start staff spend many hours, five days a week, with the children is one critical reason to focus on the *transfer* of knowledge and skills, in contrast to more typical consultee-consultant arrangements. The group therapists, who have been increasingly called mental health leaders by those at the Head Start agencies, also cultivate individualized, lively, and meaningful ongoing relations with each child's teachers and parents. In these collateral contacts, each party comes to see the other as a partner in the work with child and family to foster progressive growth.

Parallel partnerships develop between trainer and trainee, Head Start directors with one another and with the JBFCS-Institute director, and between all participants and the researchers. Sometimes a staff therapist models principles of practice by co-leading a playgroup with a trainee or another Head Start staff member. Those who have had this experience recall both the clarity and vivacity of knowledge that was gained by working alongside a seasoned therapist. Some of these individuals have gone on to create further parallel process by including other Head Start staff members as assistants in *their* playgroups.

RELATIONSHIPS FOR GROWTH PROJECT SERVICES

The service delivery process begins at the beginning of each school year. JBFCS-Institute staff train, support, and collaborate with Head Start staff (of whom at least two are *RfG* trainees) to observe all children in the agency and identify some for peer playgroup psychotherapy. Clinical consultants and staff therapists assist Head Start agency staff in reaching out to parents to establish an intervention relationship and ultimately receive informed consent from 98 percent of parents offered services, assist in the provision of peer playgroup psychotherapy, consult with other Head Start staff, and collaborate with other Head Start agency training endeavors. Through these activities, a collaborative bridge is built that connects the islands of education and mental health.

Referrals to Intervention Levels

RfG provides for early identification of child vulnerabilities across and between all developmental domains. Many observations by teachers, the educational director, JBFCS-Institute staff, and *RfG* trainees of every child in a variety of situations serve to identify those children who do not appear to be developing well along one or more domains. The position taken is that children who are evidencing problems in preschool are at risk for continuing challenges in school. In contrast to other mental health service models, referrals are made based on in-school observations alone. These referrals are made to the following three intervention levels: (1) individual plans for them in their classrooms, (2) selection to participate in biweekly playgroup sessions, and (3) referral for additional services to the Committee on Preschool Special Education (CPSE). A description of each of these intervention levels follows.

Intervention Level 1: *Individualized*

- At the *universal,* or preventive, level, each child is observed by several Head Start and ECGT staff members in the classroom and participates in Head Start screening and assessment procedures.
- Impressions and results are aggregated and shared by a team made up of the Head Start teacher, family service provider, ECGT trainers, and others as appropriate.
- Each child is considered and planned for.

Intervention Level 2: *Targeted*

- At the *targeted,* or intervention, level, individual children are selected to participate in playgroups.
- When playgroup intervention is recommended, the child's parents and other significant adults are integrated into the process.
- Children are selected for this intervention because they have emotional, social, behavioral, cognitive, communicative, developmental, or health vulnerabilities that may be severe or may lead to severe problems. Over 30 percent of children entering preschools may be in this category (Boyer, 1991; Carnegie Corporation of America, 1994).

Intervention Level 3: *Expanded*

- The *expanded,* or referral, level is for children who have had or who warrant a CPSE evaluation or diagnosis (required to be at least 10 percent of children entering Head Start) for developmental challenges.
- Children in this category are included in a playgroup when it will enhance their individual treatment plans or help their parent accept referral to CPSE.

Playgroups

Two to five children are included in each group with one to two leaders, depending on the number of children as well as the training needs and readiness of the staff. *Relationships for Growth* provides services to children with a wide range of developmental and social-emotional challenges. Thoughtful consideration is given to the placement of each child, with an eye toward the balance of temperaments, regulatory styles, and learning profiles in each playgroup. An effort is made to counterpoise the presence of the quiet, "disappearing" (internalizing)

child with that of the noisy, demanding (externalizing) one. Playgroups meet twice weekly for one-hour sessions in a small room within the agency. The rooms are equipped with a variety of materials suitable to the stimulation of symbolic activities.

One of the most distinctive aspects of *RfG* is that it assists Head Start agencies in providing support and intervention to children with extremely challenging behaviors because it connects with children in states of intense emotion (Shahmoon-Shanok, 2000). Many teachers find such high-energy, high-affect behaviors hard to cope with, even frightening (Halpern et al., 2003). The playgroups are able to absorb these intense feelings and accompanying behaviors due to the reduced dimensions of stimuli—fewer children and fewer toys—and the increased focus, availability, and resources of the therapist. These same features serve the withdrawn child as well, who will be less lost than among the competing stimuli and relationship demands of the classroom.

It is our impression that the initial benefit of being in a playgroup is having more access to an adult who offers a scaffold for each child's process of relating, often in a one-on-one way. Indeed the initial interactions between children in a playgroup may be rather chaotic, disorganized, and sparse. So the nascent benefit is the increased access to an adult who keeps them safe, welcomes them, and respects their initiative and who relates contingently with care, energy, and attunement.

As the adult is seen as an increasingly reliable partner, she provides both a harbor and a source of coregulation. Motivated by growing interest in peers, the child, in turn, begins to shift more energy into peer interactions. As this process unfolds simultaneously (although at different rates and rhythms) for each child, the adult can move beyond scaffolding individual children to extending relational resourcefulness. In turn, the playgroup develops a coherence that provides an experience for children of satisfying, relatively stable—even if intense—teamwork.

ECGT trainers and—over time—trainees understand the enabling agents through which progressive change in peer playgroups unfolds (Shahmoon-Shanok, 2000). For example, diminishing the scale allows attention to be concentrated on relationship development. Children come to experience the group space as familiar, but on a smaller scale than the classroom. Each child's thoughts, feelings, and behaviors are placed "on a pedestal" as though a sculpture in a museum to be noted and appreciated.

As adults think aloud, observing, commenting, and wondering about each child's behaviors ("Juan loves to play at the water table," . . . "I wonder why Janine is not in school today," . . . "Carter is helping

Susie move the blocks"), children come to know how some adults think. In time, they learn to articulate their own thoughts and observations about their peers and their group. They also learn or progress in their abilities to play. Representational play, along with symbolic expression using graphic materials, fosters the social-emotional development and expressiveness critical to school success.

Playgroups include children with different developmental attainments in language, play, and interactive behaviors. Those children who begin their playgroup experience unable to use materials symbolically are placed in close proximity to others for whom representing experiences and feelings in play seems more effortless. Such children become teachers for the others. Similarly, children whose demands for attention label them as "disruptive" in the classroom have their needs met through acceptance, along with benign rejection of primitive feeling states.

The diminished scale of the playgroup environment permits the child to titrate proximity to adults and other children, while maintaining visual and auditory awareness of their activities. A quiet, retiring child may benefit from being able to process his surroundings and mobilize his intentions. With the therapist keeping things safe and being available enough, the pull of the peer pack and communication arousal lure most children into symbolic and interactive activity. Ultimately, the emotionally vibrant, interactive communication that is the hallmark of peer play psychotherapy groups helps build or refashion the foundational capacities of self-regulation and cooperation for children who are delayed or whose processes have developed in limited, maladaptive ways.

Peer playgroups stimulate initiative, mastery, and social relatedness while promoting self-regulation, differentiated language, preliteracy, metaphor, and play. Warm attachments to adults and other children and their motivation both to succeed and connect meaningfully with one another become the basis for the development of a richer emotional range and empathy for others. Children learn to differentiate and tolerate a wider range of feeling states and develop greater capacities to negotiate and work through conflicts.

These changes are beneficial not only to the children but also to their families and classrooms. Such benefits (especially increased self-regulation, mastery, richer emotional range, and empathy for others) appear also to make a strong contribution to the children's capacities for moral reasoning, their values, and their capacities for conscience.

RfG, then, is a mental health observation, identification, and intervention endeavor carried out by Head Start staff who are trained,

mentored, and supervised by experienced JBFCS-Institute staff. People work side by side toward the commonplace yet truly lofty goal of helping even the most challenging children "become ready for school."

PARENTAL ENTHUSIASM FOR PLAYGROUPS

By providing on-site services together with Head Start staff, *RfG* bridges the gap between education and mental health that sometimes characterizes other treatment models and standard educational practice. Traditional treatment models demand that parents recognize problems, cooperate with an evaluation, accept a diagnosis, and take their child to treatment at a mental health center. Instead, in *RfG,* familiar staff join with them to describe their child's needs and strengths in ways that feel compassionate and helpful. In this context, the suggestion of playgroup participation, led by a trained staff member from within their Head Start agency, can be experienced with less trepidation and more hopefulness.

Because of this staffing pattern, the location of services, and the lack of fees, parents have a very positive attitude toward their children's participation. In the pilot, 98 percent of families of all ethnic groups from each of the participating Head Start agencies accepted *RfG* (mental health) services for their children. Further, over time, some parents requested that their children participate even if the children had not been identified and selected. More than four hundred children, 16 percent of all enrolled children at the three Head Start agencies over four years, received intervention services. The program dropout-withdrawal rate was less than 1 percent (see Table 19.1).[6]

These levels of participation stand in contrast to typical teacher, director, or mental health consultant referrals. The literature on barriers to mental health services for children is limited, and the effects

Year	*Total Enrollment in Three Head Start Agencies*	*Children in Playgroups*	*Number of Playgroups*	*Percentage of Children*
1	716	95	26	13
2	711	92	25	13
3	674	125	33	19
4	661	129	25	20
Total all years	2,762	441	109	16

Table 19.1. How Many Children Were Served in the *RfG* Project?

of various obstacles to service uptake and retention are poorly understood (Owens et al., 2002). However, many structural and attitudinal barriers prevent parents from accepting referrals for mental health evaluation and maintaining participation in treatment (Rogers, Fernandez, Thurber, & Smitley, 2004). In addition, services are not available in many neighborhoods. And dropout rates from both assessment and intervention services are high across all socioeconomic groups (Kazdin, Holland, & Crowley, 1997).

Those children with the greatest observable difficulties on relational, regulatory, developmental, cognitive, linguistic, internalizing, externalizing, and physical disability dimensions and those known to have encountered violence or other potentially traumatizing experiences were selected to be in the targeted *RfG* intervention Level 2 group. Confident that they can now serve them, one of the *RfG* Head Start agencies has begun accepting larger numbers of children with identified difficulties significant enough that they spend half of their day in programs designated for children with disabilities.

EVALUATION OF *RELATIONSHIPS FOR GROWTH* PROJECT

Central to understanding how the *RfG* approach to integrating mental health services influences the work of Head Start staff in the classroom, in the playgroups, and with families was the inclusion of program evaluation components. As much as possible, these components involved not only Head Start staff receiving the most intensive ECGT training but all Head Start staff, JBFCS-Institute training and supervisory staff, Head Start and ECGT directors, and Head Start children and their families. Overall and to the extent possible, program evaluation processes made use of existing documentation and supplemented this material with evaluation procedures designed for minimal added burden on already overtaxed staff and families.

Gathering Information

In the initial phase of *RfG,* focus groups, interviews, and videotapes were used to document knowledge and beliefs about mental health, child development, and classroom practice. Quantitative measures were investigated and piloted during the first year. Two measures of social-emotional functioning—the Penn Interactive Peer Play Scale (Fantuzzo, Mendez, & Tighe, 1998; Fantuzzo et al., 1995) and the Devereux

Early Childhood Assessment (LeBuffe & Naglieri, 1999)—were selected and administered by teachers and parents to provide ratings of child change.

In order to minimize increasing strain on teachers' and parents' time and energy, information about children's health, developmental milestones, academic readiness and progress, and family status were extracted from the Head Start records. Likewise information about the playgroups themselves was obtained both through focus groups and interviews with group leaders and through access to the notes that leaders kept about each child and session. Some group leaders videotaped some of the playgroup sessions.

Early in the second year of the project, the quantitative measures were translated into the major languages of the three participating Head Starts: Spanish, Haitian-Creole, and Chinese. In the second year, ECGT trainees were also asked about their experiences in training and supervision.

As the *RfG* project progressed, follow-up interviews and focus groups were held. It became clear to the program evaluation team that to be able to detect and study the "ripple" would require a more consistent on-site presence and many less formal interactions with Head Start and JBFCS-Institute staff. To that end, an ethnographer was added to the team to observe and record the ripple, both through the more formal focus group and interview processes and through casual conversation, observation in classrooms and playgroups, and attendance at JBFCS-Institute training and senior team meetings.

Now that the pilot is drawing to a close, these diverse program evaluation sources are being processed: quantitative data entered and analyzed; and interviews, focus groups, and ethnographic material transcribed. A sourcebook to guide future *RfG* Projects is also being developed.

Preliminary Findings

Using self-control, initiative, attachment, play behaviors, and behavioral concerns as social-emotional indicators of school readiness, the quantitative data indicate the following:

- Children selected for therapeutic playgroups based solely on observation were initially well behind their classmates on all the selected social-emotional measures.

- Playgroup children did not decline further but by the end of the school year made large gains on social-emotional indicators of school readiness.
- The pattern of parent observations of their own children supported the teachers' observations. Initially, parents of playgroup children reported less social-emotional competence regarding their children than those of the non-playgroup children.

Results from preliminary ethnographic data analyses reveal the following:

- Teachers reported that the playgroup children's enhanced social-emotional skills and interpersonal strengths were observed not only in the playgroup but in the classroom as well.
- Many Head Start staff and parents of children in playgroups expressed strong, positive feelings about the benefit of playgroups as a way of getting children ready for school and of strengthening their social, emotional, interpersonal, cognitive, and linguistic skills.
- Through their involvement with *RfG,* Head Start parents and staff learned and implemented social-emotional development techniques and principles.
- Head Start staff and parents found that *they* could bring about significant social-emotional growth in children without focusing on a diagnosis or specific behavioral problems and without taking the child to a mental health center.

The data indicate that building relationships among children, families, and staff at each Head Start agency may form the foundation for healthier, higher-quality, and more effective working and learning environments for children, staff, and parents (Halpern et al., 2003). To provide an indication of the scope of Head Start staff affected by the *RfG* Project, ten Head Start staff completed the two-year ECGT Training Program over four years, and two additional Head Start staff members are currently enrolled in ECGT training, out of a total of eighty-nine family workers, teachers, teacher assistants, family service coordinators, and administrators. Thirty-seven additional Head Start staff served as playgroup co-leaders and participated in reflective

supervision. All Head Start staff were affected by the JBFCS-Institute staff presence, by their *RfG*-Head Start staff colleagues, and by *RfG*-led staff meetings.

Comments typical of staff and parents include the following:

- "I have seen them progress academically and socially. . . . I think it's very beneficial for the children who are having problems. . . . It was a real learning experience for me in the way it touches on the way I was brought up, too, to see the real difference in culture. And the progress the kids make kind of surprised me at the end. . . . One day, the child was really aggressive or not social and then just opens up. It clicks . . ." (Head Start teacher, *RfG* playgroup co-leader).
- "[In playgroup] children grow the way they need to balance, like in one of my groups, a shy girl became talkative, mischievous, curious, and lively" (Head Start teacher, playgroup leader).
- "The kids go home and are excited about their playgroup, and before you know it, I'm in tight with the parents and they want to be involved. . . . We became bonded with parents we used to be afraid of. Everybody should have this program, even public schools" (family worker, playgroup co-leader).
- "The more I communicated with [the playgroup leader], the more I saw it was good for [my daughter]. She has been given a chance to realize that her voice counts in the school environment. She's free to express herself however she wants. . . . And there isn't any right or wrong about what she wants to do [in playgroup], just how she sees it. Just the whole thing of expressing herself. She feels free. I think that does a lot. . . . The program has helped me, too, to tell the truth, because sometimes I was holding her by other people's standard[s]" (Head Start parent).
- "One girl in our center received CPSE services and then attained the expected educational standard on the testing. Even though her mom objected, the committee terminated services for her. The mom was right because, behaviorally speaking, this girl was still very problematic. I was so happy that playgroup was available and the mom gladly accepted. The girl got much better" (Head Start teacher, playgroup leader).
- "As director . . . I know how valuable [*RfG*] is for children, parents and staff. . . . Children's challenging behaviors improve. . . . Teachers experience less stress in the classroom, so staff morale improves.

The ripple effect results in less staff turnover, which equals more experienced staff" (Head Start director).

- "The culture here is changing to one in which change for the good is possible, and one in which there is enough to go around" (unidentified Head Start staff member).

THE RIPPLE EFFECT

It was hypothesized at the beginning of the evaluation that the quality and direction of the trainees' professional capacities and the children's development and adaptation would improve through *RfG.* In turn, such an improvement would result in overall gains in each classroom's functioning. Through their experiences, mental health leaders would learn to relate better to children with challenging behaviors, extending the competence, independence, and cognitive capacities of these children. In addition, the skills of classroom teachers would be enhanced, resulting in increasingly individualized support for social-emotional, cognitive, linguistic, and moral development for all children.

Improved maturity across these domains in the most vulnerable children would increase stability and control in the classroom environment, increasing opportunities for "teachers to get on with teaching." Ultimately, work with families also would become more individualized, more sustained, and more energized. Definitive results for all of these hypotheses await further analysis of the ethnographic and other data. However, we are confident that the emerging results will demonstrate the efficacy and impacts of *RfG* for children, parents, and Head Start staff alike, because anecdotal evidence has already confirmed that.

Anecdotal impressions indicate that children's gains sometimes precede their parents' gains. Children's improving development appears to relieve parents. Indeed, occasionally, parents accept outreach only after their children begin to progress: parents tend to respond to their children's improving relational-developmental appropriateness with greater optimism and pleasure. It is a very rare parent who does not respond favorably to a young child's more age-appropriate functioning.

In addition, *RfG* provided in-house support and services that made a substantial impact on the Head Start environment as a whole. The effects of *RfG* appear to be both powerful and cost-effective. Having

participated in training, reflective supervision, and playgroup sessions, the selected Head Start staff members eventually become mental health leaders who, with continued ECGT mental health supervision and consultation, will be able to sustain *RfG* within their agencies.

In other words, teaching and learning become ripples, which become knowledge transfer, which become that which tips the whole (Gladwell, 2000) toward improved practices. The *RfG* model therefore has the potential to provide support for positive change in the life of the entire Head Start community. The complex and relatively diffuse gains seen among staff, classrooms, and agency resulting from the *RfG* Project serve to illustrate the notion of a "transformational enterprise."

It should be noted that neither ripple effect nor transformational enterprise were ideas that we had at the outset. It has only been in retrospect, as we wondered about the large overall shifts that we have observed in the three Head Start agencies and as one author remembered and reviewed the transformative impact of Zero to Three's City TOTS, that we recognized, analyzed, and named these processes.[7] (See Chapter Twenty-One, this volume.) We nevertheless suspect that awareness of their potential to galvanize change will make a contribution to future *RfG* initiatives and to other service and training programs that make use of them.

This chapter has detailed an example of a training and apprenticeship-driven set of services that with increasing momentum over the four years of the pilot project "rippled" through the service delivery system of three urban Head Start agencies, yielding increasingly seamless integration of mental health services and classroom-family approaches within each agency. *Relationships for Growth* began with several organizations and individuals sharing a clear mission—namely, to promote children's development across all domains to ready them to succeed in school. In bringing a set of endeavors that based on experience they knew helped children in need—observing children, planning for each one, reaching out to their parents, beginning playgroups—ECGT trainers provided a terrain that engaged each trainee. And in working on the endeavors together, each trainee encountered respect, reciprocity, open communication, and a sense of significance.

Through observing children in a variety of situations and engaging in reflective practice, trainers and trainees created and shared knowledge. At the same time, they built and expanded relationships

and ways of being together with mutuality. Working together purposefully and successfully in a respectful and reciprocal environment helped people to feel allied, intentional, and empowered. The outcome of the seemingly prosaic, day-to-day activities described here and elsewhere (Shahmoon-Shanok, 2000; Chapter Twenty-One, this volume) is, we believe, that *RfG* operates as a regenerative collective activity—a transformational enterprise—in which something more than knowledge transfer, learning, and service provision is taking place.

Given the fact that many children in today's society are at grave risk for developmental and educational delay because of constitutional, family, or other vulnerabilities (Shonkoff & Phillips, 2000), it is both urgent and essential that the field of early childhood discern and use all available resources. The energy mobilized here—called the ripple effect and transformational enterprise—is often not employed because it has remained just outside awareness to some and invisible to others. The overall mission of the zero-through-five field—to weave a safety net for all young children and families—can be energized in existing programs such as Head Start as well as in new ones, using the group learning principles and parallel processes delineated in the *RfG* Project (Chapter Twenty-One, this volume).

Indeed other programs in the field have this potential to alter the context of training and service by weaving a mission-driven community where in some ways everyone is a learner and everyone a teacher. The sense of sharing, learning, interdependence, and increasing self-efficacy promotes ongoing capacities that exert an impact on many other activities and relationships in a synergistic, this-is-larger-than-any-part-alone fashion. This momentum has direct impact on the nitty-gritty of day-to-day hour-to-hour case-by-case work. When the basis of the model is individualized relationship and reflective capacities reciprocally woven into learning groups over time, the result is developmental progress for the children, parents, and staff alike.

Notes

1. Chapter Twenty-One in this volume—Apprenticeship, Transformational Enterprise, and the Ripple Effect—describes the training and transformational aspects of the *Relationships for Growth* Project.
2. The *RfG* Project partners note with enthusiastic gratitude the financial support of New York City Administration for Children's Services-Head Start, which made this demonstration project and evaluation possible. We also

note with the deepest appreciation the enduring intellectual, communal, and financial commitment of JBFCS to the development of ECGT treatment and training modalities for over three and a half decades.

3. JBFCS had pioneered, implemented, and developed Early Childhood Group Therapy through its Child Development Center. As a service and training program, ECGT, in time, established several other programs that are now joined under the Institute for Infants, Children & Families of JBFCS.
4. JBFCS-Institute's ECGT Program gratefully acknowledges original funding by the National Institute of Mental Health, JBFCS philanthropic sources, as well as substantial support from the Harris Foundation since 1994 and more recently the Lynn and Philip Straus Foundation.
5. *RfG* is currently in its last funded year, the fifth, which is funded for data analysis only. This chapter is written as data continue to be examined and other documentation about the results is being prepared. A sourcebook is also being written this year. Enough data have been analyzed that confirm the efficacy of ECGT approaches.
6. In other ECGT sites, 91 percent of the parents who are required both to pay for the services on a sliding scale by Medicaid or insurance and to accept that their children are patients of a mental health program (although they are seen in their preschool) accept services. It should be noted that serving 16 to 20 percent of enrolled children represents the limits of *RfG* personnel; many children identified for Level 1 intervention could have benefited from playgroup. Research is being completed and planned to investigate the true level of need for Level 2 services within Head Start agencies.
7. City TOTs (Training of Trainers) were a series of intensive courses for teams of practitioners from across the country run in the late 1980s and early 1990s by Zero to Three. It was chaired by Rebecca Shahmoon-Shanok.

