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Infant & Early Childhood Mental Health in Child Protection

Core Skills for Evolve Therapeutic Services Clinical Staff

Queensland Government

Infant & Early Childhood Mental Health in Child Protection: Core Skills for Evolve Therapeutic Services Clinical Staff

This publication may contain images of deceased Aboriginal and Torres Strait Islander peoples.

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Acknowledgements

The “Infant & Early Childhood Mental Health in Child Protection: Core Skills for Evolve Therapeutic Services Clinical Staff” document was written and created by Stacie Gill. This was in consultation and with significant contribution from Warren Bergh (Evolve Therapeutic Services State-wide Program Manager, Children’s Health Queensland Health and Hospital Services).

Appreciation and acknowledgement:

- Craig Heron (Indigenous Program Coordinator, Cairns ETS, Cairns and Hinterland Health and Hospital Services).
- ETS State-wide Infant Mental Health Child Protection Advisory Group (2016/2017):
    - Warren Bergh (ETS State-wide Program Manager, CHQ HHS)
    - Stacie Gill (Professional Development Coordinator, Cairns ETS, Cairns and Hinterland HHS)
    - Jessica Arday-Wild (Mental Health Clinician, Toowoomba ETS, Darling Downs HHS)
    - Bettina Bettinzoli (Mental Health Clinician, Ipswich ETS, West Moreton HHS)
    - Shona Bradford (Team Leader, Toowoomba ETS, Darling Downs HHS)
    - Joanne Chapman (Indigenous Program Coordinator, Ipswich ETS, West Moreton HHS)
    - Kay Clifford (Mental Health Clinician, Harvey Bay ETS, Wide Bay HHS)
    - Tara Douglas (Indigenous Program Coordinator, Townsville ETS, Townsville HHS)
    - Rechelle George (Mental Health Clinician, Brisbane North ETS, CHQ HHS)
    - Robyn Kemble (Mental Health Clinician, Sunshine Coast ETS, Sunshine Coast HHS)
    - Libby Morton (Program Manager, Queensland Centre for Perinatal and Infant Mental Health, CHQ HHS)
    - Jeanette Pittaway (Team Leader, Ipswich ETS, West Moreton HHS)
    - Rachel Smith (A/Professional Development Coordinator, South Brisbane ETS, CHQ HHS)
    - Brandon Vilaysack (Mental Health Clinician, Townsville ETS, Townsville HHS)
    - Dr Rebecca Wild (Psychiatrist, Sunshine Coast ETS, Sunshine Coast HHS)
    - Ashley Strum (A/Team Leader, Gold Coast Evolve Therapeutic Services, Gold Coast HHS)

"Just as infants must develop, so must our theories about what they experience and who they are."

Daniel Stern

Introduction

This document has been developed in increasing knowledge and skills with the 0-4 age range within the child protection context - one part of a larger professional development process to assist Evolve Therapeutic Services (ETS).

It has been designed to provide an overview of Infant and Early Childhood Mental Health in Child Protection, with links to important resources and further information. It is not the intent of the document to replace formal education, any other forms of knowledge / skill development and most importantly not to replace the importance of clinical consultation with senior mental health staff and Consultant Psychiatrist.

> While no skill development document can be exhaustive, this particular document attempts to outline key activities and information required.

Clinicians should obtain clinical consultation with their ETS Consultant Psychiatrists and/or (as necessary/suitable) operational line managers, if unsure about content or applicability. It is advisable, and best practice, that ETS clinicians working with consumer aged 0-2 years to seek appropriate clinical supervision with an Infant Mental Health supervisor (where available). The importance of clinical and reflective supervision is discussed further within this document.

Target Audience

This document has been developed specifically for ETS staff in mind only. In particular clinical staff who will have case management responsibility of infants/children aged 0-4 years old. The content of the document, however is still relevant and informative for others within the program.