References

Boyer, E. L. (1991). *Ready to learn: A mandate for the nation.* Princeton, NJ: Carnegie Foundation for the Advancement of Teaching.

Brusiloff, P., & Merkin, M. N. (1981, Spring/Summer). *Family and Child Mental Health Journal, 7*(1). New York: Human Sciences Press.

Brusiloff, P., & Witenberg, M. (1973/1983). *The emerging child.* Northvale, NJ: Aronson.

Carnegie Corporation of America. (1994). *Starting points: Meeting the needs of our youngest children.* New York: Author.

Cope, S. (2000). *Yoga and the quest for true self.* New York: Bantam Books.

Fantuzzo, J., Mendez, J., & Tighe, E. (1998). Parental assessment of peer play: Development and validation of the parent version of the Penn Interactive Peer Play Scale. *Early Childhood Research Quarterly, 13*(4), 659–676.

Fantuzzo, J., Sutton-Smith, B., Coolahan, K. C., Manz, P. H., Canning, S., & Debnam, D. (1995). Assessment of preschool play interaction behaviors in young low-income children: Penn Interactive Peer Play Scale. *Early Childhood Research Quarterly, 10*(1), 105–120.

Gladwell, M. (2000). *The tipping point: How little things can make a big difference.* Boston: Little, Brown.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth.* Reading, MA: Addison-Wesley.

Halpern, E., Lamb-Parker, F., Fisher, R., Klujsza, V., Peay, L., & Shahmoon-Shanok, R. (2003). *Relationships for Growth* Project: Preliminary evaluation of a relationship-based, systemic mental health model in Head Start. In F. Lamb-Parker, J. Hagen, R. Robinson, & H. Rhee (Eds.), *Summary of conference proceedings for Head Start's Sixth National Research Conference* (p. 868). Washington, DC: DHHS Administration on Children, Youth and Families.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination of child therapy. *Journal of Consulting and Clinical Psychology, 65*(3), 453–463.

Lamb-Parker, F., Greenfield, D. B., Fantuzzo, J. W., Clark, C., & Coolahan, K. C. (2002). Shared decision making in early childhood research: A foundation for successful community-university partnerships. *National Head Start Association Dialog, 5*(2&3), 356–377.

LeBuffe, P. A., & Naglieri, J. A. (1999). *Devereux early childhood assessment technical manual.* Lewisville, NC: Kaplan Press.

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., Sheppard, G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry, 41,* 731–738.

Rogers, K. N., Fernandez, M., Thurber, L., & Smitley, A. (2004). Exploring differential attrition rates among system of care evaluation participants. *Journal of Community Psychology, 32*(2), 167–176.

Shahmoon-Shanok, R. (2000). Infant mental health perspectives on peer play psychotherapy for symptomatic, at-risk, and disordered young children. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *World Association for Infant Mental Health handbook of infant mental health, Vol. 4: Infant mental health in groups at high risk* (pp. 198–253). New York: Wiley.

Shanok, R. S., Welton, S., & Lapidus, C. (1989). Group therapy for preschool children: A transdisciplinary school-based program. *Child and Adolescent Social Work Journal, 6*(1), 72–95.

Shonkoff, J. P., & Phillips, D. A. (Eds.). National Research Council/Institute of Medicine. (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

Toomey, M. (2004, June 11–13). *What is leadership? Create, listen, sustain, and develop.* Rowe Leadership Program. Rowe, MA: Rowe Campe and Conference Center.

Zigler, E., & Valentine, J. (Eds.). (1997). *Project Head Start: A legacy of the war on poverty* (2nd ed.). Alexandria, VA: National Head Start Association.

PART FIVE

Transforming Practice Across Systems of Care

CHAPTER TWENTY

The Role of Reflective Process in Infusing Relationship-Based Practice into an Early Intervention System

Linda Gilkerson, Ph.D., and Tina Taylor Ritzler, M.A.

Over the past decade, it has become accepted in the field that working with infants and their families from a relationship perspective requires ongoing, regular opportunities for reflection (Fenichel, 1992; Bertacchi, 1996; Norman-Murch, 1999; Gilkerson & Shanok, 2000). Here we explore how providing the time for reflective process might be accomplished in a large system of services and the benefits that can result. Starting with a pilot effort, we look at the training, program structures, and ongoing processes needed to support and sustain "going to scale" with relationship-based reflective practice.

THE SOCIAL-EMOTIONAL PILOT

Since 2002, the Illinois Department of Human Services (IDHS) Early Intervention Bureau, with the endorsement of the Illinois Interagency Council on Early Intervention, has been involved in a Social-Emotional (SE) Pilot.[1] The SE Pilot was initiated in response to

recommendations from multiple advisory groups and stakeholders that the capacity of the early intervention system be strengthened to (1) provide emotional support to all families in early intervention, (2) work more closely with each family to support social-emotional development of their child, and (3) provide screenings and when needed specialized assessment and intervention to address social-emotional and behavioral concerns. Inherent in these goals is a shift toward relationship-based reflective practice in early intervention.

The Illinois Early Intervention (EI) System includes twenty-five Child and Family Connections (CFC) offices that serve as points of entry to EI in their local service areas. CFCs provide service coordination, including conducting intake interviews, coordinating evaluations for eligibility, developing the appropriate Individual Family Service Plan (IFSP) with family and providers, and helping families choose service providers. The CFCs monitor the delivery of services and provide support to families transitioning out of EI. Each CFC is staffed with a manager, service coordinators (SC), parent liaisons (PL), and a local interagency coordinator (LIC). CFCs contract with developmental pediatricians for medical consultation. Services are provided by professionals credentialed through the EI system in their specific disciplines. The majority of service providers are independent, rather than program-based. Teaming is mandated for IFSP development and highly encouraged for service provision. At present, Illinois serves over twelve thousand children in EI.

Prior to the SE Pilot, 100 percent of the CFCs that responded to a statewide survey indicated that they were not prepared to address the social-emotional needs of children and families (Cutler & Gilkerson, 2002). In fact, only 9 percent of the children in EI were identified as having social-emotional issues by the CFC at intake, when 24 percent were eventually seen as having social-emotional needs by the providers. In addition, focus groups with parents in early intervention revealed that the two greatest unmet family needs were both related to the social-emotional area: (1) emotional support for families, including parent-to-parent contact, and (2) help with the children's challenging behaviors (Cutler & Gilkerson, 2002).

The IDHS convened a planning committee to develop a pilot project to address the unmet needs for social-emotional support for children and families in EI and identified three CFCs to participate in its design and implementation. The planning committee developed the pilot around the principles of relationship-based practice articulated

by Weston, Ivins, Heffron, and Sweet (1997) and Heffron (2000). The principles include the following:

- Centrality of relationships is reflected in all aspects of the effort.
- Process is as important as content in intervention.
- The development of a respectful, collaborative alliance with families is central.
- Relationships are seen as the organizer of early development, so focus is placed on supporting parent-child relationship and paying attention to both the parent's experience of the child and the child's social-emotional world.
- Knowledge of parallel process—how relationships affect relationships—is essential: how management-staff relationships affect staff-family relationships, how staff-family relationships influence the family-child relationships, and so forth.
- Development of self-awareness is a professional competency.
- Reflection is encouraged at all levels.

To infuse a relationship-based approach into a system of services, each aspect of the pilot needed to reflect the principles just articulated. The planning committee held as its mission the development and modeling of a collaborative process that would influence each element of the pilot. In this endeavor, the committee served as a holding environment for the effort: regularity of contact was maintained through monthly conference calls and quarterly meetings; a safe environment was cultivated to encourage the free exchange of ideas and mutual support; and development of all components was a joint effort, including training, outreach, service delivery, and evaluation. A national consultant, Mary Claire Heffron (Heffron, 2000; Chapter Six, this volume), worked closely over time with the committee and its cochairs to support the committee process, design and provide training in relationship-based early intervention, offer consultation at quarterly meetings, and provide assistance in developing training resources.

A formative evaluation plan was developed in consultation with the planning committee and implemented by the coauthors. Feedback was provided during and at the end of the pilot year. Based on the success of the pilot, the planning committee developed recommendations for expansion and now is providing mentorship to new CFCs as the

effort rolls out statewide. (See Gilkerson and Cochran Kopel, in press, for implementation statewide; *Illinois Guide to the Social-Emotional Component of Early Intervention,* in development by the planning committee.)

KEY ELEMENTS OF THE SOCIAL-EMOTIONAL MODEL

The model that was developed during the pilot includes ten elements, briefly described here. The elements of the approach support the vision of the Illinois Interagency Council for Early Intervention and the state's commitment to meaningful, timely early intervention for infants, toddlers, and families. These elements are designed to provide the training, program structures, and ongoing processes needed to bring relationship-based early intervention into daily practice.

Social-Emotional Specialist

"Having a clinical person present at the CFC is instrumental. This has been needed since the inception of the CFC."

Central to the model is the addition of a social-emotional (SE) specialist to each CFC. The SE specialist brings extensive clinical expertise in early intervention or infant mental health (or both) and is skilled in reflective supervision, process consultation, and group facilitation. The SE specialist primarily serves as a consultant to and partner with the manager to infuse relationship-based, reflective practice throughout the early intervention process, from intake through assessment, IFSP planning, and service delivery. For two sites, the specialist worked on-site, half-time. The third site, in a rural area of the state, piloted a distance consultation model, employing a specialist from the Chicago area who provided consultation via the telephone and monthly on-site visits.

Relationship-Based Training

"This should be mandatory for everyone."

To launch the SE Pilot, all participants, including the manager, SE specialist, service coordinators (SC), and a cadre of between fifteen and twenty providers who agreed to join the pilot for a year, participated in a two-day training. Developed by the national consultant, this training provided a shared framework for relationship-based practice

and began to build an understanding of the practice skills that are needed, including the capacity to (1) listen carefully, (2) demonstrate concern and empathy, (3) promote reflection, (4) observe and highlight the parent-child relationship, (5) respect role boundaries, (6) respond thoughtfully in emotionally intense interactions, and (7) understand, regulate, and use one's own feelings.

Pre-post measures indicated significant benefit from the two-day training for participants in both knowledge and skills related to relationship-based practice, including initiating discussions with parents about relationship and behavioral concerns, helping parents observe their child's cues and preferences to develop supportive interventions, encouraging pleasurable parent-child interactions, integrating SE outcomes with other outcomes, providing SE support to families, and knowing when and how to make a mental health referral. The training was followed by regular opportunities as described in the following discussion for each group—manager, service coordinators, and providers—to deepen their understanding of relationship-based work and grow in its practice. At the end of the pilot year, the knowledge and skill levels stayed at the higher levels reported at posttraining, suggesting that the processes put in place were successful in sustaining and consolidating the new learning.

Reflective Consultation

"Experiencing reflective process nurtures the leader."

The SE specialist provided the manager with weekly reflective consultation. The primary goal of the consultation was to help the manager begin to implement reflective supervision with the staff by modeling the process—that is, by offering the manager the lived experience of a safe, regular holding environment where she could process the complex demands of her multifaceted role and experience reflective supervision firsthand. The manager and specialist also used this time to plan and monitor the implementation of all of the aspects of the pilot.

Reflective Supervision

"Supervision provides a safe space to process complex situations and emotions."

With the ongoing support of the SE consultant, the manager provided or mentored the assistant manager to provide monthly

reflective supervision for the service coordinators (SCs) and parent liaison (PL). SCs carry high caseloads, work on their own in the field, and are always under the pressure of tight deadlines with much paperwork to complete. The opportunity to pause, if only monthly, allowed them to explore the emotional content of the work and consider their role from a relationship perspective: the SC's impact on families and providers and their simultaneous impact on her. The empathy and help offered by the manager appeared to foster greater empathy and support from the SC for families.

Social-Emotional Screening

"*With the SC listening and responding supportively, families have an opportunity to reflect on concerns and needs.*"

The relationship-based approach began for families at intake. The SC approached the family from a posture of listening and learning. The Ages and Stages Questionnaire: Social-Emotional (ASQ: SE) (Squires, Bricker, & Twombly, 2003) opened the dialogue about SE needs and helped the SC feel more knowledgeable about and connected to the family and child right away. Families had a chance to share concerns that otherwise might have waited. This opened the door to explore all services within the context of social-emotional needs of child and family and to think about any special supports that might be needed.

Specialized Evaluation and Relationship-Based Intervention Planning

"*The hope is that families are 'heard,' services are strength-based, and concerns are validated.*"

The SCs consulted with the SE specialist around the findings from the ASQ: SE. These consultations provided a natural learning opportunity for the SCs as they considered the implications of the ASQ: SE for the overall evaluation (for example, what disciplines should be included, what special expertise would be required to answer parents' concerns, how the family wanted to be involved). After the evaluation, the SC and SE specialist explored the findings and considered next steps. The SE specialist was available on an ongoing basis to consult with the SC and with the EI providers about their work with the child and family.

Case Consultation

"*The goal is to develop and practice a relationship-based approach.*"

Monthly case consultation sessions offered another opportunity to develop understanding and skills in relationship-based EI. The specialists and managers or assistant managers led small groups, using a guided process that helped SCs, PLs, and in some settings providers to consider their work with each child and family. Work was considered from multiple perspectives, including that of the child's social-emotional development within the context of family relationships.

Integrated Provider Work Groups

"*It's about looking at SE development for all kids and families, not just where there are red flags.*"

Specialists led work groups every other month to support the cadre of providers who were participating in the pilot and to encourage teaming. The sessions included minitrainings, case consultations, and informal peer consultation. Because most providers worked independently, the group offered much needed opportunities to network, exchange community resources, and share the emotional experience of the work.

Parent-to-Parent Mini-Grants

"*The parent liaison really heard what I was saying.*"

To enhance support for families, each CFC was provided with a mini-grant. The sites used the mini-grants in different ways: they developed a parent newsletter, created parent-to-parent linkages through a parent liaison, held a family day, attended a parent-to-parent support seminar, and held support meetings where families could safely process feelings and build supportive relationships with other families. To strengthen the work with parents, the PL participated in reflective supervision and in case consultations.

Specialist Consultation Network

"*We bring our struggles, define our roles, and share our resources.*"

To ensure that attention was paid to relationships at all levels, the SE specialists met together to provide peer consultation and support. The trust and mutual respect built in these sessions allowed the specialists

to freely share materials, resources, and training ideas and to support one another in the new role. As the pilot expands statewide, the network will mentor new specialists and support their development over time.

REFLECTIVE PROCESS SUPPORTING RELATIONSHIP-BASED EARLY INTERVENTION

In the remaining sections of the chapter, we focus on three elements of the approach that offer regular opportunities to support and sustain relationship-based work through reflective process: reflective consultation for managers, reflective supervision for SCs, and case consultation for SCs and providers. Here we describe the role that reflective process played in supporting relationship-based practice in each of these forums, the issues that were considered, and the relative benefits from the participants' perspectives. Our descriptions are based on a thematic analysis of rich contact logs that the specialists and managers kept over twelve months.

Because reflective process is used to improve practice, it is integrally tied to the roles and functions of the persons involved. The topics differ across groups but the process is the same: the continual conceptualization of what one is observing, doing, and feeling. Now enter into the world of relationship-based EI, see the issues that are brought to supervision, consider how essential consultation is to leadership, and feel what it is like to be on the front lines, "doing, learning, and coming to know" (Tremmel, 1993, p. 438).

Reflective Consultation for the Managers

As noted, the SE specialists provided weekly reflective consultation for the CFC managers. Each site successfully maintained the weekly schedule over twelve months, missing sessions only during vacations and one maternity leave, or holding shorter sessions when interrupted by urgent or unexpected administrative concerns. Altogether 140 sessions were held; the average length was 49 minutes, with a range from 15 to 110 minutes. Telephone consultations tended to be shorter (38 minutes) than on-site consultation (53 minutes).

THEMES. We reviewed 237 entries in the consultation notes to ascertain the themes for reflective consultation for managers. For managers, reflective consultation was used in large measure to help them think

about their primary responsibility: how to support staff (42 percent), particularly how to address complicated or conflictual staff relationships. Managers also used the time to plan the components of the pilot (30 percent), mostly how to implement reflective supervision, and to reflect on their role, responsibilities, and role strain (21 percent). Very little time was spent on systems concerns (4 percent) or operations (2 percent).

SUPPORTING STAFF. As noted, consultation around staff issues related predominately to staff dynamics (28 percent). Managers also discussed staff recruitment, hiring, and evaluation (8 percent) and how to help staff with their work with children, families, and providers (6 percent).

STAFF DYNAMICS. Managers primarily used consultation to build their capacity for *sympathetic conflict resolution* related to staff relationships. Bertacchi and Stott (1991) also found that directors-managers use consultation to address the complexity of professional relationships: "Interestingly, the work problems that group members [directors-managers] present typically have very little to do with the dynamics of families or children being served, but involve, rather, the struggles that supervisors and supervisees experience within the agency or institution" (p. 34).

Bertacchi and Stott (1991) note that although women managers in the "helping professions" are generally able to be supportive and empathic to their staff members, they are less comfortable with intense emotion, particularly their own feelings of anger, and with conflict. As a result, they are less confident in helping in emotionally charged situations, being clear about expectations, setting boundaries, and enforcing rules: "The supervisor [consultant] is responsible for creating an environment where such 'risky' sharing can take place; she pursues and focuses on conflict, rather than avoiding it. The supervisor thus helps the supervisee achieve new levels of mastery, both of personal conflicts aroused by the work and of skills needed to accomplish the work itself" (p. 38).

In the SE pilot, the SE specialists created and sustained an environment where managers could openly explore management dilemmas. Through the weekly sessions, the managers built their capacity to hear and contain strong feelings, internal and external, and to formulate supportive and effective responses, both in individual interactions and within the group. Their larger goals were to model and support healthy professional relationships, build the staff's capacity

for supportive peer-to-peer relationships, and thus create a more trusting work environment.

In the safe space of consultation, managers explored their own "triggers" in interactions and looked critically at their methods of supporting staff. They debriefed after difficult meetings, planned for challenging engagements, and brainstormed about how to supportively address the need for individual staff to change behaviors that undermined their performance. They talked about how to set limits and enforce appropriate expectations and how to handle staff conflict and build relationships when new staff joined the team. For example, in a consultation, the SE specialist noted, "Debriefed manager's intervention re staff conflict, anger, and hurt feelings validated her skills at directly addressing these issues while supporting each involved staff member."

Consultation helped the managers think about the well-being of the whole group during times of imposed change, transitions, or losses affecting the team. Managers also talked with the consultants about staff feelings of overload and burnout—a common issue brought to them in reflective supervision. Within the consultation relationship, the managers grew in their capacity to hear and contain staff feelings, to explore feelings underlying "staff overwhelmedness," and to solve problems and support staff around their caseload.

In each setting, consultation notes recorded the manager's reflection on her own growth and the rewards of seeing this growth reflected in staff's increased skills. This illustrated the parallel process in action.

HIRING, TRAINING, AND EVALUATING STAFF. Managers talked with the consultants about the difficulty in hiring SCs: the difficulty of finding competent candidates, the energy needed to interview and train new staff, and the challenge of providing meaningful services throughout all the counties with the full-time equivalents (FTEs) allotted. Consultation addressed issues around performance appraisals: the stress inherent in staff evaluation, the need to objectify the process, ways to create an empowering and safe process that facilitated accurate self-awareness, and ways to validate and celebrate staff achievements. Once again, managers used consultation to help them be effective in challenging situations, such as preparing for a difficult performance appraisal or thinking through ways to talk with staff about weaknesses or address "static" performance. Overall managers used consultation to help them create an environment and a process conducive to a

"genuine assessment of skills" from the perspectives of both the manager and the service coordinator.

HELPING STAFF WITH THEIR WORK WITH INFANTS, FAMILIES, AND PROVIDERS. Although the managers provided staff with a great deal of support around their work with children and families, this was not a central part of their consultation with the SE specialist, separate from the time spent planning and processing reflective supervision and case consultation. Like all recipients of consultation-supervision, when safety is present, one explores the most difficult challenges of the work. For these managers, as for the managers in Bertacchi and Stott's groups (1991), the knotty challenges lay in staff-staff relationships and staff-manager relationships, where the manager was more likely to be directly (personally) involved and in an evaluative role.

IMPLEMENTING COMPONENTS OF THE PILOT. Managers and consultants focused most of their collective energy on how to implement reflective supervision, how to integrate the ASQ: SE into the intake process, and how to lead case consultation groups. In addition, they reflected on how the SCs and providers were responding to the pilot.

In the early months, managers planned for or debriefed from reflective supervision sessions and explored the meaning of SCs' behaviors in supervision and the overall staff responses to supervision. As the months went by, reflective consultation provided opportunities for the manager to improve her reflective supervision skills by (1) asking questions that elicit reflection and (2) understanding reflective supervision as parallel process (for example, her empathy for the service coordinator affects the SC's empathy for parents).

Consultation helped each site with its unique challenges with reflective supervision. In one site, the challenge was the difficulty of maintaining regularity in supervision, given the demands on the manager's time and the number of SCs; in another site, the challenge was how to develop the process for group supervision.

With the ASQ: SE, managers and consultants used the time to plan the introduction of the tool, discussed how to use the information obtained and how to disseminate it to evaluators, and reflected on the responses (mostly positive) of SCs and providers to this aspect of the pilot.

In the beginning, case consultations were the most problematic aspect of the pilot for the managers and specialists to implement. They encountered "resistance" on staff's part to the time taken and to the

format: "We already do this; we talk with each other all the time." Managers and specialists experienced not only staff's anxiety and dissatisfaction but also their own anxiety about how to make these sessions meaningful.

Reflective consultation sessions offered both facilitators—the consultant and the manager—a forum for reflection, mutual support, and problem solving as they worked toward an effective approach. Over the months, as the sites developed their own guided process for case consultation, comfort with and effectiveness of the case consultations increased. Reflective consultation provided the manager and specialist with time to reflect on their own relationship, to consider any tensions engendered in co-facilitation, and to provide mutual support around any discouragement they felt when staff were less able to be open and tolerant with families.

In weekly reflective consultation, the specialists and the managers assessed how the pilot was going overall and monitored staff and provider responses. They explored the challenges, the impact, and the next steps, staying closely attuned to the current stage of acceptance and participation.

REFLECTION ON THEIR ROLE, RESPONSIBILITIES, AND ROLE STRAIN. Managers used consultation to process the stresses of their multifaceted position—"stress of management of crises" (for example, stolen laptop, reports due, advocating to hire new clerical and SC staff to handle burgeoning number of referrals)—and the strain from "the dynamic nature of their duties," which often lacked a sense of closure. They discussed the ever present challenge of maintaining a healthy separation between work and home life. They also used consultation for support around their relationships with upper agency management, brainstorming ways to improve communication and mutual trust with the host agencies.

PERCEIVED BENEFITS. The perceived benefit of reflective consultation on the work of the manager was reported by the managers and the SE specialists on questionnaires at the midpoint and end of the pilot year. Two questions were included: (1) How beneficial was reflective consultation to the work of the manager? where responses were given using a five-point Likert scale (1 = not at all, 3 = some, 5 = very beneficial) and (2) an open-ended question: What impact did reflective consultation have on the work of the manager?

Overall reflective consultation was highly rated by the managers both at the midpoint and at the end (4.00 at midpoint, 4.67 at end). In fact, the managers rated reflective consultation as the most beneficial of all the pilot components. Managers reported that the structured time set aside to consult with the SE specialist was of great value: "The mandatory carving of time from the schedule has forced me to stop and reflect upon the multitude of issues that occur on a daily basis." At midpoint, managers reported a positive impact on their handling of staff issues, including understanding staff better, being better able to support and build on staff strengths, and being better able to develop proactive steps to problem solving. At the end of the pilot year, managers reported that the positive benefit of consultation continued in their work with their staff and had extended to their work in the system as a whole.

Reports from the SE specialists confirmed that the managers were more reflective and skilled in their roles. The specialists reported that the managers exhibited greater ease when dealing with conflict, demonstrated increased ability to consider multiple perspectives, modeled use of relationship-based strategies in their daily encounters, and grew in their ability to create and enforce a safe atmosphere in individual and in group interactions.

It is noteworthy that the specialists reported lower ratings of the benefit of reflective consultation on the manager (3.33 at midpoint, 4.00 at end). These lower ratings suggest that the specialists underestimated the impact of their consultation on the manager. Several explanations are possible, including these: (1) the specialists were creating a new role; it was challenging in the beginning to know how to be helpful and if they were effective in their developing role; (2) because the managers' jobs are very stressful, the specialist may have felt that consultation alone was too little to influence their well-being and functioning; (3) the managers had never had reflective consultation and were highly appreciative of the additional support.

It is clear that the match between the SE specialist and the manager was a crucial factor in the success of the consultation relationship. In the pilot, and in the statewide implementation of the model, the manager has primary responsibility for selecting and hiring the specialist. The specialist position is conceived of as a trusted ally for the manager, offering complementary skills and knowledge that together with the manager's leadership will help build the CFC's capacity to meet its performance goals using a relationship-based, reflective approach.

Reflective Supervision to the Service Coordinators

Reflective supervision was provided individually to SCs in two sites and in small groups of two to four SCs at the third site. PLs and LIC coordinators also participated in reflective supervision. Managers provided individual supervision; SE specialist and the manager or assistant manager provided group supervision. The manager provided biweekly reflective supervision to the assistant manager to expand her leadership role and develop her supervisory skills. At all sites, supervision for the SC was provided monthly through the first three months of the pilot. Because of the large number of SCs, one site moved to bimonthly individual supervision, with monthly supervision available on request. In all, 185 sessions were held. Time in individual supervision averaged 78 minutes per session, with a range of 15 to 160 minutes. Group supervision averaged 73 minutes.

THEMES. We reviewed 382 entries from supervision logs to identify themes in supervision of the SC. Supervision was primarily used to support SCs in their work with infants, families, and providers (40 percent) and to explore the tensions SCs experienced in their role (31 percent). SCs and managers also talked about the pilot components (12 percent), staff dynamics, and relationships within the CFC (7 percent), CFC operations (5 percent), hiring, training, and evaluating staff (3 percent), and larger systems issues affecting the SCs' work (2 percent).

SUPPORTING SERVICE COORDINATORS' WORK WITH INFANTS, FAMILIES, AND PROVIDERS. SCs used supervision first and foremost around their work with families. Although they discussed a multitude of issues, one theme appeared to dominate: self-knowledge, emotional awareness, or use of self. SCs sought to understand the more complex and intense aspects of their relationships with families so that they could work in the most helpful way. To this end, SCs explored their anger with families who did not follow through, their frustration when feeling scapegoated and blamed for events not within their control, and their sense of being stuck in the middle, between families and providers when, for instance, a family did not want a medical diagnosis and the team did. SCs talked about how they felt unsafe at times during "family meltdowns" or when they were the recipients of verbal abuse. Moments of anguish and grief were experienced when families suffered losses or when a child died.

SCs used the safety of supervision to "share and own" their feelings, to learn "how to work *past* and *with* those feelings," and at times to "learn to work appropriately in spite of own affect"—to "act appropriately when feeling contrary to the action." "If you don't have practice 'dealing' with issues, you may really blow up when you have to," one commented. In sharing these strong emotions, SCs received much needed and important validation for the important work they do and help with generating new strategies for difficult situations. They used supervision to find "the emotional energy needed to do the job." For one SC, this meant to have the inner confidence and respect for one's role to accept that a parent wanted another SC and to work through this in supervision so to "be OK with it." Another SC was able to reflect on why three families pulled out unexpectedly and wondered what she—or the system—could have done differently.

SCs shared the mixed emotions evoked when transitioning families, from the feeling of "abandoning the client" to "owning feelings of dumping." With support, they learned to give themselves permission to feel good when a family moved on from EI. They shared the challenge of working with overburdened families who were overwhelmed with life challenges. When the SC, in turn, felt overwhelmed with families' needs and "dependency," managers helped them to differentiate and to respond flexibly. For some families, part of the challenge was learning how to help set limits around the SC role and helping the family to access additional supportive resources. For others, it was learning how to help families so that they were not overwhelmed with services. SCs talked about their experiences with families who were difficult to reach (for example, had no phone, did not return phone calls, did not follow through) and problem solved with the manager on how to "stay on top of their job" in these circumstances.

The SCs recognized their therapeutic role in relationship, even though they felt at times that their role was viewed as "paper pushing." When the SC was able to transfer the empathy and support felt in the presence of the manager to her work with families, service coordination was transformed from tasks to relationships. "When the SC calls, I don't get 'Hi, how are you?' Instead she focuses on services: 'Okay, what do we have to do for Rachel now?'" (Cutler & Gilkerson, 2002, p. 51). Could this be what the SCs experience without opportunities for reflective process? Could it be that SCs, too, feel as if no one is asking, "How are you?" Rather, they are confronted with demands:

"Did you call the family within forty-eight hours?" "Were all the consents signed?" "Where are the therapist's reports?" "You have an irate parent on the phone."

Relationship-based service coordination monitors progress by addressing the parents' concerns and the child's development. For instance, "I know you were concerned about Devon's walking and really hoped he would be taking his first steps by now. I was wondering how it was going for you and for him? Do you feel like your concerns about his legs are being heard?"

Supervision offered the opportunity to follow the SCs' concerns and professional development and to process their relationships with providers, in which they often struggled with feelings of not being valued or respected ("how to get as much respect as we give and what to do if that never happens"). The manager and SC problem solved around ways to approach providers in difficult circumstances, such as when confidentiality was breached, or when the SC felt that the provider was misleading a family, or when a parent had brought up an issue that concerned the provider.

SCs discussed being frustrated with their lack of control over the quality of providers, coupled with their responsibility to find providers for families within a forty-five-day time line. The managers helped them understand the perspectives of the providers and thus increased their capacity to respect providers' needs, to understand their defense mechanisms, and to work more effectively as a team.

With their increased strength and skill in "sympathetic conflict resolution," gained through reflective consultation, managers helped SCs move toward open dialogue and conflict resolution. The greater comfort and skill with conflict was acknowledged in supervision and mentioned in the notes: "relationship going better since SC brought conflict out in the open" or SC "recognizing the value of conflict [in] driving better services and developing team." Supervision also provided the place for SCs to note improved relationships and take pleasure in successful teaming.

SUPPORTING SERVICE COORDINATORS AROUND PROFESSIONAL IDENTITY AND ROLE TENSIONS. Of the supervision sessions that related to SCs' role and role strain, SCs spent time discussing their feelings about their workload (13 percent), balancing work and family life (11 percent), and their overall roles and responsibilities (7 percent).

FEELINGS ABOUT WORKLOAD. SCs spoke of feeling overwhelmed with the many responsibilities of their job, being "behind the eight ball," having "too much on my plate," and feeling that "the SC jar is full." The majority of workload themes related to explicit discussions about caseloads (55 percent) and involved the SCs' belief that their caseload was too high. Managers held and contained these feelings for the SC, as the SE specialist did for the manager, and together they brainstormed about ways to make it easier and relieve or manage pressure. SCs also talked about when their caseload size was about right or had been reduced to their satisfaction. Through this process, they "felt heard by administration" and "celebrated the decrease in caseload," because it meant they had more time to relate to families. One commented, "When the caseload is low, the job is much better, even fun." At these times, reflective supervision became a time to share the pleasure in work experiences, express increased job satisfaction, and experience validation in their professional role.

BALANCING WORK AND FAMILY LIFE. SCs talked about the impact of work stress on their personal lives and on their own children and the challenge of balancing the intense SC schedule and their personal lives (for example, "stress of balancing duties, responsibilities, and priorities"). SCs were often dealing with their own major life events, including health concerns, getting married, pregnancy, raising young children, going to graduate school, moving to a new home, and helping to care for ill and aging parents. Personal and work experiences and the emotions associated with them had reciprocal effects (for example, "preparing for motherhood and meshing identities to perform SC role").

Supervision served as a forum for safe sharing of these aspects of SCs' personal lives, as well as a forum for discussing personal goals and professional identity and receiving validation for their role. Some SCs discussed job requirements and concerns that they did not have the skills to engage in relationship-based work—concerns that one hopes will surface and be explored as part of the supervisory relationship.

PERCEIVED BENEFITS. SCs, managers, and the SE specialists reported the perceived benefits of reflective supervision on the work of the SCs on questionnaires at the midpoint and end of the pilot year. There were two questions concerning benefits: (1) How beneficial was reflective

supervision to the work of the SC? where responses were given using a five-point Likert scale (1 = not at all, 3 = some, 5 = very beneficial) and (2) an open-ended question: What impact did reflective supervision have on the work of the SC?

Average perceived benefit reported by the SCs was moderate (2.96 at midpoint, 3.22 at end). Although not statistically significant, the trend over time is toward increased ratings of the benefit from supervision. Interestingly, there appears to be a positive relationship between the perceived benefit of supervision and the amount of time in supervision. The site with the highest perceived benefit had the longest supervision sessions; the site with the lowest perceived benefit had the shortest supervision sessions. Individual versus group supervision had no effect on the length of the sessions or the SCs' reports of perceived benefit.

We have speculated about what might account for the moderate rating for reflective supervision when many SCs were actively engaged in the process. The low intensity of monthly or bimonthly schedule may well have dampened the effect of supervision, as perceived benefit did correlate with the amount of time in supervision. Some SCs felt discomfort that supervision was needed at all; it seemed like a sign that they were not doing their job well enough, rather than an indication that they were trying to do it better. Others felt that it was redundant with support that already existed from peers-colleagues. Still others resented the time required for supervision, especially with the high caseload demands.

At the midpoint and end, the managers and SE specialists rated the benefit of supervision to the SCs more highly than the SCs rated it (managers were 3.67 at midpoint, 4.33 at end; specialists were 3.5 at midpoint, 4.33 at end). The managers' ratings of increased benefit over time paralleled the trend for the SC ratings. Although the ratings were in the midrange, SCs felt that reflective supervision helped in five areas: (1) helps the manager and the SC understand each other, (2) feels safe—one can express feelings without worry, (3) structured time conducive to reflection (not hit-and-miss), (4) feel they have a support system, and (5) helps with work with families (for example, "I felt very supported in dealing with all the emotions that occur in my work with families").

Managers concurred with the SCs: (1) felt that they had a better understanding of each staff member, (2) felt that they could see things from their perspective, (3) felt that the SC was more connected to the

manager, and (4) felt that they could be more open to concerns and questions.

Case Consultation for Service Coordinators, Parent Liaisons, and Providers

At all three sites, the specialist and manager or assistant program manager jointly facilitated case consultation group sessions. At two sites, these included only SCs and PLs, and the third site included providers as well. Sixty-seven group sessions were held over the year. An average length of a group session was 64 minutes (range from 30 to 120 minutes). The typical session included five or six people, but participation ranged from two to fifteen people. At one site, case consultation sessions were structured according to a four-step process: (1) sharing background information, (2) discussing practice concern and utilizing group knowledge, (3) determining next steps, and (4) summarizing case consultation group benefits. At another site, the Portage Project (Copa, Lucinski, Olsen, & Wollenberg, 1999) model was used. As noted earlier, a guided process was essential to increasing the comfort and satisfaction with case consultations.

THEMES. We reviewed 305 entries in the case consultation log to identify themes. We determined that case consultation was primarily used as planned: to assist SCs to increase their knowledge of relationship-based concerns and develop and practice relationship-based techniques (72 percent). Case consultations also served as a venue for discussing issues related to case consultation (19 percent), other pilot components (6 percent), and system issues (3 percent).

Although it took some time to establish a comfortable process, case consultation played a unique role in the SE pilot. This was the one forum in which *all* aspects of relationship-based early intervention were considered: child's health and development in all domains; family constellation, structure, and process; parent-child relationship, including the subjective and objective aspects; family's cultural beliefs and practices and those of the interventionists; the interventionists' experience of the relationship, both objective and subjective; qualities of the provider-parent relationship and provider-provider and team relationships. In fact, of the three reflective process forums discussed, case consultation was the only arena where substantial focus was placed on the child.

The addition of the ASQ: SE clearly enhanced the SCs' knowledge of the child and the meaning of the child in the family. Case consultation provided the chance to go further. It was a venue to integrate child development theory and practice, to hone skills for observation and reflective functioning, and to try on different perspectives in a supportive setting. The group had the undivided attention of the manager and the specialist and permission to explore all aspects of the work from administrative and policy issues to clinical concerns and team dynamics. The manager and specialist experienced the group together, and through reflective consultation they grew to better understand the dynamics at play in each group.

INCREASING KNOWLEDGE OF RELATIONSHIP-BASED CONCERNS. Of the consultation sessions that related to increasing knowledge of relationship-based concerns, sessions related primarily to team collaboration with families (45 percent), understanding parent-child relationships (9 percent), and more general family dynamics (7 percent). A significant number of the discussions involved families with complex needs, including social-emotional issues of the child and parent.

Case consultation served as a forum for exploring and understanding the parent-child relationship from multiple perspectives, including temperament styles, attachment concerns, and the impact of children's and parents' social-emotional issues on parent-child relationships. For example, one discussion centered on the emotional development of a two-year-old in relation to the parent's depression (for example, "acting out more to awaken attention of remote caretaker"); another explored "inconsistent interactions" between a mother and child (for example, "feeling happy with some activities with her child but becoming overwhelmed when her child tantrums or clings"). SCs were also concerned when parents seemed "inflexible" and were "not attuned to child," including cases where "parents' concerns and child's needs appeared to be mismatched." Participants explored ways to think about relationship issues, to wonder what it is like for each partner, and to consider any need for an infant mental health or social work referral.

Participants explored family dynamics as an integral part of service provision, particularly where there appeared to be conflict within the family. For example, SCs discussed an extremely isolated family with an unstable living situation and shared their anxiety about the potential for abuse of a toddler after observing family interactions

with and expectations of the child. During case consultation, the SC was able to formulate an action plan that took the parents' needs, as well as the child's, into account.

Participants also discussed cultural differences between themselves and families. SCs discussed how they might attempt to understand these families' cultural beliefs and practices, particularly the ways cultural expectations played a role in how parents understood their child's behavior. They explored how their own cultural backgrounds influenced and possibly interfered with their ability to interact with families. In addition, they considered the use of interpreters during assessment and the concerns about the quality, responsibilities, and training of interpreters.

UNDERSTANDING TEAM RELATIONSHIPS. In case consultations, participants discussed and reflected on team relationships in order to move toward "good team collaboration." This included identifying and resolving team conflict and involving team members in providing families with needed supports. For example, one SC discussed a family with a baby with a complicated medical condition that required multiple surgeries and daily procedures that the parents had decided not to do. The providers were intensely involved with the parents, and eventually conflict erupted among them, with some providers feeling the others were unethical. During case consultation, they explored how feelings are contagious and how the team was experiencing some of the family's emotional state. They thought about whom the family trusted most—the parent liaison—and developed a plan to collaborate to meet the family's needs by asking the parent liaison to serve as the primary contact and to explore the family's willingness to allow other social and medical supports in the home.

DEVELOPING AND PRACTICING RELATIONSHIP-BASED TECHNIQUES. In case consultation, participants took turns presenting to the group in order to collectively reflect on and practice applying relationship-based techniques to their work with infants, families, and providers. As in reflective supervision, SCs learned to hold and contain intense feelings evoked in the work and build the capacity for self-knowledge, emotional awareness, and use of self. They learned more about their own sensitivities and reactivity and about how to recognize parallels in their own lives. For example, a therapist recognized her own feelings of sadness for a foster child, exasperation with the foster parent

who chose not to adopt the child, and—with support from the group—how this paralleled her personal experience. This process involved acknowledging affect and its value in catalyzing change and growth.

Case consultation groups modeled for SCs how to help parents feel safe so that differing views could be explored. For instance, they discussed a family situation where there was "anger at parent who seems unable to follow through with therapy appointments and who seems to avoid SC contact (for example, fails to return calls, not home for therapist appointments)." In consultation, participants practiced identifying new ways to understand what the parent might be trying to communicate and why it triggered their anger. SCs and providers learned how to present difficult information to parents, including how to support parents who were receiving the child's diagnosis, how to understand parents' capacities to receive and process information, and if and how to make statements about behaviors being typical for age.

Participants also practiced learning to set limits and boundaries in their relationships with families. For example, they discussed how to understand and cope with an "angry parent screaming at SC and provider" and how to appreciate the parents' feelings while setting rules for phone engagement, limits on SC intensity of involvement, and reasonable expectations for time and energy commitments. Part of this process involved SCs' working through their role definition, developing confidence in their role, and gaining more comfort in explaining it to others.

Participants discussed a "shift from deficit- to strength-based work." They practiced identifying family strengths and learning to build on those. For example, a SC had trouble empathizing with a young mother after learning that her baby was born drug exposed. The group helped her see possible strengths, such as the mother's follow-through with EI referral, regain her footing, and begin again with the mother.

Finally, participants practiced taking the perspective of others. This process was intended to facilitate understanding, rather than judging, and create shared meaning in order to validate parents' feelings. With each case, participants explored the child's perspective and their perception of the child's needs, while supporting the child's agenda, understanding the child's signals, and trying to understand and address the child's sense of felt security. Participants also explored the parents' understanding of their child and considered how to hold

the different representations presented by each parent. They considered the meaning of developmental delay to parents, the effect of the disability on the parents' relationships with their other children, and its impact on the parents' image of the child's future.

PERCEIVED BENEFIT. The perceived benefit of case consultation on the work of the SCs was reported by the SCs, managers, and the SE specialists on questionnaires at the midpoint and end of the pilot year, using two questions: (1) How beneficial was case consultation to the work of the SC? where responses were given using a five-point Likert scale (1 = not at all, 3 = some, 5 = very beneficial) and (2) an open-ended question: What impact did case consultation have on the work of the SC? At the midpoint, managers, SE specialists, and SCs reported low to moderate benefits of case consultation. However, by the end of the pilot year, we observed a significant increase in SCs' perceptions of the benefit of case consultation (2.42 at midpoint, 3.19 at end). Specialists also reported higher benefit ratings at the end of the pilot (3.33 at midpoint, 4.33 at end).

In contrast, managers generally reported decreases in the benefit of case consultation on SCs (3.33 at midpoint, 2.67 at end). Their open-ended responses shed some light on these quantitative findings. For example, SCs reported receiving benefit from brainstorming about difficult family situations and support from the group. Representing the vast majority of SCs' sentiments, one SC reported this: "It really helps . . . when I have a complicated case. I can look to the consultation for help with ideas, support, suggestions, and I enjoy hearing others' outlooks on things that can benefit me." Specialists also reported that SCs were benefiting from connecting with and receiving support from one another.

At the end of the pilot, specialists reported that SCs were demonstrating improved observational skills, increased emotional self-awareness, increased empathy for parents, and increased self-confidence in their work. The managers, in many cases, qualified their responses by reporting that "some have been able to benefit more than others." One reported, "Some staff are still looking at case consultation at a surface level and not realizing full gain from the process. The majority of staff have started the case consultation process and taken time to step back, analyze, and make informed choices." Another manager reported that case consultation "has caused some confusion, because many felt this process was already happening informally." In

general, the managers reported that case consultation provided an important venue for SCs to consult formally with their peers and supervisors regarding the social-emotional needs of families: "It has helped them get to know each other and has begun to improve communication."

The Illinois SE Pilot planning committee designed a multilayered process for supporting the introduction and continuation of reflective, relationship-based practice into the early intervention system. The process included ten elements: (1) addition of a SE specialist, (2) training in relationship-based early intervention, (3) reflective consultation for leadership, (4) reflective supervision for staff, (5) addition of the ASQ:SE, leading to (6) more integrated assessment and intervention planning, (7) case consultation and (8) integrated provider work groups, (9) parent-to-parent mini-grants, and (10) specialist network.