Structure

The document has been divided into 2 separate sections. The first section focuses on general knowledge of infant and early childhood mental health. The second section focuses specifically infant and early childhood mental health in the ETS context, including assessment and treatment.

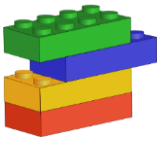
Icons

To enhance the readers experience and knowledge, is intended that this documented is used as a self-paced learning module. To facilitate the learning experience, allow for easy orientation and navigation throughout the document five different icons will be used. Each is a prompt to assist the reader and are as follows.

***Reflect**:* Use this opportunity to reflect on what was read / learnt to that point and complete the reflective prompts and cues outlined in the associated box.

Read: Enhance understanding of core concepts further by reading provided seminal article.

Watch: The visual tool, link to video clips, to further enhance understanding of core concepts.



Explore: Link to additional resources and tools to deepen understanding of core concepts.

Key message: A take home message that summaries the main body of information.

Training Objectives

The objectives of this document include:

- To develop a shared language and an understanding of the Infant and Early Childhood Mental Health across the ETS program
- To enhance understanding of key terms and theories within the field
- To have a greater appreciation of the impact of trauma during pregnancy to age 4 and beyond
- To be able to identify key assessment and therapeutic approaches that are best practice from the 0-4 population that are referred and access the ETS program.

Section One: Introduction to Infant Mental Health

Infant Mental Health Theory

Overview and Key Theories in Infant Mental Health

The first question we are often asked is "How does an infant have mental health issues?", and for most clinicians, the searing anxiety associated with their own lack of understanding on "How do I assess and treat mental health in infants?"

Great question!

First let's start with some basics. You will often hear the following terminology used interchangeably; 'Infant Mental Health', 'Infant and Toddler Mental Health', 'Perinatal & Infant Mental Health', 'Early Childhood Mental Health' and 'Infant and Early Childhood Mental Health'. Essentially we are talking about the same thing (with a slight exception in the case of Perinatal & Infant Mental Health). The following terms are usually applied to the 'little ones' in our world:

- **Neonate**: The neonatal period is considered to be the time from birth up to 3 months of age.
- **Infant:** Infancy is generally considered to encompass the period between 3 months of age, and 12 months. It can often be extended up to 24 months or 2 years, depending on the school of thought being considered.
- **Toddler:** Toddlerhood is usually accepted as the period from 12 months to 36 months of age (1-3 years)
- **Young Child/Early Childhood**: A young child or the period of 'early childhood' is generally considered as the period post toddlerhood before formal preparatory education (usually up to 4 years of age, so 3-4 years).

So, terminology aside, and in lieu with Australian and International trends, the term 'Infant & Early Childhood Mental Health' (IECMH) will be adopted throughout this document, which encompasses the 0 - 4 year age range.

Influences/Theories in IECMH

The origins of the field of 'Infant Mental Health' reveal that this is not however a new concept. IECMH can be traced back as a stand-alone recognised specialty in Child and Adolescent Mental Health just over 40 years ago. As a multidisciplinary "sub-specialty" field, IECMH has had numerous theoretical and knowledge-based influences, which affect the current understanding of the mutual interaction between an infant, and the environment in which they live.

A very brief summary of key influences and theorists in the infant mental health space are outlined below.

Area	Focus	Key Theorists (in relation to infants)
Psychoanalytical Theory	Development of self; Caregiver/Infant Relationships; Influence of transgenerational issues on optimal development; Therapeutic relationship between clinician and client/s (transference/counter-transference/projection).	Selma Fraiberg Esther Bick Beatrice Beebe