Implementing this process in three CFCs during the pilot year required continual attention to infusing at all levels the same principles of relationship-based practice that guide the work with infants and families. Each element of this multilayered process supports and shapes the quality of activity in the subsequent element. It is the quality of relationships and collaboration at the planning committee level that enabled the managers and specialists to influence the quality of relationships and collaboration at the CFC level, which brought about changes in practice that ultimately affected children and families.

To date, the pilot has succeeded in beginning the shift in practice toward a relationship perspective. End-of-year questionnaires reveal that 100 percent of the managers report changes in their practice such that they "understand that all work is relationship-based." Ninety-two percent of the pilot providers report changes in practice, including increased self-awareness with families, greater awareness of how intervention strategies affect the parent-child relationship—positively or negatively—and greater capacity to listen longer before formulating a response, even an internal one. Sixty-five percent of the SCs report that they are doing things differently, including having an increased capacity to see the bigger picture, to look at the family as a whole, and to focus on strengths. In addition, SCs report a statistically significant increase in satisfaction with their work with infants and families and with their role in the early intervention system.

As the process goes to scale in all twenty-five CFCs in Illinois, the challenge will be to maintain the focus on relationships and reflective process throughout the system of services for infants, toddlers, and families. The ultimate goal of the SE component is to offer each child and family the experience of early support, where the social-emotional needs of children and families are acknowledged; where the relationships between the child, parents, and other family members are central to all intervention efforts; and where parents work with professionals who are able to listen and collaboratively develop goals that are truly meaningful to children and families.

Note

1. The SE Planning Committee is cochaired by Carolyn Cochran Kopel, Illinois Department of Human Services, and Linda Gilkerson, Erikson Institute. Funding is provided by the Illinois Early Intervention Bureau, Janet Gully, Bureau Chief. The CFC managers include Carol Harvey, April Leopold, and Delores Nickel, and the SE specialists are Sonja Hall, Mary Marovich, and Nancy Segall. Mary Claire Heffron serves as the national consultant, Tina Taylor Ritzler as the evaluation coordinator, and Lynn Liston as the Illinois Association for Infant Mental Health representative.

References

Bertacchi, J. (1996). Relationship-based organizations. *Zero to Three, 17*(2), 3–7.

Bertacchi, J., & Stott, F. M. (1991). A seminar for supervisors in infant/family programs: Growing versus paying more for staying the same. *Zero to Three, 11*(2), 34–39.

Copa, A., Lucinski, L., Olsen, E., & Wollenberg, K. (1999). Promoting professional and organizational development: A reflective practice model. *Zero to Three, 20*(1), 3–9.

Cutler, A., & Gilkerson, L. (2002). *Unmet needs project: A research, coalition building, and policy initiative on the unmet needs of infants, toddlers, and families. Final report.* Chicago: University of Illinois-Chicago and Erikson Institute.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A*

source book. Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Gilkerson, L., & Cochran Kopel, C. (in press). Relationship-based systems change: Illinois model for promoting social/emotional development in Part C early intervention. *Infants and Young Children.*

Gilkerson, L., & Shahmoon-Shanok, R. (2000). *Relationships for growth:* Cultivating reflective practice in infant, toddler, and preschool programs. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *World Association for Infant Mental Health handbook of infant mental health, Vol. 2: Early Intervention, evaluation, and assessment* (pp. 33–79). New York: Wiley.

Heffron, M. C. (2000). Clarifying concepts of infant mental health: Promotion, relationship-based preventive intervention, and treatment. *Infants and Young Children, 12*(4), 14–21.

Illinois guide to the social-emotional component of early intervention. (in preparation). Illinois Department of Human Services Early Intervention Social/Emotional Planning Committee.

Norman-Murch, T. (Ed.). (1999). Reflective practice in relationship-based organizations. *Zero to Three, 20*(1), 2–35.

Squires, J., Bricker, D., & Twombly, E. (2003). *Ages and Stages Questionnaire: Social-Emotional (ASQ: SE).* Baltimore: Brookes.

Tremmel, R. (1993). Zen and the art of reflective practice in teacher education. *Harvard Education Review, 63*(4), 434–458.

Weston, D. R., Ivins, B., Heffron, M. C., & Sweet, N. (1997). Applied developmental theory: Formulating the centrality of relationships in early intervention: An organizational perspective. *Infants and Young Children, 9*(3), 1–12.

CHAPTER TWENTY-ONE

Apprenticeship, Transformational Enterprise, and the Ripple Effect

Transferring Knowledge to Improve Programs Serving Young Children and Their Families

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Our burgeoning new field of "infant mental health" has been deeply influenced by twenty-five years of cross-disciplinary pollination fertilized by the zero-to-three movement. It is currently wending its way toward acceptance of a generic base of knowledge for all practitioners working in conception- through kindergarten-age programs. Practitioners from diverse disciplines must both "know" this information and be able to put it into practice in order to achieve best practices, no matter what their job role or their setting.

Given the diversity of programs that serve young children and their families, early childhood practice increasingly attracts and involves a wide array of practitioners. These include professionals and paraprofessionals in parental-infant health; developmental pediatrics; early

childhood and special education; speech-language pathology; social work; clinical, consulting, and developmental psychology; child development; psychoanalysis; psychiatry; occupational and physical therapies; and arts therapies. Current knowledge about appropriate ways to support the "mental health" needs of young children and families reflects this diversity, given the last twenty-five years of increasing collaboration among the many disciplines and systems that hold "a piece of the baby."

Indeed it is not possible either to deliver a comprehensive system of mental health care, support, and services for young children and their families or to prepare practitioners to work in such a system by preparing only mental health practitioners or by preparing practitioners in isolation. The concept of mental health in young children implies the integration and synthetic functioning of many lines of development within the child and in the relationships and interactions of the child with family members. The complicated challenges inherent in serving very young children and their families often require a complex set of intersecting supports. The younger or more vulnerable the child and family, the more likely this is to be true.

It is therefore increasingly being recognized that in order to work with the "whole baby," it is necessary to prepare practitioners to work together. Practitioners must work with one another constructively in multi- and interdisciplinary ways. They must know something of one another's fields by cross-disciplinary approaches, or they must be prepared to utilize a generic, transdisciplinary base of knowledge with roots branching upward from each of the fields.

Weaving together the inspiring work of pathbreakers with bits and pieces of financial support, model programs of service and research for young children and their families have sprung up over the last three or four decades across North America and other countries.[1] More recently, between the last decade of the twentieth century and the present, new postdegree training programs have been conceived to prepare professionals for infant-toddler-preschooler—parent services in existing as well as recently established systems such as Early Intervention and Early Head Start.[2] Still none are nearly large or comprehensive enough to serve even a fraction of their own communities' needs. Initiative, resources, and will remain woefully insufficient both in North America and elsewhere.

The following, then, are the interrelated tasks for the next two and a half decades:

- The range of services needed by and within each community needs to be developed.
- A critical mass of professionals who hold a generic base of content and process knowledge, including both leadership and a workforce capable of delivering best practices, must be trained.
- Research must guide us as we replicate and disseminate existing successful services and develop new ones to serve as yet unmet needs.
- Mediocre or inadequate programs must be improved.
- Finally, programs and systems must be merged into a comprehensive network.

Such a safety net of services and communal supports is necessary to catch, hold, and support young children and new families before incipient challenges become unrealized potential, society's losses, and sometimes its liabilities.

The creation of this safety net requires rethinking professional and paraprofessional development. This volume, *The Handbook of Training and Practice in Infant and Preschool Mental Health,* is an effort to consolidate, organize, and offer for discussion conceptions of exemplary training and practice in infant and preschool mental health. We believe that content and process are inextricable. Without losing sight of content, however, this chapter emphasizes the *process and the social context of training and service delivery.*

REFLECTIVE PRACTICE WITHIN SERVICE AND TRAINING CONTEXTS

In recent years, *reflective practices* have emerged from the mental health fields of psychoanalysis, social work, psychology, and psychiatry (see Fenichel, 1992; Gilkerson & Shahmoon-Shanok, 2000; Shanok, Gilkerson, Eggbeer, & Fenichel, 1995a, 1995b; see also Chapter Six and Chapter Twenty, this volume) to improve clinical awareness and self-awareness among those who work with very young children. Reflective practice is currently being discussed by and applied to all of the professional fields that work with young children and new families, at least to some extent. Indeed several of those fields, such as early childhood education, also have a growing reflective element in their approach.

More recently, the idea of *reflective function* (see Fonagy, 2002; Slade, 2002; Mayes, 2002) has been identified as a key relational capacity in parents' abilities to help their children grow. This constellation is being investigated in the context of parent-infant relationships and in parent-infant-intervener relationships. In parallel, our fields have focused their attention on relationship-based and reflective practices as they emerge between supervisor and supervisees. However, they have not yet examined the *organization of experiences*—the social context—within which that reflection is generated.

Viewing relationship-based, reflective approaches as fundamental, this chapter shifts the spotlight to illuminate the potential power available to training and service efforts by attending to social contexts and continuities, processes and partnerships of trainees and staff members. We suggest that a commitment to long-term, reflective, in-service training relationships should be part of all services. Furthermore, by attending to the social and aspirational character of training and service contexts, knowledge transfer can be sufficiently energized to propel both the individuals and the programs within which they serve toward synergistically improving practices.

In this chapter, we identify and describe program design, implementation, and training elements that appear to hold this growth-inducing potential.[3] As a program example and source, we will highlight *Relationships for Growth (RfG),* an early childhood mental health service and training program that constitutes a joint project of the Institute for Infants, Children & Families, Jewish Board of Family and Children's Services (JBFCS-Institute) and New York City's Administration for Children's Services, Head Start (ACS-Head Start). By using *Relationships for Growth* as our example to focus on in-service training, we ask how practitioners in our fields can consult with, train, and provide services within existing programs in ways that affect the whole and raise the bar of actual daily practice.

The mission of all high-quality training programs in early childhood and related fields is to share, nurture, and transfer content (intellectual) *and* process (social-emotional) knowledge in order to improve every type of program serving young children and their families. All such training and most services evolve in and depend heavily on a variety of subgroups that themselves become the context of growth. This chapter endeavors to describe the principles governing on-the-job training and practice contexts so that readers may productively consider them. In doing so, we hope to stimulate dialogue

within our fields by elevating attention both to group processes and long-term, in-service, advanced training as the heart, mind, and energy of service program excellence.

Given the idea of reflective practice, the questions guiding the discussion here are these: What does it mean to become something? What does it mean, for example, to *become* a teacher, a psychologist, an occupational therapist, a parent? (Pine, 1985; Shahmoon-Shanok, 1990; Shanok, 1987). What does it mean to *train someone* or to be *trained* in infant and early childhood practice? How do adults take on and experience their new roles? What experiences best facilitate the kind of becoming that yields empathic, knowledgeable, grounded, and resourceful practice? How is the formation of a professional identity affected by the context and qualities of relationship fostered within the training and service contexts? How can we achieve relationships for growth for each person involved within a program—children, parents, *and* staff? What role does mission have in engaging the development of professionals and paraprofessionals?[4] Finally, how does relational, reflective, emotionally wholesome practice come to infuse a whole program, tipping it (Gladwell, 2000) toward individualized and attuned services?

APPRENTICESHIP, TRANSFORMATION, AND THE RIPPLE EFFECT

As functioning families are for growing children, so apprenticeships are for learners: small human groups responsible for imparting the skills necessary to become something . . . a dancer, a plasterer, a lawyer, a teacher. Formal and informal apprenticeships are ubiquitous across the trades, arts, and professions. As with families, it is hard to imagine another way, let alone a better route, for transferring the skills and processes needed to become a capable someone, whatever that role in society is. And like families, apprenticeships are an age-old societal system, an inheritance of structures for learning gifted to us from the distant past.

Generally, when we talk about the distant past in our fields, we refer to parents, grandparents, and perhaps great-grandparents. The psychodynamic idea of transference patterns, "ghosts" reasserting themselves from the past (Fraiberg, Adelson, & Shapiro, 1980), sometimes startles us with parallels, echoes, and repetitions rattling up from the distant intergenerational past. Yet to look squarely at apprenticeship

and what we shall call a *transformational enterprise* is to redefine the word *distant* in the phrase *distant past.*

The idea of apprenticeship as transformational enterprise is dramatically illustrated in a remarkable article about the birth of ancient toolmaking, which suggests that toddlers' investigations of toy tools may be a phylogenetically inspired echo of the development and use of ancient tools (Bower, 2003):

> In the Indonesian island village of Langda, located on Irian Jaya near its border with Papua New Guinea, a half-dozen men sit in an open space, chipping fragments out of rocks. It's not rocket science, but it's a veritable rock science still practiced by a handful of groups around the world. The men are making double-edged stone blades for adzes, scythe-like tools with wooden handles that the Langda have traditionally used to clear land and to work wood. Several of the men show great dexterity in shaping stones into implements, a process known as stone or flint knapping. Each man holds a grapefruit-size stone in his right hand that he uses as a hammer to strike a rock braced against a piece of driftwood with his left hand.
>
> . . . The men's work is going well. One craftsman proclaims his joy by crying out the name of a mythical figure revered as the provider of adze-worthy stone. A second man smiles and describes the stone strips, or flakes, that he's pounding from a blade as "peeling off like sweet potato skin." A third experienced adze maker talks excitedly of wanting to slice flakes off "every stone in the river."
>
> Their duties encompass more than knapping stones. The skilled workers pause periodically to monitor and advise apprentices gamely pounding at their own potential blades. "Work more slowly," they might say. Or they might offer advice on proper knapping technique and posture or outline strategies for shaping a particular stone [pp. 234–236].

The author makes the point that the craftworkers' activities are of interest to anthropologists in part because their work today illuminates what are thought to have been the customs of our ancestors working together several thousand and perhaps a couple of million years ago. Ancient past or simply present, what he illustrates is apprenticeship: cooperative learning ventures by two or more people to attain a shared goal. The delight in imitative learning and the cooperation evident among these junior and senior coworkers will resonate with readers knowledgeable about imitation and early learning that has

been documented to occur in infants as early as an hour after birth (Meltzoff & Moore, 1977).

In the example of the toolmakers, each participant appears to be at full attention, in a state of concentration and total involvement, which is called *flow* by Csikszentmihalyi (1997, 1993, 1990). Imitation and flow coalesce. The toolmakers' skills are mastered over years of practice through an apprenticeship group energized by relationship, reflection, and rejoicing about conjoined purpose. Shared understandings and a delighted sense of mastery ripple from one colleague to another, while meaning is conferred within and among them. This synergy constitutes the transformational aspect of their work. What the whole does becomes larger than what any part alone may accomplish. Each individual, master flint knapper and apprentice alike, resonates by feeling and being part of a team with a mission that holds significant meaning to everyone. Each one contributes to the mission and each one is affected by it. Mutuality, motivation, and openness to learning burgeon as a result.

Apprenticeship as Transformation

"The culture here is changing to one in which change for the good is possible, and one in which there is enough to go around" (unidentified *RfG* project member/Head Start staff member).

It is sometimes said that there is nothing new under the sun. Like the relationships for learning that develop between the senior and apprentice toolmakers, field placements, internships, fellowships, and residencies in every one of the birth-to-five disciplines (from medicine to education, from mental health to the physical, language, and arts therapies) include significant apprenticeship experiences. These experiences are built on a set of endeavors prescribed by the school, agency, mental health center or hospital, in concert with the discipline-based associations involved.

Yet with industrialized society's emphases on each individual's own academic achievements and on the pursuit of cognitive (informational) knowledge, all of our fields have emphasized measurable knowledge and the completion of academic and apprenticeship requirements as they are accomplished by individuals. Too often, connections to mutuality, mission, and meaning dwell far from day-to-day pressures to master information and to fulfill courses, levels-of-service, and other practice requirements in both training and service programs.

While acknowledging that discipline-based training expectations for individuals are both necessary and valid, this chapter focuses on some of the group processes that become the very context of learning, including the relational medium in which learning takes place. We suggest that the usual emphases on training individuals and on the fulfillment of requisites may inadvertently sacrifice the potential to bring individuals, staffs, and ultimately programs to what has been called the *tipping point* (Gladwell, 2000), wherein improved practices actually become the norm.

We gather and enumerate the concepts governing the process through which trainees are inspired and in which both intellectual and process knowledge are transferred, in such a way that the whole is improved. In doing so, we focus on the social, affective, and aspirational properties of training. In a very different context, Stanley Greenspan often teaches that *intentionality*—the vitality and motivation inherent in having direction—is an emotion underlying all learning and growth. How do we engage the intentionality of the people we train, and how do we grow it on behalf of young children and their families so that they may all flourish?

Creating Ripple Effects

"As director, . . . I know how valuable [*RfG*] is for children, parents, and staff. . . . Children's challenging behaviors improve . . . teachers experience less stress in the classroom, so staff morale improves. The ripple effect results in less staff turnover, which equals more experienced staff" (Head Start director).

Engagement with a training program should go beyond "participation." As Farran (2000, p. 531) notes, "Belief in the efficacy of a program and in children's potential to learn and progress" is possibly the most critical element in developing effective early childhood interventions. He goes on to say, "In training new implementers, it may be less important to train them in the fine points of the curriculum than to imbue them with a strong sense that they will be effective and that change is possible."

The parties involved blend a new, enhanced awareness into daily interactions and activities; we have dubbed these simultaneous staff relational shifts in orientation the *ripple effect,* each ripple being a communicating circle that touches others. When, for example, the parties include educators, paraprofessionals, assistants, aides, family

workers, social workers, and psychologists as well as other resources, all perspectives are enhanced so that individualized and developmentally appropriate practice and a sense of ownership of a new *mental health awareness* emerge in daily interactions and activities. Staff at all levels themselves become ripple makers, imbued with the strong sense that they are being effective and that it is possible to bring about (positive) change in the children, in the parents, and in themselves (Halpern et al., 2003). Teaching-learning becomes ripple, which becomes knowledge transfer, which becomes that which tips the whole toward improved practices.

The following section notes the guiding principles of the field vis-à-vis the idea advanced in this chapter of transformational enterprise. Examples of the complex and relatively diffuse gains among staff, classrooms, and agency resulting from the *Relationships for Growth* Project serve to illustrate this exposition.

THE GUIDING PRINCIPLES OF KNOWLEDGE, OBSERVATION, RELATIONSHIP, AND REFLECTION

All human services may be regarded as joint endeavors—human beings coming together for shared purposes with overlapping but distinct responsibilities. For example, observing a child in a variety of situations and then joining and aggregating each observer's perceptions and knowledge in a conference is a commonly accepted relationship-based and reflective joint endeavor. A joint endeavor becomes a conjoined, transformational enterprise whose meaning increases and deepens—thus affecting all parties across hierarchies—when each person's perspective is deeply valued over time and linked to case outcome and to mission.

In such a context, collegiality and mutuality can blossom. People begin to find vantage points beyond their own personal, discipline, culture, or role-specific perspectives. The capacity for critical thinking, for reflecting across perspectives, and for the reciprocity that is so fundamental to working resourcefully with young and vulnerable children and with families emerges. A sense of effectiveness flourishes within each person and in the team as they see their work yielding accelerated, generative development in those children about whom they had previously worried or about whom they had felt defeated.

In the late 1980s and early 1990s, following a series of intensive training endeavors in the infant-parent field, elements key to the training of practitioners working with young children and their families were identified. They include three overarching elements—namely, knowledge, observation, and relationships bound together through reflective exercise. A description of each of these key elements follows.

Key Elements of Training for Infant Through Preschool Child-Family Practitioners

- Knowledge—a knowledge base built on a *framework of concepts common to all disciplines* concerned with infants, toddlers, preschoolers, and their families
- Observation—opportunities for direct *observation and interaction* with a variety of young children and their families
- Relationships
- Individualized reflective supervision that enables the trainee to *reflect* on all aspects of work with infants and young children, their families, and colleagues from a range of disciplines
- Collegial support, both within and across disciplines, that begins early in training and continues throughout the practitioner's professional life

These core concepts coalesce as reflection, the process that assists in integration of information, awareness across fields of inquiry, and awareness of other and self across emotional dimensions (Eggbeer, Fenichel, Pawl, Shahmoon-Shanok, & Williamson, 1994).

It cannot be overemphasized that each of these elements, even reflective supervision itself, is filtered through the awareness-generating process of consideration identified as reflection. It is an attitude of mind cultivated in relational exchange that enables people to see several levels of interchange from many angles. This awareness-generating ability converges with the capacity, so necessary in child-parent work, to identify with—to see from the eyes of—everyone who is part of "the case."

Knowledge

Within the *Relationships for Growth* Project itself and within the Early Childhood Group Therapy (ECGT) Training Program of JBFCS-Institute, the emphasis is on the integration of bodies of knowledge.

Multimodal teaching techniques (for example, lecture, videotape, role play, and discussion in small and large groups) are often used in a single seminar. Sustained attention over the two years of training is given to a broad range of topics, conveyed both intellectually and experientially, which come from across disciplinary topics. Seminars are organized by module and include but are not limited to the following.

Seeing children from the inside out: the art of observation	Speech and language	Play and play therapy
Typical development: two- to five-year-olds	Attachment	Role of the therapist in the playgroup
Atypical development: two- to five-year-olds	Special education and special needs	Benefits of group therapy
Stages of development: parents and other adults	The enabling agents of peer play psychotherapy	Occupational therapy: sensory processing
Outreach: engaging the range of parents	Mental status and diagnostic planning	Transitioning: services and referrals
Race, ethnicity, class, and immigration	Introduction to early childhood group therapy	Transference and countertransference
Systems: Individuals, families, day-care and Head Start centers	Group formation and beginnings: benefits and goals	Practice issues
		Termination: children, families, staff, therapists

Aided by thoughtful supervision over time, each trainee completes and presents a comprehensive, integrative project by the end of the second year—an intellectually based "product" and a presentation to ECGT training program peers and faculty that bring together theory and experience across several domains. Each also participates in weekly individual and group supervision and in regularly occurring team and staff meetings.

Often a supervisee arrives for supervision in a state of anxiety. It may be said that as the supervisee organizes and tells her story, the anxiety moves out of her body and transmutes into the contents of mind and feeling being shared by supervisee and supervisor. In this

mutual regulatory process, the supervisee almost inevitably calms down. In teams and other groups, both the anxiety and the coregulation may be magnified. Becoming aware of such shifts is a goal of the training, and they often emerge for observation and discussion in groups that are tactfully facilitated. Insights that occur collaboratively in training groups support similar processes in individual supervision and vice versa.

Ultimately, the goal is for trainees to comfortably traverse the path from clinical practice to theory and other intellectually encountered knowledge and back to clinical practice. "The establishment of linkages between affect and cognition is essential for the development of an agentic sense of self and the capacity to establish close emotional relationships" (Fonagy, 2002, p. 4). In addition, the training group is helped to become self-aware of its own formation as a group, even as it is forming and generating "group-ness" among the children in playgroups. This requires nondefensive openness to criticism on the part of supervisors and leaders. Active use is made in seminars of personal experiences to understand the range of material from readings to case relationships. When responded to with tact and empathy, exposure of vulnerabilities in a group becomes a leavening agent, cooking in reciprocity, mutuality, humility, and respect.

Observation

Although each discipline contemplates different categories of information, an element fundamental to all conception-through-five professional development is observation. Teachers, occupational therapists, mental health workers, speech-language therapists, physicians, nurses, and parents alike all observe. We see the same child, the same body, behaviors, interactions, and emotions, but we all see from a different perch.

Brainstorming is enriched greatly by the lenses of others, perhaps especially by people of another profession or culture. When such opportunities are available over time by people who are mutually respectful with one another and devoted to and responsible for a particular child and family, shared understanding and conjoined resolve often emerge.

The observational approaches brought by JBFCS-Institute staff to the centers engage everyone as a team with an individual child and family. Each involved person does observations and brings them to

team meetings to be considered in the mix of others' observations. Considerations are shared and explored, and with guidance by ECGT site-based trainers, plans are made case-by-case. The process, which is respectful to all participants, is woven by taking strands from each, while utilizing a relational, developmental, and individualized template that is simultaneously absorbed. People feel valued in the process as they come to value this reflective, observation-based way of learning and planning together. Each also comes to consider how to generatively be involved with the child and family while going forward, as plans for next (classroom and possible on-site service) steps are developed in tandem. These observational team meetings also are used to promote awareness and self-awareness, as well as to model ways that staff members can be with one another. A larger sense of shared meaning and group purpose based on what we see and know together tends to emerge—to ripple outward—over time.

Relationship

Relationship development is the core, the very soul, of everything practitioners in the field of supporting young children's development "do." Relationship refers to respectful, responsible, reciprocal transactions that build into shared meaning among people over time, with open communication flowing in all directions. Although it can be defined and conceptualized, relationship is in essence a process-and-practice capacity. Training, apprenticeships, services, and programs of all kinds are in essence systematically offered relationships. Relationship is a unit of observation, assessment, and intervention. Further and fundamentally, the younger or more vulnerable the child, the more a few contingent relationships hold the key to the child's sense of safety and optimal development.

Relationship, then, is a central organizer of all work with small children and their families. It also forms the core of training in our field. "Training must address the importance of supportive relationships with very young children and their families as the *medium* through which all services are offered. An explicit focus on relationships . . . seems to hold promise for enriching the work of professionals and paraprofessionals, regardless of career level, setting, or discipline" (Eggbeer et al., 1994, p. 54, italics added). This includes the relationships between developing children and their families; among and between children, families, and service providers; and between

colleagues coming together from across agencies in and among community-based services.

Most people who work with small children and families are fundamentally committed to making a lasting, sustainable contribution, yet they may not see the way to succeed with some of those for whom they are responsible. *RfG* brings an approach that is effective, in part, because it takes the best of each person's commitment and contribution, reframes their ideas as the significant contributions that they are, and creates the listening space in which to craft a unique set of plans for each child and family. Trainers help by "listening generously. . . . [Indeed,] listening for the commitment in what people are saying changes the way we hear. . . . Listening like this creates all kinds of new opportunities" (Toomey, 2004). Not incidentally, such listening teaches others to hear deeply, as well. When such openness occurs in small groups over time, people discover one another, themselves, and their conjoined aspirations that through communicative circles refuel their commitments to the children and families.

The capacity for dialogue often begins by means of exchanges about the here and now. These exchanges weave shared attention and over time co-construction of meaning. Trainers do not have all the answers. Rather, they foster methods of inquiry and strategies to develop next steps that are based on observation, experience, collaboration, and reflection. What is being developed is flexible knowledge and simultaneously an expression of values concerning ways to be with one another—that is, respectfully and mutually. Reflective practice, then, often begins solidly with the preoccupations of the staff member, whatever they are. Over time, as strengths are knitted together and trust is built, even initially resistant staff become interested enough to consider new ideas and to join the supervisor in her thinking or by her desk.

Asymmetry in Relationships: Considerations of Power and Hierarchy

Any partnership that involves bringing more than one program or program unit together also involves developing partnerships that may be complementary yet asymmetrical at the same time. For example, in *RfG,* the three Head Start agencies involved serve very different populations, hold varying histories, differ in size, and have been

directed over many years by women of dissimilar personalities and backgrounds. All members of a large national network with established written codes for practice, they came together to become partners with a small, informally organized, novel mental health and training unit, as well as a set of researchers anchored in a large, academic institution.

Along similar lines, trainees and trainers each have a significant role to play in the mission to improve existing programs and to develop a critical mass of workers and leaders in the infant, early childhood, and family field. Trainee and trainer need each other to develop fine programs, but their roles and their sense of power are quite different.

They are partners, complementary yet not identical helpmates. Each brings something quite different to the association, not unlike children and parents do. The training experience is different for trainees and for trainers, both in terms of the concentration of power and the direction in which knowledge is being transferred. Yet each has power while relying on the other; each learns and each teaches. Analogous to the relational turn in psychoanalysis that moved understandings of therapeutic action from a one-person to a two-person field (see Greenberg & Mitchell, 1983; Mitchell, 2000; Seligman, 2003), these relational shifts in awareness and process move in all directions, albeit asymmetrically (Bronfenbrenner, 1979, p. 57; Shahmoon-Shanok, 1997, pp. 42–44).

Recognizing that there are tensions built into any relationship between people whose perspectives, roles, and power differ greatly, even when they are working toward a common goal (see Shanok, 1992), enables trainers to foster perspective exchange. It also provides the opportunity for trainees to take first responsibility for their own evaluations. The trainer is an expert because of her years of education, experience, and skill. She brings a conceptual framework and a process of inquiry to the task of finding a way of working with a particular family or child. She plays midwife to the emergence of each trainee's own strength and style.

> The trainer-trainee relationship is about power, but it doesn't need to be about dominance or control. Any supervisee recognizes her supervisor as someone with power over her. The greater the felt power, the greater will be the trainee's anxiety. As much as possible, then, the power needs to be transferred. In the relationship model described here, the

> power is shared (which is a great relief not only to the supervisee, but also to the supervisor!). The supervisor facilitates the articulation of a contract, even as she helps supervisees make explicit their contracts with families. The supervisee needs to have the right to . . . take first responsibility in analyzing her own work; and contribute meaningfully to her own evaluation" [Shanok, 1992, p. 39].

When training people from a program with which one is partnering, however, trainees remain *employees* of that program who are *assigned* to the training program. The trainee's employer is the one to make decisions about promotions, demotions, or terminations. Such demarcations, particularly in the areas of power, rights, and responsibilities, are often difficult to identify, but if they are ignored, they can lead to unpleasant or even disastrous consequences. Communication between partners and between trainers and trainees is therefore absolutely essential. It is very important to create frequent, built-in opportunities for communication to flow in all directions. Even with regular opportunities to confer, however, misunderstandings may occur between partners who come from different systemic cultures.

As people work together with regularity and frequency, endeavoring to open communication in all directions, trust begins to emerge (Fenichel, 1992). Then, when inevitable problems emerge, a terrain already exists where those challenges can be exposed, considered, and worked through. People will then move on with a greater sense of understanding, each being strengthened by the other. As with children, when adults with very different backgrounds, styles, and systemic contexts work together, states of high affect may emerge. Between people, there are always mismatches. It is what we do with the mismatch that matters.

When we realize that intense emotional states emerge because people care deeply, it becomes easier to step into the perspective of the other. *How* we negotiate with one another can then be guided by respect and an absolute dedication to repair. In *RfG* we managed to get through crises fueled by the positive changes we saw in the children and families, the nourishment of a step-back reflective attitude, a sense of hope linked to shared mission, and our growing tolerance of one another's vulnerabilities and vantage points. Relationships are deepened when feelings emerge and a commitment to trying to understand one another is fostered.

Reflection

Reflective training is *doing* with support. Reflection has been described as "the continuing reconceptualization of what one is doing, observing, and feeling" (Gilkerson & Shahmoon-Shanok, 2000, p. 50). Reflective supervision and reflective practice "provide an oasis in time, a place to breathe, remember, consider, and plan" (p. 48).

Reflective practice is a continuous improvement model in that honest, yet tactfully offered, feedback encourages enlivened and responsive practice. Increasingly, with the help of one another, people are heard and interactions and behaviors witnessed, relived, reflected upon, and rereviewed with scrutiny and sensibility. How do we see all there is to see? We cannot. Yet people are cherished, remembered, and held in mind (Slade, 2002; Mayes, 2002) as we struggle to see from the other's eyes (Fonagy, 2002, p. 2). We take trouble to witness one another, and in the doing we become a community of collaborative workers who care for our young. As has been said about mothers, "No one is resilient in isolation" (Black, 2004).

Mutuality, Reflective Function, and Learning by Doing

At both service and training program levels, "mutuality is a core relational principle central to organizational development which is oriented to social change. When it is present, it has the power to erode the dominant 'I' consciousness that pervades our universe of 'power-over'-type institutions, and . . . begin[s] to replace it with a 'We' consciousness where 'power-with' engages us in the co-creation of new types of participative organizations. . . . Mutuality is a way of seeing, being and acting in a world that was founded on the belief that human growth is a shared process" (Leonard, 1999, p. 12).

Hierarchy remains, as it should, but it grows softer when communication and awareness flow. When attached to mission, the mutuality and interdependence that can be generated in the intimate environments of individual and group reflective supervision, case conferences, team meetings, and myriad informal interactions—all small groups fostered with sufficient presence and respect—tend to ripple outward and touch all the levels of an organization.

As supervisors "cherish strengths and partner vulnerabilities" (Shanok, 1992, p. 40), so, too, do trainees increase their capacities to cherish strengths and partner vulnerabilities with children, families,

and one another. They are helped to focus on individual and group strengths, needs, and goals by becoming engaged in reflective, relationship-based practice, which promotes self-awareness, problem solving, planning, and goal setting. This attitude does not require a neglect of challenges; rather, it is only by taking full stock of problems and symptoms that a person or group can feel fully understood and deeply partnered by their intervener (see Zeanah, 1998).

The process of listening and of sharing attention (see Greenspan, 1992) and contents of mind (see Fonagy, Gergely, Jurist, & Target, 2002) brings people along in mutual understanding and enhances their capacities. Through the myriad transactions of supervisory relationships, the supervisee changes and grows. Her new capacities move from what has been called the domain of the new and "tacked-on" to the domain of the familiar and indispensable (Pine, 1985, p. 120, in Gilkerson & Shahmoon-Shanok, 2000, p. 39).

By co-creating narrative, reflective function, and history with one another, supervision facilitates an individual's *becoming* an empathic teacher, an early childhood mental health worker. "In her daily work with infants, toddlers, and their families, the [trainee] . . . learns by doing; in supervision, she learns by reflection" (Shanok, 1992, p. 37). Reflective practices are continually vitalized and nourished in regularly occurring small groups like group supervision, team meetings, and case conferences. . . . These are living, breathing actions and attitudes of mind. To develop, they must be practiced and tasted.

Each staff member involved in a case brings forward her observations, perspective, and concerns. With appropriate facilitation, everyone is and comes to feel herself to be part of the whole. Planning emerges from this guided-to-become-mutually-respectful group process, as do loops of feedback whereby each person can see and take pride in cases that go well and can discover next steps when dilemmas and would-be impasses crop up.

To emphasize the last point because it is so important, when things do not go as we planned or hoped, we do not consider it as defeat. Instead such challenges are viewed as further information to serve us to figure out next steps together. As we do when being with the children, we are dedicated to continuity and, whenever necessary, to repair (see Shahmoon-Shanok, 2000, pp. 233–235). The work in supervisory dyads or groups and in teams or small conferences allows us to discover what makes sense to try next while it generates mutual support.

The tension inherent in challenging situations can be accepted thanks to a commitment to work out problems and a belief (based on experience) that it is in the working through that growth—of insight, of the individual, of the relationship, and of the system—is generated. This worldview becomes a teachable capacity that diminishes anxiety and despair and cultivates both patience and the capacity to be fully aware of, yet tolerate, difference over time.

Open Communication Becomes a Learning Organization

Open communication in the learning groups is key, with all critiques and comments carefully considered and often added to an increasingly layered and rich picture of a child, a family, and a situation. *Dialogue*—from the Greek dia:Logos, "flow of meaning"—has been demonstrated to be a basic element of team learning in research at MIT (Senge, 1990, p. XII). Over time, the agency, program, or department gradually becomes a *learning community* where increasing rings of people become involved and mutually helpful contributors.

In discussing an approach to managing large organizations, like corporations, toward their becoming learning organizations, Peter Senge captured the personal-organizational dialectic of this potential: "The changes required will be not only in organizations, but in ourselves as well. . . . Our organizations work the way they work, ultimately, because of *how we think and how we interact.* Only by changing how we think can we change deeply embedded policies and practices. Only by changing how we interact can shared visions, shared interactions, and new capacities for coordinated action be established" (p. XIV, italics in original).

When asked to think about the process of training—the personal path they traversed on the way to becoming—trainees highlight the experience of reflective supervision: of having had one or more supervisors, the best of whom created a regular (weekly) time that was safe, supportive, and protected from interruptions. During these meetings, the supervisor endeavors to offer nonjudgmental acceptance of vulnerability and encouragement of resourcefulness. Supervisees who participated in the *RfG* Project recalled the reflective questions that when posed by the mentoring person, enable them to be more questioning and reflective of themselves and of others. Typical questions

remembered were: "What would happen if . . . ? I wonder why . . . ? How was it for you when . . . ?"

Self-Awareness, Other-Awareness

Over time, all of the candidates came to know, implicitly or explicitly, that the highest achievement for each would be a growing awareness of their emotions and reactions, leading them toward a capacity to contain impulsive actions. They also understood that their growing abilities to self-reflect would benefit the children, the parents, and the teachers. The process of reflection was challenging for some, but they all experienced and came to know that reflection is an awareness of self and others that is internalized through myriad minuscule experiences that are transformed into a way of being, thinking, and doing.

- Michele, a midcareer special educator in her second year of training was still feeling uncertain about her emerging skills as a therapist. One day, as a four-and-a-half-year-old boy in her group ranted and raged at her, she understood for the first time the meaning of *transference.* As she related it later, "It became clear as a cloudless sky that his rage was not about me at all . . . but brought here to the safe space of the playgroup room for me to help him make sense of." Michele was thrilled with her awareness and was able to use her newly burgeoning skills with greater confidence. In her own words, "On that day, I felt like a therapist for the first time! I could listen to the boy and hear his very strong feeling and not be drawn into it."
- Pam, a skilled and well-educated teacher, recalls a pivotal moment in her development, several years after her formal ECGT training, when she was at work as a staff therapist in the *Relationships for Growth* Project and cherishing her reflective supervision time. In this moment, she experienced an unfamiliar calm as a boy tore up paper and threw the many pieces into the air, . . . gleefully revved up, running to and fro, as the pieces of paper fell to the floor. Pam reported that she surprised herself with words that brought intentionality and meaning to what had originated from the child as disorganized, overly excited behavior. The boy responded with delight to the words he heard from his therapist, "Oh, a party . . . what kind of party should we have . . . a birthday party . . . great! Look at all this food!" The two smiled at each other as they made eating gestures, picking up paper bits from the floor, placing the pretend food onto make-believe plates.[5]

Interventions such as these help children differentiate emotions and experiences that are not yet accessible to language. Mental health leaders acquire skills to translate potentially communicative elements, such as body shifts, movement, behavior, sounds, and emotion, into meaningful exchanges and to elevate overexcitement, aggression, tantrums, and curses into attempts at communication. The children in the program grow in verbal and social capacity, and in their ability to digest and integrate their experience and their own feeling states in a range of settings.

Pam believes that the years of support and her increased awareness of her own process gained through reflective supervision brought her to the point where she could imagine more than her initial internal "Oh, what a mess!" response. Her intervention elevated the boy's behavior so that it became both communicative and symbolic, and he in turn could respond in kind. In a process analogous to the circle of communication between parent and child (Greenspan & Wieder, 1998) (which, under "good-enough" circumstances can be so generative), when workers see changes in a child and family, they are motivated to do more and to grow (Greenstein, 2003). Pam's own sense of empowerment and growing professional identity was fostered by her recognition of the virtually parallel unfolding that she was fostering in the boy and in the other children with whom she worked.

Even when respectful, reflective practice is a guiding principle, however, adherence to it by supervisors is not always simple. When faced with what appears to be ignorance or incompetence or when the supervisor is anxious about the trainee's approach or anxiety level, there is a tendency to tell and to teach. How this balance is maintained is crucial—the supervisor does have to be concerned with safety and competence. The success of the *RfG* Project is nonetheless a testament to mismatch and repair: even when we are not "perfectly" reflective and there are breaches, the overall experience has been positive, as reported by Head Start and JBFCS-Institute staff members across roles.

So in this way, the elements of relationship, reflection, knowledge, and observation that are so basic to the field of early childhood and family work of all kinds—and especially relationships and reflection, the unambiguously process elements—have been reviewed through an additional lens, one that magnifies their potential for generative change in adult learning groups and organizations. Like the endeavors of the stonecutters on an Indonesian island, transformational enterprises are generated by relationships of vitality developed over

time in groups that share vision, commitment, and labor. They can become a movement.

Indeed the zero-to-three field itself—which is often called a "movement"—and many programs within it could each be described as a transformational enterprise.[6] Transformational enterprises engage the intelligence, energy, will, and emotions of each individual in the group. Group members support one another in their growth and—in ripples—amplify their communal mission as they work together shoulder to shoulder, day in and day out. All participants in the enterprise are transformed, which yields dynamic shifts in their sense of conviction and in the running of the program day by day, hour by hour.

In community-based programs, the on-site relationship building that results in the camaraderie of a transformational enterprise occurs more readily when there is sufficient presence. By *presence,* we mean a kind of strength that might be measured in different ways, such as number of hours; number of people representing the new knowledge and skills; level of stature and respect of the trainer, consultant, or coordinator; and an imprimatur conferred by the director or by the overarching system.

Presence often also rests on the sense of warm and trustworthy flexibility, confidence, industry, and willingness to join the life of the host setting conveyed by the training resource. Such a presence should be consistent over a sufficient period and accompanied by training in the form of didactic seminars with discussion of seminar material, case conferences (both in formal training and within sites), and reflective supervision and mentorship.

The configuration of these elements spawns opportunities for cognitively known knowledge and process knowledge to complement and strengthen each other not only for each individual but also for the undertaking as a whole. Perhaps this is particularly true for learning experiences that reach toward critical thinking across disciplines, perspectives, experiences, and educational levels. In any case, ample presence propagates ripple formation in several spots until, over time, they touch one another.

FLATTENING HIERARCHIES: TRANSFERRING KNOWLEDGE ACROSS DISCIPLINARY AND ROLE BOUNDARIES

When people, disciplines, and roles join together in a training and service partnership to undertake a substantial endeavor that has meaning to them in terms of conjoined objectives and goals, vision and

mission, a sense of greater possibility and promise emerges that boosts a sense of the possible and—not incidentally—of hope. As people work together with regularity and frequency (Fenichel, 1992), endeavoring to open communication in both (or all) directions, trust emerges. Then when problems emerge (as inevitably occurs when systems, disciplines, roles, educational and socioeconomic levels, and ethnic groups join forces), those challenges become exposed, are worked through, and people can move on with a greater sense of understanding, each being strengthened by the other.

Although there are often tensions in coming together (especially at the outset), a thoughtful, relationally oriented facilitation can turn tension into a learning experience. The goal here is to *transfer* knowledge across boundaries so that both trainees and trainers learn something not only about what it is the other sees but also about *how* the other sees. In this case, "the other" may be another system, another discipline, another role, another experience level, another culture, another class, or another personal background.

Inevitably, when one learns in these ways about the other, one simultaneously becomes more aware of self. Together, relationally then, the generic basis of knowledge that all workers with young children need is built. Neither the content nor the process is built haphazardly. It is planned through a variety of experiences, but it is also built improvisationally as people connect over goals and insights, with new perceptions and enlarging commitments sometimes bordering excitement as people see further and work with more animation and creativity. Keith Jarrett, the remarkable classical and jazz pianist, once remarked in a radio interview, "Improvisation is the confidence that you don't need to *know* to meet the moment."

Professionals who are hired by community-based programs tend to focus on what they know and can teach. They tend by virtue of their training to be professional- and expert- and knowledge-centric. Without minimizing the great value of knowledge and expertise, it is also worth noting that all individuals are experts about their own culture and about how they see things. Like parents, for example, what family workers may not bring in terms of prior training, they do bring in terms of emotional vitality, salient observations, and hopes for their communities. They listen with vitality for a strand that, extended, can become a bridge between people who have very different experiences. Analogous to a baby coming into a family, causing a huge disruption and garnering enormous care and attention, everyone in a system

affects the other, and communication of all kinds travels up, across, as well as down the hierarchy.

When we model compassionate, protective, respectful interaction with the children and other adults, the effect is to soften hierarchical boundaries. Like what seemed to occur among the stonecutters, a new tone emerges when people who share a mission create a sense together that a path to their dream is possible.

JBFCS-Institute's ECGT Program has been training professionals from widely disparate disciplines, roles, ages, and socioeconomic and educational levels since the late 1970s. The *Relationships for Growth* Project was the first time paraprofessional family workers were added to the mix. With careful design (in this case, the family worker audited seminars, co-led a playgroup, was part of a team, and received group and individual supervision for about a year before being enrolled in the formal training program), including the addition of one element at a time and frequent discussions in the process, people can be helped to find their way to more sensitive and generative practice. All are enriched. The endeavor is not always smooth, but it is very worthwhile.