Area	Focus	Key Theorists (in relation to infants)
Object Relations Theory	Interest in the infant's development through relationships and how 'object seeking' (the need to form social relationships) as a primary motivator resulting in internalised representation of self, other and ensuing relationship.	Melanie Klein W. Ronald Fairbairn Donald Winnicott
Attachment Theory	Development of primary attachment relationships; role of secure attachment in optimal development; impact of transgenerational relationships on optimal development.	John Bowlby Mary Main & Erik Hesse Carol George & Judith Solomon
Developmental Psychology / Psychopathology	Infant development: social, cognitive, psychological and social-emotional-cultural.	Ed Tronick T. Berry Brazelton Dante Cicchetti & Donald Cohen Charley Zeanah
Neurobiology	Influence of genetic and biological contributions to optimal brain development; role of social environment and attachment in achieving optimal brain development; impact of early trauma.	Allan Schore Michael De Bellis Martin Teicher Bruce Perry Stephen Porges
Systems Theory	Functioning of the infant/caregiver dyad and family as a system – collectivist and external influences on relationships.	Salvador Minuchin Arnold Sameroff Urie Brofenbrenner
Infant Research	Infant's own innate capacity for self-regulation, communication, interactions.	Daniel Stern Ed Tronick
Population Mental Health	Cultural and social factors impacting infant development and mental health; risk and protective factors; social policies, advocacy.	Urie Brofenbrenner James Mustard

One of the key premises in IECMH is that infants develop in the context of key caregiving relationships. Contemporary approaches conceptualises presenting concerns within the caregiving relationship rather than attributing problems to either the individual child or parent. Furthermore, IECMH has been defined as the following:

- *"Multi-disciplinary field of research and clinical practice. At its core is the recognition that infancy is a foundational developmental period (physically, psychologically and socio-culturally)"* (Mares, Newman, Warren, 2011).
- *"the young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished in the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development"* (Zero to Three, 2001 from Zeanah, 2009).

- Zeanah and colleagues (2009) further describe infant mental health as *"a multidisciplinary professional field of inquiry, practice and policy, concerned with alleviating suffering and enhancing the social and emotional competence of young children. Infant Mental Health is multidisciplinary Because of the complex, interrelated nature of human development and its deviations requires expertise and conceptualisations beyond the capabilities of any particular discipline."*

1 - Ghosts in the Nursery.pdf

Read:

'Ghosts in the Nursery' by Fraiberg, Adelson & Shapiro (1975).

'Infant Mental Health' was a term coined by Selma Fraiberg in her seminal article 'Ghosts in the Nursery'.

The article explored difficulties in 'impaired' Mother-Infant dyads from a Psychoanalytical perspective, and how such difficulties are a result of a parent's 'emotional baggage' or own unresolved childhood emotional difficulties (hence, the influence of a caregiver's 'ghost' on the developing infant and subsequent transmission of attachment patterns within families.

2 - The Scope of Infant Mental Healtl

Read:

'The Scope of Infant Mental Health' by Zeanah & Doyle-Zeanah (2009).

This is a great article for clinical staff to conceptualise infant mental health as a sub-specialty of child and youth mental health.

Reflect:

How do the key influences/theories of IECMH align with your own practice frameworks? Is IECMH in line with Recovery and Strengths based models in contemporary CYMHS models?

Key Message:

Contemporary approaches to both infant and perinatal mental health emphasise and **focus on the infant-caregiver relationship** rather than an individual within a dyad (AAIMHI WA, 2015).

Theoretical shifts in IECMH

Over recent years, a shift as occurred in infant research, from "one-person developmental psychology" (that is, focus on the mother, baby, and mother-baby interaction) to a systemic approach whereby each individual is part of a wider, more complex system whereby a symbiotic relationship exists (i.e. one part or aspect of the system will affect other aspects, and ultimately the system or environment as a whole). A systems perspective on IECMH would therefore consider not just the health and function of an infant, but the complex organisation of the whole support system (Sander, 2000). For example, a systemic approach to IECMH may include the infant, caregiver, extended family, community, culture, and society as a whole. Although each of these systems is equally complex within themselves, the complex matrix of their component parts are all in direct relation to the function of the living system (i.e. infant-caregiver). A state of coherence - part is related to part, part to whole, and whole to part provides the integration or unity essential for the optimum developmental outcome for the infant who remains the central focus (Sander, 2000). Systems Theory plays a particularly crucial role in IECMH interventions, whereby an all-inclusive systemic approach and state of coherence is an essential feature of enduring change in the infant, caregiver, environment and society.