In our experience, transdisciplinary training contributes to the rippling energy described here. In contemplating universities, Wendell Berry could have been writing about the various disciplines and roles involved in caring for the young. He wrote the following:

> There is a degree of specialization that is unavoidable because concentration involves a narrowing of attention. . . . There is a degree of specialization that is desirable because good work depends on sustained practice . . . but to assume that there is a degree of specialization that is proper is to assume that there is a degree that is improper. The impropriety begins . . . when the various kinds of workers come to be divided and cease to speak to one another. . . . Part of the problem is this loss of concern for the thing being made and, back of that . . . the loss of agreement on what the thing is that is being made. The thing being made [in a university] is humanity [Berry, 1987, p. 77].

Should the zero-through-five field not recognize the same truth about children's services as well as about the training programs that prepare people to work in them?

We have learned that it is possible to blend strengths, cultivating a generic hybrid of approaches that enhances each of them within an emotionally and socially engaging enterprise. In our experience, it is extremely

rare for an individual to misuse the training by doing things she is not licensed to do, perhaps because reflective self-awareness and relational connections are so central to our approach. At the same time, we readily assert that the great value of receiving supervision from individuals trained in other disciplines complements but does not replace the supervision and leadership of someone trained in one's own discipline, which is so crucial to each trainee's maturing professional identification.

It is in relationship that the sense of being part of something lofty comes alive and this sense can be multiplied in groups. The relationships among children and between children and group leaders in the playgroups take a trajectory similar to those among trainees and between trainees and trainers in *Relationships for Growth.*

Children with a range of strengths and challenges are placed in the same playgroup. They rely first on the adults and then on one another to increase their capacities to develop a richer emotional range and empathy for others as they learn to accept a wider range of feeling states and develop patience when facing conflicts. Playgroups stimulate initiative, mastery, and social relatedness and promote differentiated language, literacy, metaphor, and play (Shahmoon-Shanok, 2000; Halpern et al., 2003).

So, too, trainees and trainers are stimulated in group exercises that emphasize open communication about both feelings and ideas—from attending seminars, to team meetings, to clinical staff meetings, to individual and group supervision—to see and think about experiences other than their own and to think about their own from many new angles. Over two years of training, and following the establishment of trust in the group, a "freedom for deeper and more differentiated exploration of interpersonal themes as they are related to the work with children, families and the center staff and, with one another, is palpable" (Levine, 1979, p. 71).

Similarly, the different disciplines, experiences, and levels that trainees bring into the program sometimes appear, in the early phases, to threaten the possibility of the group meshing into a cohesive whole. Group cohesion often occurs around the resolution of crisis with an authority figure. Once cohesion is established, the group-as-a-whole becomes less dependent on the authority of the trainer. When the trainer has been able to permit a transfer of power to group members and to demonstrate the appreciation for the burgeoning strengths of individuals and the group, the trainer will then become a group member as well (Levine, 1979, p. 77).

One adult group, interdisciplinary, intergenerational, and representing five different ethnic groups, formed around a commitment to the mission of helping children with challenges by bringing peer playgroups to their center. Meeting weekly, they navigated the phases of group development to establish a well-knit body and established a group identity and name, the Wednesday Group. They weathered some minor power struggles and over time switched the direction of communications from trainer to one another.

Over a two-year period, shared challenges and celebrations became their history together. They processed the tragic death of a center family's three-year-old, several pregnancies and births of group members, and came to terms with a Chinese child-rearing practice that had initially been extremely upsetting to several group members. In thinking through each child and family, many discussions of cultural differences in child rearing, celebrations of holidays, births, and varied responses to the death of a family member were shared—the personal enhanced the professional.

It was with this history that the Wednesday Group, whose agency is located less than a mile from Ground Zero, was able to use their time together to process their reactions to the events of September 11, 2001. Over many weeks, Wednesday Group meetings were flooded with feelings. They listened, they cried, they covered their eyes, and they sometimes groaned as they heard old, horrible memories that the World Trade Center attack evoked in some of them. Knowing each other well, they protected one another. Five weeks after 9-11, when a plane bound for the Dominican Republic crashed nearby on Long Island soon after takeoff, one group member—recalling how upsetting television images had been to her colleague after 9-11—told her that only a radio could be brought into the office (for further detail, see Lapidus, 2002).

Wednesday Group members shared indelible experiences, learning to hold the feelings of others in their hearts and minds and to have their feelings held in the same way. 9-11 underscored the legitimacy of emotional connections being made in the workplace as ways of enhancing awareness and interpersonal connections. That trainers and trainees alike were all affected by the same event taught the trainers very deeply how much we could receive as well as offer. Repeatedly, we saw, both before and after the attack, that paying attention to people's emotions helped them find their stories, which, in turn, allowed them to get back to the children, to families, and to one another with renewed energy and understanding.

This process-oriented training approach cultivated by the training team is like a root system that nourishes the work that people are doing. By parallel process—in ripples—the sense of being in community is fostered. "It did what we know a good community does: It supported itself, amused itself, consoled itself, and passed its knowledge on to the young" (Berry, 1987, p. 182).

This chapter suggests that the caring for young children and their families that brings many practitioners into the field can be harnessed to empower training and transform practitioners and programs in relationally and reflectively vital directions. It emphasizes the potential of affect and aspiration in mobilizing social forces within training contexts, such as teams, service programs, and apprenticeships. Laboring together on something people care about—something that fulfills their personal, professional, and programmatic vision—helps people feel allied, intentional, and alive.

When each person's perspective is deeply valued and palpably linked to mission, working and learning together over time as colleagues becomes a transformational enterprise. This kind of energy could become the force that promotes both program excellence and the development of the critical mass of reflective, relationally aware workers, both of which are urgently needed across North America and beyond. Urie Bronfenbrenner anticipated this when, in a chapter called Interpersonal Structures as Contexts of Human Development (1979), he wrote the following:

> Reciprocity, with its concomitant mutual feedback, generates a momentum of its own that motivates the participants not only to persevere but to engage in progressively more complex patterns of interaction, as in a Ping-Pong game in which the exchanges tend to become more rapid and intricate as the game proceeds. The result is often an acceleration in pace and an increase in complexity of learning processes. The momentum developed in the course of reciprocal interaction also tends to carry over to other times and places: the person is likely to resume his or the other person's "side" of the joint activity in other settings in the future, either with others or alone [p. 57].

The linkage of training with services is underscored here. Indeed the authors take the view that all services for small children and their families should include ongoing, reflective, relationship-centered

training—apprenticeship—at their core. When such reciprocity is integrated with the daily life of a program over time and interwoven with a sense of mission and possibility, the momentum for social-emotional growth tends to carry over to other times and places, as Bronfenbrenner suggested, such that it touches everyone at all levels of the enterprise. It may be said that a measure of success in program transformation is the program in which reflective opportunities for all staff are provided as routinely and essentially as are record-keeping obligations.

In a field dominated by the need for competent workers and leaders, and by systems and programs that need strengthening, inspiration needs to become connected day to day to both training and service programs at all levels by integrating relational, reflective, and developmental guidelines. The Western world's emphasis on individual academic achievement tends to obscure the potential for organizational growth available when an emphasis is placed on people working together, using their best talents toward mutually evolving, agreed upon—and deeply meaningful—goals. The following considerations, then, apply:

- There is a great need for ongoing continuing inservice education in all programs that serve young children and new families.
- Such training needs to be long-term, on-site, relationship-centered, dialogic, reflective, and focused on the children and families encountered in daily practice.
- To foster optimal process and content learning, trainers need to listen with generosity and be open to critical feedback and new ways of seeing things.
- Training that is closely connected to practice is apprenticeship. Apprenticeships have the potential, when linked to mission in a social context over time, to become a motivating force toward improved practice, an endeavor that transforms individuals and programs.
- Bringing together practitioners from different fields and levels of practice in process-oriented, receptive training helps them see from varied perspectives. As a result, the practitioners are able to weave a safety net by coalescing integrated, generic, and hopeful perspectives on screening, practice, and intervention strategies for young children and their families.

Apprenticeship is experiential training in a social group over time. As the late Sally Provence liked to point out about parent-child interactions, the relational mix that becomes the miracle of growth happens in myriad everyday exchanges when changing diapers, at bath time and feedings—the daily work of caring for a child. So, too, in apprenticeship. It helps trainers, as it helps apprentices, as it helps parents, to appreciate that in the little details, something grand is taking place.

RfG has the potential to become a safety net within preschools and schools by catching, holding, and supporting at-risk and diagnosable children before challenges become failures.[7] At the same time, it may improve agency and classroom quality to support all children and their families. Just as *Relationships for Growth* was developed to train staff in Head Start agencies to help all children—including those at-risk and diagnosable—become ready for school, we believe that by employing the principles elaborated here, other programs will be able to take on the safety net function as well. That is, other programs can perform their designated functions optimally, as well as learn how to screen, assess, identify, and even serve participants in need so that the children in their care do not fall further behind.

For the authors of this chapter, there is a transcendental aspect to such programs—namely, that the experiential practices link through conjoined aspirations to the intuitive, nonrational part of knowing. They engender a strong sense of participating in making the world a better place for the children and adults who dwell in it. To do work that resonates with people's values, ideals, and sense of social responsibility is to make life both meaningful and significant. Bringing hearts, minds, and daily work together over time generates a sense of yes! in individuals, which, when multiplied, galvanizes a force for change.

Returning to the questions, what does it mean to become something? What experiences best facilitate the kind of *becoming* that yields empathic, knowledgeable, grounded, and resourceful practice? What role does mission have in engaging practitioners in professional development? And how does relational, reflective, emotionally wholesome practice come to infuse a whole program? Responses to these queries spring to life in a set of relationships and within a role *in a social context* over time.

It has been stated, "Science is not just a giant bowl of facts to remember, but rather a way of thinking" (Loftus, 2004, p. 8). Paraphrasing, we

can say that mental health practice in the human services is not just a bowl of methodologies, but rather a way of thinking, being, and doing that are best learned in reflective relationships and best empowered in mission-driven learning groups. Such groups are apprenticeships in the most generative sense, becoming social contexts for development. When the interactions engendered within them are trustworthy, reflective, reciprocal, and open, when participants consider challenges together, when they consistently undertake repair as needed, and when they see results that fulfill their commitments and ideals, relationships that sustain growth emerge—rippling outward in communicating circles—at all levels of the agency.

We therefore propose that training and service programs will benefit by looking beyond the individual and beyond the dyad, the paradigms that currently dominate thinking in the zero-through-five fields. Paradoxically, in creating aspirational work groups, a source of energy is mobilized to help those programs flourish as learning organizations, such that they may nurture individualized relationships for growth for each small child, each family, and each staff member whom they touch.

Notes

1. It is difficult to imagine these developments without the pivotal contributions of Irving Brooks Harris, seminal thinker, brilliant strategist, passionate activist; of Zero to Three, the National Center for Infants, Toddlers, and Families; of the World Association for Infant Mental Health (WAIMH); and more recently of the Interdisciplinary Council on Developmental and Learning Disorders (ICDL). Stanley Greenspan, founding president of both Zero to Three and ICDL and a tireless force in the development of new knowledge and integration across disciplines and perspectives, has had a profound, generative influence on the field of young and vulnerable children. This chapter is dedicated with enthusiastic and enduring gratitude to each of these individuals and organizations and to everyone associated with the organizations. Together our ripple has become both a movement and a field, an enterprise transforming the lives of countless little children, their families, and the professionals who care for them.
2. For information about training and related issues, go to www.zerotothree.org. Information about the Harris Professional Development Network, a loose association of training programs in the United States and Israel supported by

the Harris Foundation, is also on the Web site. In 1994, one such two-year professional development program, the Infant-Parent Study Center, was founded and continues to be directed by Rebecca Shahmoon-Shanok. This program is a conceptual and mission-related beneficiary of the Early Childhood Group Therapy Program begun in 1966 (described in Chapter Nineteen) and likewise a training program within the Institute for Infants, Children & Families, Jewish Board of Family and Children's Services. JBFCS is a nonsectarian, mental health, social service agency with extensive services throughout New York City. It includes an in-depth, postdegree in-service and advanced training arm for its staff and other professionals, the Martha K. Selig Educational Institute, which has been chartered by the New York State Board of Regents since 1976. Part of the Selig Educational Insitute, the Institute for Infants, Children, & Families' ECGT Training Program has been including individuals from all related disciplines since it began in 1976.

3. As a demonstration project, the generative effects of *Relationships for Growth* for the children, families, staff, and programs have been established although not yet published. Descriptive details and vignettes are contained in Chapter Nineteen in this volume.
4. From here on, we will usually shorten the phrase "professional and para-professional" to "professional." However, our experience working with both suggests that the principles developed here are applicable equally to para-professionals and professionals.
5. All names and identifying information have been altered.
6. Examples of such programs are the Zero to Three organization itself, the Infant-Parent Program at San Francisco General Hospital (pioneered by Selma Fraiberg and continued by Jeree Pawl and Judy Perkarsky), and the Harris Doula Project founded by Rachel Abramson within the Chicago Health Connection.
7. JBFCS-Institute's ECGT program has successfully used these approaches with children ages two to nine.

References

Berry, W. (1987). *Home economics: Fourteen essays.* San Francisco: North Point Press.

Black, K. (2004). *Mothering without a map: The search for the good mother within.* New York: Viking Penguin.

Bower, B. (2003). The stone masters: Tool makers at work and children at play reflect ancient technology. *Science News, 163,* 234–236.

Bronfenbrenner, U. (1979). Interpersonal structures as contexts of human development. *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience.* New York: Harper Perennial.

Csikszentmihalyi, M. (1993). *The evolving self.* New York: HarperCollins.

Csikszentmihalyi, M. (1997). *Finding flow.* New York: Basic Books.

Eggbeer, L., Fenichel, E., Pawl, J. H., Shahmoon-Shanok, R., & Williamson, G. G. (1994). Training the trainers: Innovative strategies for teaching relationship concepts and skills to infant/family professionals. *Infants & Young Children, 7,* 53–61.

Farran, D. C. (2000). Another decade of intervention for children who are low income or disabled: What do we know now? In J. Shonkoff & S. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 510–548). New York: Cambridge University Press.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A source book.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Fonagy, P. (2002, December 15). *Discussions of affect regulation, mentalization and the development of the self by Peter Fonagy, Gyorgy Gergely, Elliot Jurist and Mary Target.* New York: Other Press.

Fonagy, P., Gergely, G., Jurist, E., and Target, M. (2002). *Affect regulation, mentalization and the development of the self.* New York: Other Press.

Fraiberg, S., Adelson, E., & Shapiro, V. (1980). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In S. Fraiberg (Ed.), *Clinical studies in infant mental health: The first year of life* (pp. 164–196). New York: Basic Books.

Gilkerson, L., & Shahmoon-Shanok, R. (2000). *Relationships for growth:* Cultivating reflective practice in infant, toddler, and preschool programs. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *World Association for Infant Mental Health handbook of infant mental health, Vol. 2: Early intervention, evaluation, and assessment* (pp. 33–79). New York: Wiley.

Gladwell, M. (2000). *The tipping point: How little things can make a big difference.* Boston: Little, Brown.

Greenberg, J., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory.* Cambridge, MA: Harvard University Press.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International Universities Press.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth.* Reading, MA: Addison-Wesley.

Greenstein, B. (2003, June 1). Faculty meeting. NY: Infant-Parent Study Center.

Halpern, E., Lamb-Parker, F., Fisher, R., Klujsza, V., Peay, L., & Shahmoon Shanok, R. (2003). *Relationships for Growth* Project: Preliminary evaluation of a relationship-based, systemic mental health model in Head Start. In F. Lamb-Parker, J. Hagen, R. Robinson, & H. Rhee (Eds.), *Summary of conference proceedings for Head Start's Sixth National Research Conference* (p. 868). Washington, DC: DHHS Administration on Children, Youth and Families.

Lapidus, C. (2002). Voices from the field, echoes from the past. *Zero to Three, 22*(3), 40–42.

Leonard, M. (1999, Winter). Looking together in the same direction. *Nonprofit Quarterly, 6*(4), 12–15.

Levine, B. (1979). An overview of dynamics of group development. In B. Levine (Ed.), *Group psychotherapy: Practice and development.* Upper Saddle River, NJ: Prentice Hall.

Loftus, E. (2004). Why study psychology? *American Psychological Society Bulletin, 17,* 8.

Mayes, L. (2002). Parental preoccupation and parental mental health. *Zero to Three, 22*(4), 4–9.

Meltzoff, A. N., & Moore, M. K. (1977). Imitation of facial and manual gestures by human neonates. *Science, 198,* 75–78.

Mitchell, S. A. (2000). *Relationality: From attachment to intersubjectivity.* Hillsdale, NJ: Analytic Press.

Pine, F. (1985). *Developmental theory and clinical process.* New Haven: Yale University Press.

Seligman, S. (2003). The developmental perspective in relational psychoanalysis. *Contemporary Psychoanalysis, 59*(3), 477–508.

Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization.* New York: Doubleday.

Shahmoon-Shanok, R. (1990). Parenthood: A process marking identity and intimacy capacities. *Zero to Three, 9*(2), 1–9, 11.

Shahmoon-Shanok, R. (1997). Giving back future's promise: Working resourcefully with parents of children who have severe disorders of relating and communicating. *Zero to Three, 17*(5), 37–49.

Shahmoon-Shanok, R. (2000). Infant mental health perspectives on peer play psychotherapy for symptomatic, at-risk, and disordered young children. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *World Association for Infant Mental Health handbook of infant mental health, Vol. 4: Infant mental health in groups at high risk* (pp. 198–253). New York: Wiley.

Shanok, R. S. (1987). *Identity and intimacy issues in middle class married women during the marker processes of pregnancy.* Unpublished doctoral dissertation. NY: Columbia University, Teachers College, Department of Clinical Psychology.

Shanok, R. S. (1992). The supervisory relationship: Integrator, resource and guide. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A source book* (pp. 37–42). Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Shanok, R. S., Gilkerson, L., Eggbeer, L., & Fenichel, E. (1995a). *Reflective supervision: A relationship for learning* [videotape]. Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Shanok, R. S., Gilkerson, L., Eggbeer, L., & Fenichel, E. (1995b). *Reflective supervision: A relationship for learning. A discussion guide.* Washington, DC: Zero to Three, the National Center for Infants, Toddlers, and Families.

Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal health. *Zero to Three, 22*(4), 10–16.

Toomey, M. (2004, June 11–13). *What is leadership? Create, listen, sustain, and develop.* Rowe Leadership Program. Rowe, MA: Rowe Camp and Conference Center.

Zeanah, C. H. (1998, April–June). Reflections on the strengths perspective. *The Signal,* pp. 12–13. Michigan: World Association for Infant Mental Health.

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Name Index

A

Achenback, T. M., 35, 239
Adams, G., 264
Adams, S., 257, 278
Adelson, E., 8, 93, 457
Ageriou, M., 190, 191
Ainsworth, M.D.S., 37, 378
Albus, K., 275
Ammen, S. A., 207, 209–213, 218, 228
Andresen, M., 238
Anscombe, E., 218
Anson, A., 191
Aoki, Y., 368
Arendt, R., 190
Arvery, R. D., 184
Atkins, M., 264
Axiline, V., 207
Ayres, J. A., 378

B

Baenen, R. S., 238
Bagnato, S. J., 78, 240
Baker, L., 72
Balachova, T., 266
Baltman, K., 329, 332
Banerjee, L., 233, 237, 238
Barnard, K., 16, 19, 34, 258
Barron, C., 8
Barth, R. P., 183, 195, 197
Bateman, D. A., 191
Bauchner, H., 192
Baumrind, D., 42
Bavolek, S. J., 265
Bayley, N., 16, 53, 54, 65, 164
Beeber, L., 267
Behnke, M., 276
Behr, S., 277
Bell, R., 234
Bell, S. M., 378
Benham, A. L., 222
Benoit, D., 368
Berliner, L., 273
Bernstein, V. J., 170
Bernt, C., 219
Berrick, J. D., 183, 195, 197, 273
Berry, W., 476, 479
Bertacchi, J., 339, 427, 435, 437
Bick, E., 43, 329
Bisecker, G. E., 81
Black, K., 469
Black, M., 277
Blehar, M. C., 37
Blos, P., 8
Blue-Banning, M., 277
Blum, E. J., 279
Boehm, A. E., 34, 36
Boetsch, E. A., 237
Bollerud, K., 183
Bonner, B., 16, 266
Booth, P. B., 218–220
Boris, N. W., 24, 196, 265, 273, 364, 365, 367
Bower, B., 458
Bowlby, J., 37, 93, 196, 216, 378
Boyer, E. L., 411
Bracken, B. A., 53, 54
Bradley, R. H., 18, 34
Bradley, S., 242
Braverman, L. M., 208
Brazelton, T. B., 34, 98, 378
Brazy, J. E., 80
Breston, E., 266
Bricker, D., 16, 264, 270, 432
Bromwich, R. M., 35
Bronfenbrenner, U., 467, 479, 480
Brooks-Gunn, J., 368
Brownell, C. A., 263
Brunner, S., 275

Brusiloff, P., 402, 403
Bryant, D., 260
Burns, K. A., 191, 192
Burns, W. J., 191, 192

C

Caldwell, B. M., 18, 34
Callahan, J. J., Jr., 190, 191
Campbell, B. K., 19
Campbell, S. B., 73, 78, 79, 84, 214, 215, 217, 263
Canning, S., 415, 416
Cantwell, D., 72
Carey, L. J., 218
Carlson, V. J., 5
Castro, L. E., 233, 237, 238
Chacon, M. E., 81
Chadwick, D., 274
Chaffin, M., 266
Chamberlain, P., 220, 275
Chambers, C., 220
Chase-Lansdale, L., 368
Chasnoff, I. J., 190–192
Chess, S., 76
Chisolm, K, 364
Ciario, J. A., 290
Cicchetti, D., 76, 237
Clark, C., 406
Clark, R., 35
Clarke, C., 257, 278
Clarke, L., 276
Clausen, J., 274
Cochran Kopel, C., 429, 430
Cohen, E., 359
Cohen, N. J., 102, 105, 220, 242
Cohen, R., 5
Colbus, D., 234
Comstock, C. C., 265
Conlon, M., 276
Coolahan, K., 264, 406, 415, 416
Cooper, J., 171
Copa, A., 445
Cope, S., 409
Coplon, J., 339
Corbett, R., 183
Craft, B., 288
Crowell, J., 368
Crowley, M., 415
Csikszentmihalyi, M., 459
Culp, R. E., 238
Cutler, A., 428, 441
Cutler, M. M., 222