Over the past few decades, advancements in the field of neuroscience (including neuro-imaging) have further enabled infant researchers and clinicians alike to offer more detailed and integrated psycho-neuro-biological models of both normal and abnormal development (Schore, 2001). Historically, neuroscience has provided useful insights into both circuitry, and neurochemistry and their interface with biological or hereditary/genetic influences on the developing brain (Shonkoff & Phillips, 2000). Consequently, our understanding of concepts such as cognition, emotion, and behaviour has been more acute and intricate than ever. It is recognised that early experiences have a direct effect on the growth, development, and circuitry of the infant brain (Perry, 1999; Schore, 2001; Mares, Newman & Warren, 2011). Infant brain development is experience dependent, and developing neuronal pathways respond to environmental stimulation, whereby the environment is represented by the infant-caregiver relationship (attachment) (Mares, Newman & Warren, 2011). Hence, the number of positive infant- caregiver interactions is likely to strengthen associated neuronal pathways, which act as a buffer against maladaptive brain function and associated pathology such as mental illness.

Embracing the bio-psycho-social-cultural model within IECMH, the emergence of mirror neurons and "affective neuroscience" whereby interpersonal relationships, subjective experience, and examination of the infant-caregiver dyad is dominating current research in IECMH (Siegel, 1999). Thus, neuroscience is a critical aspect of IECMH, in both research and clinical work, with the earliest intervention serving to reduce rates of maladaptive human behaviour and psychopathology and consequently the quality of life for infants, parents and society as a whole.

Key Message:

Neuroscience (and the impact of trauma on optimal neurological development) is one of the most important facets of IECMH.

Five Main Principles of Infant Mental Health

Lieberman (1998) proposed there are 5 main principles of Infant Mental Health that both define and transcend specific theoretical frameworks of traditional 'child and youth' mental health. Specifically, looking at external behaviours as an expression of inner subjective experiences, and how we as infant mental health clinicians frame and undertake interventions.

1. **Babies are by nature social creatures.**

They exist and develop in the context of relationships, and their functioning needs is assessed and understood within the framework of these relationships.

Babies often have meaningful relationships or multiple attachments to various caregivers who have a regular role in their life (e.g. day care providers, parents, kin, foster carers). This is a mitigating factor against relationship 'ruptures', and considers the infant as a member of a wider caregiving network, which is why committed family and community networks and social supports are critical.

2. **Individual differences are an integral component of infant's functioning.**

Traditional developmental principles are enhanced by each infant having individual differences (e.g. culture, temperament, epigenetic factors) influencing an infant's overall functioning.

3. **Every individual exists in a particular environmental context that deeply affects the person's functioning.**

Caregivers are not individual 'agents' in shaping their infants. How an infant is raised has been influenced by not only the caregivers experience of being raised, but also by everyday circumstances of their lives, the resources to which they have access and the quality of life they can provide (from basic safety needs, access to supports services).

Understanding the individual differences within infants needs to consider the psychological and sociological configurations created by caregiver's culture and specific circumstances.

4. **Infant mental health clinicians make an effort to understand how behaviours feel from the inside, not just how they look on the outside.**

Attunement to subjective meaning of behaviours and external circumstances propels the mental health clinician to search for answers which are often psychodynamic in context. *For example*: 'How does this 10-month-old feel when she is switched from foster carer to parent without any transition time?' or 'How does one caregiver feel when arriving home to find me (as the clinician) speaking to their partner?' or 'How does a 2-year-old feel whilst they are having a tantrum'.

5. **Clinician's own feelings and behaviours have a major impact on the intervention.**

Mental Health Clinicians need to be acutely aware of their own feelings and reactions towards each of the family/kin/caregivers involved with the infant we are working with, how we respond to our own reactions, and how this could be perceived by said caregivers.

Parallel processes in therapeutic relationships are always at the forefront of the clinician's mind, which also guides the efficacy of our interventions and changes focus from being on outer behaviours 'what we see' to 'what we can and can't see'.


"Every day in a hundred small ways
our children ask, "Do you see me?
Do you hear me? Do I matter?"
Their behaviour often reflects our
response"
L.R. Knost

‘Normative’ Infant Development

As a mental health professional, it is useful to have an understanding of normal child development. Having a basic knowledge will assist in being able to recognise when an issue may exist, when formulating, and providing an intervention.

Development is the term used to describe the changes in an infant/child’s physical growth, as well as their ability to learn the social, emotional, behaviour, thinking and communication skills they need for life. All of these areas are linked, and each depends on and influences the others.

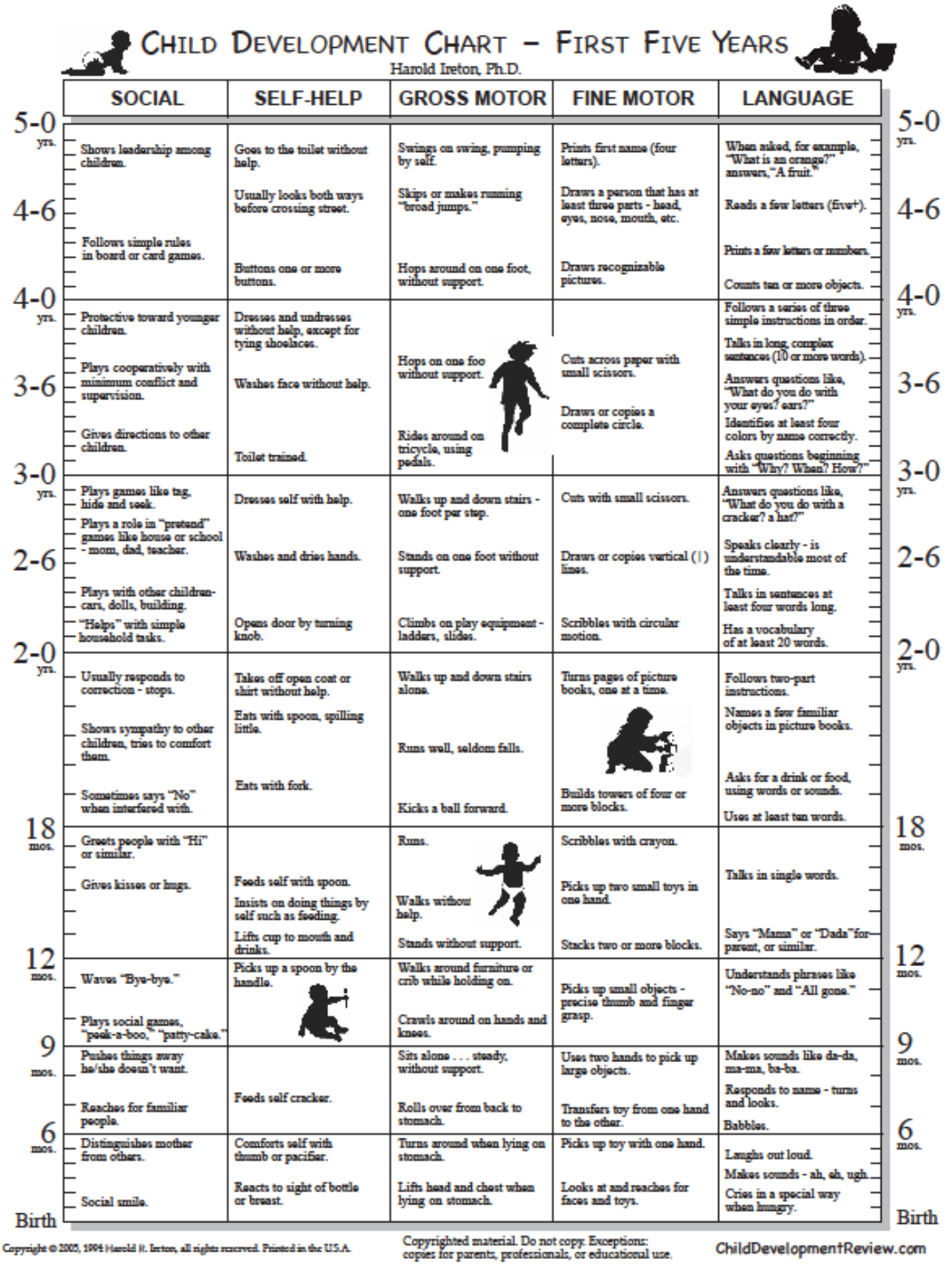
Overview of Early Childhood Development

The National Research Council and Institute of Medicine (Shonkoff & Phillips, 2000) summarised the underlying principles that guide developmental processes into the following core concepts. Consider each of the core concepts through an infant mental health lens.

1. Human Development is shaped by a dynamic and continuous interaction between biology and experience
2. Culture influences every aspect of human development and is reflected in childrearing beliefs and practices designed to promote healthy adaptation
3. The growth of self-regulation is a cornerstone of early childhood development that cuts across all domains of behaviour
4. Children are active participants in their own development, reflecting the intrinsic human drive to explore and master one’s environment
5. Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development
6. The broad range of individual differences among young children often makes it difficult to distinguish normal variations and maturational delays from transient disorders and persistent impairments
7. The development of children unfolds along individual pathways whose trajectories are characterised by continuities and discontinuities, as well as by a series of significant transitions
8. Human development is shaped by the ongoing interplay among sources of vulnerability and sources of resilience
9. The timing of early experiences can matter, but more often than not, the developing child remains vulnerable to risks and open to protective influences throughout the early years of life and into adulthood
10. The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favour of more adaptive outcomes

All children develop at different rates. Some children are slower than others (developmentally delayed) but catch up with time. Other children, however, may have underlying issues that might cause continuous delayed development. It is important for these infants/ children to get as much treatment (early intervention) as possible.

A great summary of normative child development (0-5 years) has been developed by Dr Harold Ireton (Figure 1). A copy of this can also be accessed here: http://dadsingear.ok.ubc.ca/wp-content/files/Child-Development-Chart-Handout-DIG-session-4.pdf.



Child Development Chart – First Five Years

Harold Ireton, Ph.D.