D

Daley, M., 190, 191
Daligga, B., 8
Darwish, D., 238
Davidson, C. L., 191
Davies, D., 8, 23
Davis, K., 208
Davis, S., 276
Davis, S. K., 183
Dawson, G., 82
De Bellis, M. D., 235
Debnam, D., 415, 416
DeGangi, G. A., 167, 168, 380
Delahooke, M. M., 162
Devine, D., 183
DiGeronimo, T. F., 192–194
Doering, P. L., 191
Dolce, K., 238
Dombro, A. L., 35
Dozier, M., 275
Drauden, G., 184
Drewes, A. A., 217, 218
Dubowitz, H., 183, 195

E

Edelbrock, C., 35
Edwards, M., 236
Egeland, B., 43, 46
Eggbeer, L., 21, 261, 268, 455, 465
Elliott, R., 212
Ellis, B. H., 220
Ellis-McLeod, E., 274
Emde, R. N., 12, 99, 166, 378
Erickson, M. F., 16, 31, 41, 43, 46, 47
Erikson, E. H., 192, 236, 378
Eron, J. B., 212
Escalona, S., 378
Ettorre, E., 183
Everett, J., 183
Eyberg, S., 266
Eyler, F., 276

F

Famularo, R., 234
Fantuzzo, J., 264, 406, 415, 416

Farkas, K., 190
Farran, D. C., 460
Feigelman, S., 183, 195
Feil, E., 264
Feldman, J., 181
Feldman, R. S., 234
Fenichel, E., 21, 114, 172, 261, 264, 268, 292, 427, 455, 465, 468, 475
Fenton, T., 234
Fernandez, M., 415
Field, B., 279
Field, T., 80
Fiese, B., 167
Finello, K. M., 51, 307
Finkelhor, D., 273
Finkelstein, N., 182
Finn, S., 238
Finnegan, L. P., 191
Fisher, C., 21, 220
Fisher, P. A., 275
Fisher, R., 412, 417, 461, 477
Fluke, J. D., 236
Fonagy, P., 456, 464, 469, 470
Foulds, B., 334
Fox, N. A., 364
Fraiberg, S., 4, 6–8, 11, 18, 19, 21–24, 26, 93, 256, 327–329, 338, 340, 378, 457
Frank, D. A., 192
Frankel, K. A., 21, 237
Freud, A., 378
Freud, W. E., 329
Fried, P. A., 192
Friedrich, W., 238
Frier, C., 190
Froehle, M. C., 83
Frost, J. L., 216
Funderburk, B., 266
Fundudis, T., 217

G

Gabel, S., 238
Gaensbauer, T. J., 378
Gallo-Lopez, L., 218
Ganger, W., 272, 274
Garland, A., 274
Gelfland, D., 259
Gergely, G., 464, 470
Gesell, A., 78
Gilkerson, L., 261, 268, 278, 427–430, 441, 455, 469, 470
Gist, K., 272
Gladwell, M., 457, 460
Glass, L., 181
Glennen, S., 364
Glenwick, D. S., 238
Goldberg, S., 334
Goldfarb, W., 364
Goldsmith, H. F., 290
Goldstein, A., 244
Goldstein, R. F., 80, 244
Goleman, D., 250
Golly, A., 264
Gomby, D., 258
Gordon, J., 272
Gould, S. A., 68
Graham, M., 257, 278
Grandison, C., 21–23
Grant, M., 402, 453
Grape, H., 189
Grasser, C., 288
Gray, J., 238
Green, B., 35
Green, M., 72
Greenberg, J., 467
Greenfield, D. B., 406
Greenhouse, J. B., 81
Greenspan, S. I., 23, 35, 73, 74, 87, 95, 105, 167, 168, 260, 377–380, 388, 391, 395, 408, 470, 473
Greenstein, B., 473
Griffith, D. R., 190
Grizenko, N., 238
Grotberg, E., 245
Gunnar, M., 275
Gustafson, K. E., 80
Gustavsson, N. S., 191

H

Hagen, J., 81
Hall, T., 218
Halpern, E., 402, 412, 417, 453, 461, 477
Hammer, M., 234
Hammond, M., 265
Hansen, R. I., 191
Hanson, J., 191
Hanze, D., 35
Harden, B. J., 256, 260, 262, 265, 266, 272, 273

Harmon, R. J., 21, 99, 237, 238, 378
Harns, S. L., 170
Harris, D. A., 287
Harris-Usner, D., 289, 294, 298
Harwood, R. L., 75
Hatcher, R., 191
Heffron, M. C., 114, 211, 263, 267, 298, 429
Heinicke, C., 259
Heller, A., 24, 265, 368
Heller, S. S., 265, 364, 365, 367, 368
Hembree-Kigin, T. L., 215, 217
Herbert, N. J., 266, 268
Higley, E., 275
Hinshaw-Fuselier, S., 24
Hirshberg, L., 5–7, 15, 21, 22, 24, 336
Hislop, K., 272, 273
Hoagwood, K., 414, 415
Hodges, K., 240
Hofacker, N., 15, 181
Holland, L., 415
Hollingsworth, L., 189
Holzer, C. E., 290
Honig, A., 264
Hornung, K., 237
Horwitz, S. M., 414, 415
Hough, R., 274
Howard, H., 191
Huber, A. M., 204
Hungerford, A., 263
Hunt, F. M., 240
Hunter, W. M., 82
Hyson, M., 264

I

Ialongo, N. S., 414, 415
Illig, D. C., 83
Ismond, D. R., 73, 74
Ivins, B., 171, 211, 267, 298, 429

J

James, B., 211
Jameson, P., 259
Jarrett, K., 475
Jellinek, M., 83
Jenkins-Monroe, V., 181
Jensen, P. S., 234
Jernberg, A. M., 219
Jewkes, A. M., 35
Jimenez, B., 81
Johnson, D., 288
Jones, B., 276
Jonson-Reid, M., 195, 197
Jurist, E., 464, 470

K

Kaduson, H. G., 218
Kalmanson, B., 171
Kaltenbach, K. A., 190, 191
Kaplan-Estrin, M., 327
Kaplan-Sanoff, M., 272, 276
Katz, L., 186
Kaufman, A. S., 53, 54, 65, 242
Kaufman, J., 234
Kaufman, N. L., 53, 54, 65, 242
Kaufmann, R., 359
Kavanaugh, K., 264
Kazdin, A. E., 234, 415
Keenan, K., 78, 83, 84, 87
Kellam, S. G., 414, 415
Kelly, M., 234
Kelly, S., 194
Kempe, R., 238
Kessler, R. C., 234
Kinscherff, R., 234
Kirchner, H. L., 190
Kissiel, C., 276
Klass, C., 258
Klein, N. K., 81
Klujsza, V., 412, 417, 461, 477
Knight, C., 277
Knitzer, J., 73, 256, 257, 263, 264, 267, 270, 272
Knoblauch, P. J., 218
Knobloch, H., 53, 54
Kolers, N., 242
Korfmacher, J., 43
Koslowski, B., 378
Kraemer, H. C., 234
Kupfer, D. J., 234
Kurz-Reimer, K., 43
Kutash, K., 238
Kyei-Aboagye, K., 192
Kyrios, M., 77

L

LaFauce, L., 191
LaGasse, L., 275
Lal, S., 239
Lamb, M., 264

Lamb-Parker, F., 402, 406, 417, 453, 461, 485
Landreth, G., 207
Landsverk, J., 274
Lapidus, C., 402, 403, 453, 478
Larrieu, J., 24, 357
Laukea, K., 191
Lawrence, H., 238
Leaf, P. J., 414, 415
LeBuffe, P. A., 415, 416
Leonard, M., 469
Lesh, A. T., 237, 238
Leslie, L., 272
Lester, B., 275
Letts, D., 238
Levine, B., 477
Lewis, M., 24
Lieb, S., 272, 276
Lieberman, A. F., 5, 7, 9, 10, 19, 21–24, 93, 94, 142, 196, 225, 258–259, 271, 274, 292, 338, 378, 379, 395
Limberg, B., 207
Linares, L. O., 276
Lindaman, S., 218–220
Litrownik, A., 274
Littell, J., 271
Little, V., 238
Loftus, E., 481
Lojkasek, M., 5, 102, 105, 220
Lopez, S. R., 198
Lourie, R., 378, 379, 395
Lovaas, O. I., 278, 279
Love, S., 276
Lozoff, B., 81
Lucinski, L., 445
Lund, T. W., 212
Lyman, R. D., 215, 217
Lyons, J., 276
Lythcott, M., 256

M

MacMillan, H. L., 233
Main, M., 234, 378
Makin, J. E., 192
Malik, N., 267
Malone, A., 53, 54
Maltese, J., 93
Manuel, M., 81
Manz, P., 264, 415, 416
Marquis, J., 277
Marsden, D. B., 35
Marshall, P., 364
Martin, C., 184
Massie, H., 19
Masten, A. S., 76
Matas, L., 378
Maury, E. H., 211
Mayes, L., 456, 469
McCalla, S., 181
McCarthy, D. M., 53, 54, 65, 190, 191
McClish, D. K., 81
McConaughy, S. H., 239
McDonough, S. C., 5, 46, 102, 105, 208
McGinnis, E., 244
McLaughlin, J. A., 265
McRoy, R. G., 189
McWilliam, R. A., 291
Meisels, S., 14, 21–23, 35, 166, 171, 172
Meltzoff, A. N., 458, 459
Mendez, J., 415, 416
Merkin, M. N., 402, 403
Meyers, R., 264
Miller, L. J., 53, 329
Milling, K., 16
Milner, J., 195
Minkoff, H. L., 181
Minnes, S., 190
Mitchell, S. A., 467
Mollen, E., 81
Mondanano, J. E., 182
Monzon-Kong, M., 211
Moore, M. K., 458, 459
Morgan, A., 10
Moser, J., 234
Muir, E., 5, 102, 105, 220
Munns, E., 218, 219
Munoz, G. R., 137
Munoz-Millan, R. J., 266, 267
Murphy, D., 277
Murphy, L., 378
Murray, J., 190

N

Nagle, G., 357
Naglieri, J. A., 415, 416
Nair, P., 277
Needell, B., 183, 195, 197
Needleman, H. L., 81
Neisworth, J. T., 78, 240
Nelson, C. A., 364

Nelson, E. C., 81
Nicol, R., 217
Nielsen, D. R., 238
Norman-Murch, T., 427
Nover, R., 378, 379, 395
Nuechterlein, K. H., 76
Nutter, A., 275

O

Oates, R., 238
Ochler, J. M., 80
O'Connor, K. J., 207–213, 215, 227, 228
Offord, D. R., 234
Oglesby, Z., 189
Oleksiak, C., 8
Olsen, E., 445
Ortega, S., 288
Osofsky, J., 21, 270
Owens, P. L., 414, 415

P

Palfrey, J. S., 72
Palomino, R., 24
Papineau, D., 238
Papousek, H., 15
Pardeck, J. T., 195
Parker, S., 192, 364
Patel, B. P., 83
Patterson, J., 277
Paulsen, M. K., 307, 308
Pawl, J. H., 5, 7, 8, 10, 19, 21, 24, 93, 94, 175, 208, 220, 225, 258, 296, 338, 465
Peay, L., 412, 417, 461, 477
Peckham, V. C., 273, 274
Pekarsky, J., 21–23
Percansky, C., 170
Perry, B., 235–237
Phibbs, C. S., 191
Phillips, D. A., 264, 421
Piaget, J., 208–210
Pine, F., 457
Poduska, J. M., 414, 415
Pollack, S. D., 237
Potter, L., 16
Poulsen, M. K., 71, 72, 307, 308
Prior, M., 77
Proulx, G., 8
Proulx, L., 218
Provence, S., 21, 22, 378, 481

Q

Quirk, C., 208

R

Radloff, L. S., 270
Raikes, H., 264
Randolph, I., 191
Rapoport, J. L., 73, 74
Raver, C., 264
Reams, R., 238
Reddy, L. A., 218
Reed, A., 237
Rees, J., 364
Reid, J., 275
Reid, S., 329
Reifel, S., 216
Reiss, J. A., 81
Richters, J., 71–73
Ritzler, T. T., 427
Rivera, V. R., 238
Robinson, E., 266
Robinson, J., 166
Robinson, M., 378, 379, 395
Roby, P., 277
Rogers, K. N., 415
Rohsenow, D. J., 183
Rolf, J., 76
Rosario, M., 234
Rose, T., 46
Rosenberg, F. B., 276
Rovaris, M., 24
Rubel, E., 218
Running, A., 288
Runyon, D. K., 82
Rustin, M., 329
Rutter, M., 74

S

Salvator, A., 190
Salvia, J., 78, 240
Salzinger, S., 234
Sameroff, A., 167
Sanson, A., 77
Sawyer, R., 183, 195
Sayegh, L., 238
Scarr, S., 263
Schaefer, C. E., 192–194, 218, 228
Schafer, W., 11, 24, 334, 335, 339
Scharfman, H., 279

Schnoll, S. H., 191
Schoffner, K., 368
Schore, A. N., 94
Schuerman, J., 271
Schuler, M., 277
Schwartz, R. M., 191
Schweitzer, L., 238
Scott, S., 291
Seagle, C., 402
Seifer, R., 275
Seiner, S., 259
Seligman, S., 142, 171, 467
Senge, P., 471
Severson, H., 264
Shahmoon-Shanok, R., 11, 173, 339, 402, 403, 412, 417, 453, 455, 461, 465, 467, 469, 470, 477
Shanok, R. S., 261, 268, 402, 403, 427, 455, 467–470
Shapiro, V., 8, 93, 457
Sheiber, F. J., 276
Shelby, J. S., 218, 220
Shepard, D. S., 190, 191
Sheppard, G., 414, 415
Shirilla, J., 5
Shirk, S., 35
Shonkoff, J. P., 421
Shultz, S., 266
Shure, M., 164
Shuttleworth, J., 329
Siegel, D. J., 95, 110, 236
Silovsky, J., 266
Silverman, R., 225
Simon, J., 46
Singer, L. T., 190
Slade, A., 456, 469
Sligar, K., 258
Smetana, J. G., 234
Smith, D., 191
Smith, R. S., 215
Smitley, A., 415
Smyke, A. T., 357, 364, 365, 367
Socolar, R. S., 82
Solchany, J., 258
Soloman, J., 234
Spencer, P., 218
Spitz, R. A., 378
Spivack, G., 264
Squires, J., 16, 264, 270, 432
Sroufe, L. A., 93–95, 378
St. John, M., 208, 220
Stayton, D., 378
Steiner, H., 215, 217, 218
Stenson, H., 191
Stephens, M. A., 238
Stern, D. N., 14, 96, 98, 99, 106, 378
Stevens, F., 53, 54
Stevenson, H., 264
Stiller, B., 264
Stinson, S., 5, 6
Stone, N., 238
Stott, F. M., 278, 435, 437
Streissguth, A., 191
Stretch, D., 217
Strickland, W., 184
Struthers, J. M., 191
Sutton-Smith, B., 24, 415, 416
Sweet, N., 211, 267, 298, 429
Swidle, F., 208
Szilagyi, M., 233

T

Tableman, B., 5, 6, 9, 11, 15, 21, 22, 24, 292, 336, 338
Target, M., 464, 470
Teicher, M. H., 235, 236
Teti, D., 259
Thomas, A., 76
Thompson, R. J., Jr., 80
Thurber, L., 415
Tighe, E., 415, 416
Timberlake, E. M., 222
Tizard, B., 364
Tobin, M. J., 81
Toomey, M., 408, 461
Tremmel, R., 434
Trout, M., 5, 6, 11, 15, 19, 21, 22, 24
Tuma, A., 74
Turnbull, A., 277
Tuters, E., 329
Twombly, E., 264, 270, 432

U

Uziel-Miller, N., 276

V

Valencia, G., 181
Valentine, J., 403

Valle, L., 266
Valliere, J., 24
Van Dyk, A., 218
Van Horn, P., 21–23

W

Wachtel, R., 277
Wajda-Johnstone, V. A., 357
Wakschlag, L. S., 78, 83, 84, 87
Walker, C., 16
Walker, H., 264
Wall, S., 37
Wanstrath, J., 35
Wasik, B., 260
Waters, E., 37, 378
Weatherston, D. J., 3–6, 8, 9, 11, 15, 21, 22, 24, 43, 257, 258, 292, 326, 327, 329, 331, 335, 336, 338
Webster, D., 195
Webster-Stratton, C., 265
Wechsler, D., 53, 54, 65
Weinberg, R. A., 34, 36
Weintraub, S., 71–73, 76
Weiss, A., 264
Wekerle, C., 233, 234, 273
Welton, S., 402, 403
Werner, E. E., 215
Westby, C., 209, 216, 222, 223
Weston, D. R., 35, 171, 258, 267, 298, 429
White, B., 257, 278
Wieder, S., 73, 74, 87, 95, 105, 167, 168, 260, 343, 377–379, 388, 391, 395, 408, 473
Wiedis, D., 218
Wightman, B., 329, 335
Willemsen, H., 218
Williams, C. A., 191
Williams, C. N., 190, 191
Williamson, G. G., 465
Winnicott, D. W., 22, 93, 96, 378, 395
Witenberg, M., 402, 403
Wobie, K., 276
Wolf, A. W., 81
Wolfe, D. A., 233, 234, 273
Wollenberg, K., 445
Wood, L. E., 238
Wood, M., 208
Wortham, S. C., 216
Wright, B., 17, 24, 334
Wulczyn, F., 272, 273

Y

Yoshikawa, H., 73, 263
Yuan, Y. T., 236

Z

Zablikis, D., 237, 238
Zeanah, C. H., 5, 9, 10, 19, 24, 72–74, 78, 82, 196, 257, 263, 273, 274, 364, 368, 470
Zeanah, P., 257, 263
Zigler, E., 403

Subject Index

A

Academic Communication Associates, 365
ACS-Head Start. *See* Administration for Children's Services, Head Start (ACS-Head Start; New York City)
Administration for Children's Services, Head Start (ACS-Head Start; New York City), 403, 404, 456
Adoption: and culturally competent assessment reports, 197–198; kinship, 188; and legal guardianship, 188; and placement disruption, 195–196; recommendations for substance-exposed infants and toddlers in foster care, 181–202; role of culture in, 197
Adoptions and Safe Families Act (ASFA; 1997), 185, 187, 189, 195, 196
ADS. *See* Attachment during stress (ADS)
Ages and Stages Questionnaire: Social-Emotional (ASQ:SE), 264, 270, 432, 446
Ages and Stages Questionnaires (ASQ; Squires, Potter, and Bricker), 16
Alaska, 293
Alcohol abuse, 191. *See also* Drug exposure
Alliant International University, 228
Alternative settings: and home setting, 258–263; and kitchen therapy, 256–280; and principles of young-child mental health, 257–258
American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care, 234, 235
American Psychiatric Association, 75–76, 240, 241
American Psychological Association, 75, 76, 184; Office of Ethnic Minority Affairs, 184
Anna Freud Center, 329
Apprenticeship, 457–461, 481; as transformational enterprise, 458, 460
APT. *See* Association for Play Therapy (APT)
ASFA. *See* Adoptions and Safe Families Act (ASFA; 1997)
ASQ:SE. *See* Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)
Assessment: diagnostic procedures in process of, 172–173; differences in, of adults and young children, 170–172; as first phase of intervention, 169–173
Assessment training: basic knowledge needed by practitioners in, 58–63; for birth to five-year-olds, 51–69; complexities inherent in, 53–56; determining competence in, 68–69; and developing appropriate interview skills, 60–61; general issues in, 52–57; issues of time in, 56; models, 63–65; within or across age groups, 52–54; sample course in, 65–67; supervision issues in, 67–68; and testing, 61–62; use of screening tools *versus* comprehensive, 54–55; using developmental knowledge in process of, 59–60; and who should assess, 57; and writing reports, 62–63
Association for Play Therapy (APT), 228
Association for Rural Mental Health, 299, 300
Attachment: and age at removal, 196–197; during stress (ADS), 19, 20; theory, 37; window, 196
Australia, 46

B
Baltimore, Maryland, 266
Bayley Scales of Infant Development (BSID), 16, 53, 54, 57, 65, 68, 164
BCC. *See* Bienvenidos Children's Center (BCC; Altadena, California)
Behavior, child: caregiver relationship perspectives on, 82–83; experiential perspectives on, 81–82; health and physiologically based perspectives on, 80–81; neurobehavioral self-regulatory perspectives on, 77–78; temperamentally based perspectives on, 76–77
Behavior in Babies Clinic (University of Southern California), 163
Bienvenidos Children's Center (BCC; Altadena, California), 238, 248, 251; case example, 246–247; intake assessment, 239–241; intensive day treatment programming at, 243–244; program goals and theoretical orientation at, 244–245; referrals for treatment, 241–243
Boston City Hospital, 276
Bracken measures, 53, 54
Brooklyn, New York, 276
BSID. *See* Bayley Scales of Infant Development
Building Blocks Program, 221

C
California, 138, 187, 189, 195, 197, 292, 309; Assembly Bill 1197, 248; Children and Families Commission, 308; Community Care Licensing, 248; Department of Mental Health, 308; training guidelines, 311
California School of Professional Psychology (Alliant International University), 228
Carnegie Corporation, 411
Carolina Abecedarian Project, 390
Case consultation, 433; for service, coordinators, parent liaisons, and providers, 445–450
Center on Hunger, Poverty and Nutrition Policy, 80, 81
CFC. *See* Child and Family Connections (CFC)
Child and Adolescent Functional Assessment Scale (Hodges), 240
Child and Family Connections (CFC), 428, 430, 433, 434
Child Behavior Checklist (Achenback and Edelbrock), 35
Child care settings: and activities to promote mental health, 263–265; mental health services in, 263–269; and prevention of mental health difficulties, 265–266; and special challenges in early childhood programs, 267–269; treatment of diagnosed mental health problems in, 266–267
Child Development Project in Ann Arbor, Michigan (Fraiberg), 21
Child Find, 297
Child welfare, 183–184; and assessment and intervention programs for foster children, 274–275; mental health practice in, 273–275; and therapeutic programs for biological families, 273–274
Child Welfare and Institutions Code, 185, 188
Children's Defense Fund, 185
Children's Trust Fund, 300
CIDP. *See* Clinical Infant Development Program (CIDP)
Circle of Security (Heller and Boris), 265
City TOTS (Zero to Three Task Force), 420
Clinical experience, gaining, 163–164
Clinical Infant Development Program (CIDP), 346, 378, 390
Clinical windows, 98–101
Columbia University, 406
Committee on Preschool Special Education (CPSE), 410, 411
Community Functioning Evaluation, 240
Concurrency planning, 186; relationship between, and critical stages of infant-toddler development, 193–194
Countertransference, 118