	SOCIAL	SELF-HELP	GROSS MOTOR	FINE MOTOR	LANGUAGE
5-0 yrs.	Shows leadership among children.	Goes to the toilet without help.	Swings on swing, pumping by self.	Prints first name (four letters).	When asked, for example, "What is an orange?" answers, "A fruit."
4-6	Follows simple rules in board or card games.	Usually looks both ways before crossing street.	Skips or makes running "broad jumps."	Draws a person that has at least three parts - head, eyes, nose, mouth, etc.	Reads a few letters (five+). Prints a few letters or numbers.
4-0 yrs.	Protective toward younger children.	Buttons one or more buttons. Dresses and undresses without help, except for tying shoelaces.	Hops around on one foot, without support.	Draws recognizable pictures.	Counts ten or more objects. Follows a series of three simple instructions in order.
3-6	Plays cooperatively with minimum conflict and supervision. Gives directions to other children.	Washes face without help. Toilet trained.	Hops on one foo without support. Rides around on tricycle, using pedals.	Cuts across paper with small scissors. Draws or copies a complete circle.	Talks in long, complex sentences (10 or more words). Answers questions like, "What do you do with your eyes? ears?" Identifies at least four colors by name correctly. Asks questions beginning with "Why? When? How?"
3-0 yrs.	Plays games like tag, hide and seek. Plays a role in "pretend" games like house or school - mom, dad, teacher.	Dresses self with help.	Walks up and down stairs - one foot per step.	Cuts with small scissors.	Answers questions like, "What do you do with a cracker? a hat?"
2-6	Plays with other children - cars, dolls, building. "Helps" with simple household tasks.	Washes and dries hands. Opens door by turning knob.	Stands on one foot without support. Climbs on play equipment - ladders, slides.	Draws or copies vertical (|) lines. Scribbles with circular motion.	Speaks clearly - is understandable most of the time. Talks in sentences at least four words long. Has a vocabulary of at least 20 words.
2-0 yrs.	Usually responds to correction - stops. Shows sympathy to other children, tries to comfort them. Sometimes says "No" when interfered with.	Takes off open coat or shirt without help. Eats with spoon, spilling little. Eats with fork.	Walks up and down stairs alone. Runs well, seldom falls. Kicks a ball forward.	Turns pages of picture books, one at a time. Builds towers of four or more blocks.	Follows two-part instructions. Names a few familiar objects in picture books. Asks for a drink or food, using words or sounds. Uses at least ten words.
18 mos.	Greets people with "Hi" or similar. Gives kisses or hugs.	Feeds self with spoon. Insists on doing things by self such as feeding. Lifts cup to mouth and drinks.	Runs. Walks without help. Stands without support.	Scribbles with crayon. Picks up two small toys in one hand. Stacks two or more blocks.	Talks in single words. Says "Mama" or "Dada" for parent, or similar.
12 mos.	Waves "Bye-bye." Plays social games, "peek-a-boo," "patty-cake."	Picks up a spoon by the handle.	Walks around furniture or crib while holding on. Crawls around on hands and knees.	Picks up small objects - precise thumb and finger grasp.	Understands phrases like "No-no" and "All gone."
9 mos.	Pushes things away he/she doesn't want. Reaches for familiar people.	Feeds self cracker.	Sits alone . . . steady, without support. Rolls over from back to stomach.	Uses two hands to pick up large objects. Transfers toy from one hand to the other.	Makes sounds like da-da, ma-ma, ba-ba. Responds to name - turns and looks. Babbles.
6 mos.	Distinguishes mother from others. Social smile.	Comforts self with thumb or pacifier. Reacts to sight of bottle or breast.	Turns around when lying on stomach. Lifts head and chest when lying on stomach.	Picks up toy with one hand. Looks at and reaches for faces and toys.	Laughs out loud. Makes sounds - ah, eh, ugh. Cries in a special way when hungry.
Birth					

Figure 1. Child Development Chart – First Five years by Dr Harold Ireton. (Accessed: 27.06.18)

Critical vs Sensitive Periods in Development

Ground-breaking (albeit macabre) research by David Hubel and Torsten Wiesel (1964) showed that if a kitten is deprived of normal visual experience during a critical period at the start of its life, the circuitry of the neurons in its visual cortex is irreversibly altered.

In kittens who had one eyelid sutured shut right after birth, when the eyelid was opened again at 6 months of age, the animals had lost practically all useful vision in the eye that had been sensory deprived. Yet recordings of electrophysiological activity in the ganglion cells of the retina of that eye, and the lateral geniculate nucleus cells for that eye, showed that these cells' visual fields were normal and functional. It was only the primary visual cortex cells for that eye that showed practically no activity.

So technically, the kittens weren't blind (from a structural or organic cause), but the deprivation of stimuli over the 6-month period had resulted in neurons in the visual cortex not 'firing', so the kitties couldn't see. Because Hubel and Wiesel seemed like such compassionate researchers, they replicated the results in monkeys. This opened our eyes (pardon the pun) to what is effectively known as a 'critical period' in development.

A ***critical period*** is a time when it is *essential* to be exposed to a specific stimulus in order to develop normally. It is usually very short in duration with well-defined abrupt beginning and end points. Essentially, if environmental input is not present during a critical period, brain development proceeds in a maladaptive fashion, and the associated skill acquisition will not appear.