D
DASIS. *See* Drug and Alcohol Services Information System Report (DASIS; Substance Abuse and Mental Health Services Administration)

Denver II Developmental Screening Test (Walker, Bonner, and Milling), 16
Department of Child Protective Services, 110
Department of Health and Human Services. *See* United States Department of Health and Human Services
Developmental, Individual-Difference, Relationship-Based model (DIR; Interdisciplinary Council on Developmental and Learning Disorders), 167, 377, 378; assessment process using, 380–388; case illustrations, 396–399; for comprehensive approaches to assessment and intervention, 377–399; description of, 379–380; as developmental model for intervention, 390–396; and functional developmental profile, 389–390; functional emotional developmental levels of, 380–387; and individual differences in sensory and sensory-affective processing, 387–388; relationships and interactions in, 388
Devereux Early Childhood Assessment, 415–416
Diagnosis: and diagnostic formulation, 74–76; and diagnostic overshadowing, 74; differential, 73–74; of individual difference, 83–84; and predisposing considerations in diagnostic formulation, 76–83; for preventive intervention, 84–85; training issues in, 88–89
Diagnostic and Statistical Manual of Mental Disorders: DSM IV (American Psychiatric Association), 75, 76, 85–87, 172, 173, 240, 241
Diagnostic Classification: 0-3, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Zero to Three Task Force), 17, 20, 86, 87, 96, 173, 241, 379
Dialogue, 471
Differential diagnosis, 73–74
DIR. *See* Development, Individual-Difference, Relationship-Based model (DIR)
DIR Institute Certificate Program (DIRC): as case-based competency training model, 343–354; challenge of, 348–350; and determining competency, 353–354; outline, 355–356; Phase I, 349–350; Phase II, 350; Phases III and IV, 350; process of, 352–353; structure of, 351–352
DIR Model of Infant Mental Health (IMH), 344, 345, 350; historical background to, 346–348
DIRC. *See* DIR Institute Certificate Program (DIRC)
Drug and Alcohol Services Information System Report (DASIS; Substance Abuse and Mental Health Services Administration), 182
Drug exposure, 81; and alcohol effects, 191; and cocaine effects, 190–191; and marijuana effects, 192; and opiate effects, 192; physiological growth and, 190–192; and social-emotional growth, 192–193
Dyadic therapy: critical influences on, 94–96, 107–108; and developmental scaffolding, 98–99; ethical issues in, 110–112; evaluation process in, 103–105; mental health specialist in, 94–96; model, 93; as shift in thinking, 96–98; supervision in, 109–110; and therapeutic alliance, 101–103; training in, 108–109; and unobtrusive observation, 105–107

E

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), 88
Early Childhood Group Therapy (ECGT) Training Program, 402–421, 462, 463, 465, 472, 476
Early Head Start, 265, 267, 454
Early intervention, 454; mental health practice in, programs, 277–279
ECGT. *See* Early Childhood Group Therapy (ECGT) Training Program
Ecosystemic Play Therapy (EPT), 207–229; applying, to play therapy, 219–220; case example using, 221–227; and mental health concerns with preschoolers, 214–215; overview of, 208; and representational play development, 216–217; training in,

Ecosystemic Play Therapy (EPT) *(continued)*
227–229; treatment planning, 224–225; treatment process, 225–227
EI System. *See* Illinois Department of Human Services (IDHS) Early Intervention Bureau
Elmira Prenatal/Early Infancy Project, 390
Emotional Intelligence (Goleman), 248
Emotions, child: caregiver relationship perspectives on, 82–83; developmentally based perspectives on, 78–80; experiential perspectives on, 81–82; health and physiologically based perspectives on, 80–81; neurobehavioral self-regulatory perspectives on, 77–78; temperamentally based perspectives on, 76–77
EPSDT. *See* Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Event sampling, 36

F

FAE. *See* Fetal alcohol effect (FAE)
Fagan Test of Infant Intelligence, 191
Family School (Philadelphia), 273–274
FAS. *See* Fetal alcohol syndrome (FAS)
FEAS. *See* Functional Emotional Assessment Scale (FEAS)
Feeding and Teaching Scales from the Nursing Child Assessment Satellite Training (NCAST) Project (Barnard), 19
Fetal alcohol effect (FAE), 191
Fetal alcohol syndrome (FAS), 191
Floor Time approach (Greenspan and Wieder), 95, 105, 260, 392, 394
Florida, 267
Flow (Csikszentmihalyi), 459
Foster care: evaluation of infants and toddlers in, 184–185; long-term, 188–189
Functional Emotional Assessment Scale (FEAS; Greenspan), 35, 167, 168

G

Gesell Developmental Schedules (Knobloch, Stevens, and Malone), 53–54, 54
Global Assessment of Functioning (GAF), 241
Graduate Certificate Program in Infant Mental Health, Merrill-Palmer Institute, Wayne State University: and clinical questioning essential to learning process, 335–338; description of, 328; infant and family observation in, 329–332; as interdisciplinary training model, 326–340; overview, 326–327; and supervisory relationship, 338–340; and work with clinical infants and families, 332–335

H

Head Start, 266, 267, 269, 297, 300, 402–421
Hierarchies, 466–468; flattening, 474–479
Holding environment, 339
HOME Inventory. *See* Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell and Bradley)
Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell and Bradley), 18, 34
Home settings: mental health practice in, 259–260; mental health services in, 258–263; safety issues in, 262–263; and special challenges in home visiting, 261–263
Human service settings: intervention in, 271; mental health practice in, 270–273; and staff supports, 272–273; systems issues in, 272

I

ICDL. *See* Interdisciplinary Council on Developmental and Learning Disorders (ICDL)
IEP. *See* Individual Education Plan (IEP)
IFSP. *See* Individual Family Service Plan (IFSP)
Illinois Department of Human Services (IDHS) Early Intervention Bureau, 427, 433
Illinois Interagency Council on Early Intervention, 427, 430
IMH. *See* DIR Model of Infant Mental Health 345
INCEPT. *See* Infant Nursery Caregiver Parent Training Program (INCEPT)

Individual difference, 83–84
Individual Education Plan (IEP), 278
Individual Family Service Plan (IFSP), 278, 428
Individuals with Disabilities Education Act, 277
Infant mental health: core beliefs, 6; definition of, 4–5; principles of practice, 21–22, 23–25; skills and strategies, 8–9; training, 20–26; training techniques, 24–25
Infant mental health practice, 5–6; clinical questions in, 15–20; and developing plan for intervention, 14–15; and developing relationships, 9–12; and identifying capacities and risks, 12–14; key components of, 6–7
Infant Nursery Caregiver Parent Training Program (INCEPT), 276
Infant, Preschool and Family Mental Health Initiative (California), 308
Infant-Parent Program (IPP; San Francisco), 274
Infant-Toddler Mental Status Exam (Benham), 222
Inference, 41–42
Institute for Black Parenting, 189
Institute for Infants, Children and Families (JBFCS-Institute), 402, 403, 405–410, 416, 418, 456
Integrated provider work groups, 433
Integrated services digital network (ISDN), 362
Intensive day treatment (IDT): at Bienvenidos Children's Center, 238–247; description of, 236–238; and hiring new staff, 250–251; skill acquisition for, 249; and standards, competencies, and scope of practice for paraprofessionals and professionals, 248–251; for very young traumatized children in residential care, 233–251
Intentionality, 460
Interaction Guidance (McDonough), 46, 105
Interdisciplinary Council on Developmental and Learning Disorders (ICDL), 167, 169, 344, 348, 390
Interdisciplinary team membership, 165
International Society on Infant Studies, 358
Interpretation, training in, 61–62
Intervention: assessment as first phase of, 169–173; diagnosis for preventive, 84–85; issues, 173–174; observation as, 45–46
Interview skills, development of, 60–61
Iron deficiency anemia, 81
Irving B. Harris Training Center for Infant and Toddler Development (University of Minnesota), 47

J

JBFCS. *See* Jewish Board of Family and Children's Services (JBFCS)
JBFCS-Institute. *See* Institute for Infants, Children and Families
Jewish Board of Family and Children's Services (JBFCS), 456, 462, 464, 473, 476

K

Kaufman Assessment Battery for Children (Kaufman and Kaufman), 53, 54, 65
Kaufman Brief Intelligence Scale (Kaufman and Kaufman), 241
Keck School of Medicine, University of Southern California, 163
Kinship Adoption Agreement, 188
Kitchen therapy, 256–280
Knowledge, 462–464

L

Las Cumbres Learning Services, 288, 289
Lead exposure, 81
Learning community, 471–472
Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers and Their Families (Fenichel), 114
Legal guardianship, 188
Lexington School for the Dear, 279
Long-term placement (LTP), 188–189
Los Angeles County, 245; Department of Children's and Family Services (DCFS), 238; Department of Mental Health (DMH), 238, 239
Louisiana, 274
Louisiana Infant Mental Health Association, 358
Low birth weight, 80

M
Mailman School of Public Health (Columbia University), 406
Maori (New Zealand), 293
Marschak Interaction Method (MIM; Lindaman, Booth, and Chambers), 220
Massachusetts Institute of Technology (MIT), 471
Massie-Campbell Scale of Mother-Infant Attachment During Stress (ADS; Massie and Campbell), 19
Maternal and Child Health leadership training grant, 308
McCarthy Scales of Children's Abilities, 53, 65
Medically fragile children, 195
Mental Health: A Report of the Surgeon General (Department of Health and Human Services), 75
MEPA. *See* Multiethnic Placement Act (1994)
Merrill Palmer Institute, Wayne State University, 43, 326–340
Michigan, 4, 292, 308
Michigan Association for Infant Mental Health, 21
Michigan Infant Mental Health Association, 358
Migrant Head Start programs, 300
MiHijita/MiHijito Infant Mental Health Project, 300
Miller Assessment for Preschoolers (Miller), 53, 54
MIM. *See* Marschak Interaction Method (MIM; Lindaman, Booth, and Chambers
Monterey, California, 228
Motherhood constellation, 96
Multiethnic Placement Act (1994; MEPA), 189, 197
Mutuality, 469–471

N
NAS. *See* Neonatal abstinence syndrome (NAS)
National Center for Clinical Infant Programs (Washington, D.C.), 21, 114
National Institute of Child Health and Human Development, 263, 264
National Institute on Drug Abuse, 275
National Institutes of Mental Health (NIMH), 85, 346, 378
Native Americans, 293, 297
NCAST. *See* Nursing Child Assessment Satellite Training Project
Need-reject syndrome, 194
Neonatal abstinence syndrome (NAS), 192
Neonatal Behavioral Assessment Scale (Brazelton), 34
New Mexico, 297
New Visions for the Developmental Assessment of Infants and Young Children (Meisels and Fenichel), 170
North Carolina, 267
Northern California, 163
NOSOTRAS seminar, 137; and applying theory to practice, 142–156; case presentation format, 157–161; case presentation in, 143–145; crisis to action in, 150–153; crisis to growth in, 153–156; and cultural conflict among colleagues, 147–156; need for, 138–139; program services, 139–140; and self-awareness, 146–147; socio-cultural perspective and self-awareness in, 141–142, 145–146; using model of parallel process in, 140–141, 149–150
Nursing Child Assessment Satellite Training Project (NCAST), 19, 20, 34
Nurturing Parent Program, 265
Nutrition, inadequate, 80–81

O
Observation: basic knowledge needed by practitioners using, 41–43; as core concept of reflection, 464–465; and determining levels of competence, 43–44; and how we chose to observe, 34–37; and how we make sense of what we observe, 37–44; and hypotheses *versus* conclusions, 40–41; as intervention, 45–46; and observable behavior *versus* inference, 41–42; and Seeing Is Believing, 46–49; supervision issues in, 44–45; theoretical perspectives on, 37–38; training and practice issues, 32–41, 43–44; unobtrusive, 105–107; use of, in prevention and intervention services, 31–32; and what we choose to observe, 33–34

Office of Ethnic Minority Affairs (American Psychological Association), 184
Open communication, 471–472
Ounce Scale (Meisels, Marsden, Dombro, Weston, and Jewkes), 35

P

Parallel process, 140–141, 149–150, 267
Paraprofessionals, 248–251
Parent Behavior Progression (Bromwich), 35
Parent Child Communication Coaching program, 258
Parent Child Interaction Training, 266
Parent Infant Relationship Global Assessment Scale (Green, Shirk, Hanze, and Wanstrath), 35
Parental histories, 337–338
Parent-Child Early Relational Assessment (Clark), 35
Parent-infant psychotherapy, 93
Parent-infant relationship, 11
Parent-practitioner relationship, 9–10
Parent-to-parent mini-grants, 433
Penn Interactive Peer Play Scale (Fantuzzo, Mendez, and Tighe), 415, 416
Permanency planning, 186
Pew Partnership for Civic Change, 288, 289
Philadelphia, Pennsylvania, 271–272
Placement disruption, 195–196
"Platinum Rule of Supervision" (Pawl), 175
Play therapy, 215–219; applying ecosystemic model to, 219–220; with preschoolers, 217–219; and representational play development, 216–217. *See also* Ecosystemic Play Therapy (EPT)
Play Therapy Association, 322
Portage Project (Copa, Lucinski, Olsen, and Wollenberg), 445
Power, 466–468
"Practice Parameters for the Psychiatric Assessment of Infants and Toddlers 0-36 Months" *(Journal of the American Academy of Child and Adolescent Psychiatry),* 75
Practitioner-supervisor relationship, 11–12
Preschool and Early Childhood Education Functional Assessment Scale (Hodges), 240
President's New Freedom Commission on Mental Health (2002), 85
Primary maternal preoccupation, 96
Psychological Corporation, 67

R

Reflective consultation, 431; for managers, 434–439
Reflective practice: and asymmetry in relationships, 466–468; core concepts of, 462; and internalization of self-awareness and other-awareness, 472–474; and knowledge, 462–464; and mutuality, 469–471, 469–471; and observation, 464–465; and open communication, 471–472; and reflection, 469; and reflective function, 456, 469–471; and relationship development, 465–466; role of, 427–451, 455–457; within service and training contexts, 455–457; and transferring knowledge across disciplinary and role boundaries, 474–479
Reflective supervision: and antecedents to supervisory relationship, 119; challenges of, 136; climate and support essential for, 129; essential qualities and abilities for, 119–122; evaluating effectiveness of, 135; focus of, 115–117; and home visiting, 261–262; points of confusion in, 130–134; program variations in use of, 128–129; and roles of reflective supervisor, 122–128; and SE Pilot, 431–432; to service coordinators, 440–445; theoretical considerations in, 117–118; who can provide, 134–135
Reflective supervisor: antecedents, qualities, and abilities of, 119–122; as coach and mentor, 123–124; as guarantor of quality assurance, 125–128; as model of open communication, 128; as provider of safe holding environment, 124–125
Registered play therapist and supervisor (RPT-S), 228
Registered play therapist (RPT), 228

Relationships: asymmetry in, 466–468; developing, 332–333, 339–340, 465–466; enhancing study of, 333–334; for learning, 338; and relationship-based early intervention, 434–450; and relationship-based intervention planning, 432; and relationship-based training, 430–431; supervisory, 338–340
Relationships for Growth (RfG), 402–421, 456, 460–462, 466, 468, 471–473, 476, 481; evaluation of relationships for, 415–419; historical roots of, 403–404; and parental enthusiasm for playgroups, 414–415; partnership and shared decision making in, 405–409; playgroups in, 411–414; principles of, 404–410; and referrals to intervention levels, 410–411; relationships for, 410–414; and ripple effect, 419–420; staff training and development, 409–410
Report of the Surgeon General's Conference on Children's Mental Health (Department of Health and Human Services), 234
Retraining: and benefits of interdisciplinary team membership, 164–165; as continuing process, 165–166; and gaining clinical experience, 163–164; lessons learned from, 175–176; selected workshops and trainings for, 165; and specialization, 162–165; theoretical models for, 166–168
Reunification: case example, 199–200; denial of, 187; and permanency review hearings, 187–188; recommendations of, for substance-exposed infants and toddlers in foster care, 181–202; and relative placement, 188; and termination of parent's rights, 187; time limits, 186–187
Ripple effects, creating, 460–461
Rural areas: and apprenticeship, 299–300; and assets of rural communities, 291; basic knowledge for practitioners in, 292–294; case example of developing service in, 300–301; and challenges for rural practitioners, 290–291; and challenges for rural residents, 288–289; clinical skills needed to work in, 295–298; delivering infant and preschool mental health service in, 287–303; developing competence in, 302; natural assets of, 294–295; special challenges in, 287–291; training and resources for, 298–299
Rural Mental Health Association, 290
"Rural Mental Health Practitioners Speak Out" *(Rural Mental Health),* 290

S

Safe base, 337
SAMSHA. *See* Substance Abuse and Mental Health Services Administration (SAMSHA)
Scaffolding, developmental, 98–99
School-Based Play Therapy (Drewes, Carey, and Schaefer), 218
Screening tools, 54–55
SE Pilot. *See* Social Emotional (SE) Pilot
Seeing Is Believing (SIB), 46, 46–47, 47, 48; insights and discoveries through, 47–49
Self-awareness, 472–474
Short-Term Play Therapy for Children (Kaduson and Schaefer), 218
SIB. *See* Seeing Is Believing (SIB)
SIDS. *See* Sudden infant death syndrome (SIDS)
Social Emotional (SE) Pilot, 427–430, 435; key elements of, 430–434; and social-emotional screening, 432; and social-emotional specialist, 430
Southern California, 162, 248
Specialization: journey toward, 162–166; planning training course in, 176–177; and specialist consultation network, 433–434; and specialized evaluation, 432
STEEP program. *See* Steps Toward Effective, Enjoyable Parenting (STEEP) program
Steps Toward Effective, Enjoyable Parenting (STEEP) program, 46
Stereotypes, 147–148
Strengthening Emotional Ties Through Parent-Child-Dyad Therapy (Proulx), 218
Substance Abuse and Mental Health Services Administration (SAMSHA), 182

Substance abuse programs, 275–277
Sudden infant death syndrome (SIDS), 192
Supervision: and consultation case vignettes, 362–369; cultural relevance in, 198–200; guidelines and recommendations for distance, 371–373; for intensive day treatment, 247; methods of distance, 360–362; in observation, 44–45; reflective, 114–136; and retraining, 174–175
Syracuse University Family Development Research Program, 390

T

Tacoma, Washington, 46
Tavistock Clinic (England), 329
Technology: advantages and challenges of using distance, 370; culture of supervision and culture of, 362; and guidelines and recommendations for distance training, supervision, and consultation, 371–373; and infant mental health training program, 368–369; and intervention, 367–368; and methods of distance supervision, 360–362; need for distance, 358–359; and telephone, 360–361; use of, as training, supervision, and consultation aid, 357–374; and videoconferencing, 361–362; and vignette of international research project, 363
Telephone, 360–361
Temperament, 76–77
Temperamental and Atypical Behavior Assessment Scale (Bagnato, Neisworth, Salvia, and Hunt), 240
Termination of Parental Rights, 187
Terrorist Attacks of September 11, 2001, 478
Texas Infant Mental Health Association, 358
Therapeutic alliance, strategies for, 101–103
Theraplay, 218, 220
Theraplay: Innovations in Attachment-Enhancing Play Therapy (Munns), 218–220
Time sampling, 36
Tipping point, 460
Toddler Talk Group, 365
Touchpoints, 98
Training: in assessment, 51–69; cultural relevance in, 198–200; in diagnosis, 88; in dyadic therapy, 108–109; in ecosystemic play therapy, 227–229; guidelines and recommendations for distance, 371–373; for intensive day treatment, 247; key elements of, 462; in observation, 32–91; relationship-based, 430–431; for rural areas, 298–299; and specialization, 176–177; in testing and interpretation, 61–62
Training guidelines: and content knowledge and related training topics, 312, 322; course work and, 322–323; overview, 311–312; for working with children birth to five and their families, 319–321 *Tab.14.3*; for working with infants, toddlers, and their families, 312–315 *Tab.14.1*; for working with preschool-aged children and their families, 316–318 *Tab.14.2*
Training standards: and clinical experience and supervision, 323–324; developing, 307–325; and establishing working committee, 308–309; problems and issues in developing, 309–310; and underlying principles used to develop California Guidelines, 311
Transference, 118
Transformational enterprise, 461–474
Traumatized children: and early intervention, 235–236; intensive day treatment for very young, 233–234; and neural development, 235
Treating Preschool Children (Steiner), 218
Tulane University Institute of Infant and Early Childhood Mental Health, 368–369

U

United States Department of Health and Human Services, 72, 75, 77, 83, 85–87, 234, 264
United States General Accounting Office, 181, 187
University Affiliate Program (University of Southern California), 163
University of Minnesota, 47
University of Southern California, 163

University of Washington, Department of Nursing, 292
U.S. Census 2000, 137, 288
Use of self, 118

V

Videoconferencing, 361–362

W

Washington Guide for Promoting Development in the Young Child (Barnard and Erickson), 16, 292
Watch, Wait, and Wonder program (Muir, Lojkasek, and Cohen), 105, 219, 220
Wechsler Preschool and Primary Scales of Intelligence (Wechsler), 53, 54, 65
Wednesday Group, 478
WestEd/California Early Intervention and Training Network, 163, 308
Women and Infants Clinic (Boston City Hospital), 276
Working committee, 308–309
Working Model of Child Interview, 368–369
World Association for Infant Mental Health, 325, 358
World Trade Center, 478

Y

Ypsilanti Project, 390

Z

Zero to Three Task Force (Washington, D.C.), 17, 241, 299, 358, 420