Sensitive periods open a window of opportunity where experiences have a greater impact on certain areas of brain development. During sensitive periods, the brain is most likely to strengthen important connections and eliminate unneeded ones in a specific part of the brain. It is a time when it is key for an animal to be exposed to a specific stimulus in order to develop optimally. These periods are much more 'forgiving' during development, as they begin and end steadily. During a sensitive period, a time when experience has a differential effect on development.

Other experiments in which both eyelids were temporarily sutured shut showed that normal development of connectivity in the visual cortex does not depend on the absolute activity of the neural pathways from the two eyes, but rather on competition between the relative activities of these two pathways.

Figure 2 provides a summary of this information. Figure 3 provides a visual representation of the sensitive periods of brain development in relation to language, social skills, emotional literacy etc.

Sensitive period vs Critical periods		
	Sensitive periods	Critical periods
Starts and ends	Gradually	abruptly
During the period	It is a period of maximal sensitivity	The organism has heightened sensitivity to external stimuli that are compulsory for development of a particular skill
After the period	The skill can still be learned, but less efficiently	The cortical areas allocated for the particular skill will adapt and perform a different function.
Examples	Language development	Full development of visual capabilities (from @ 8 months to 3 years)

Figure 2. Sensitive period vs Critical periods.

Source: https://www.slideshare.net/Psyccounting/sensitive-periods-and-experience-dependent-learning-vce-u4-psych-aos-1-13637930

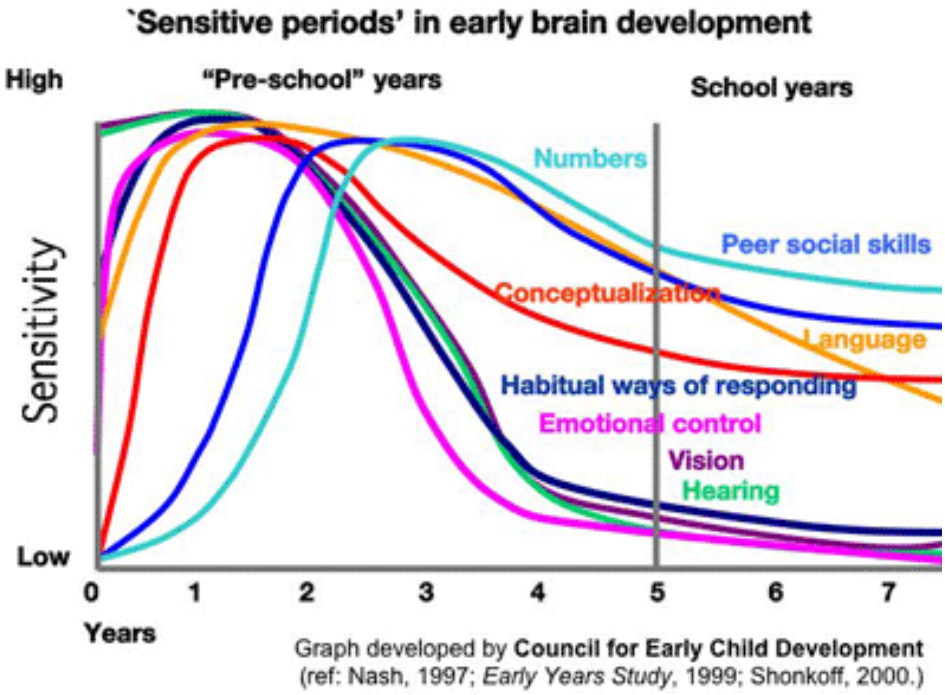


Figure 3. Sensitive periods in early brain development.

Source: https://www.newamerica.org/education-policy/edcentral/homevisiting-funding/

Figure 4 outlines critical periods from conception to birth. The red coloured bar indicates highly sensitive periods when teratogens[1] may induce major anomalies.

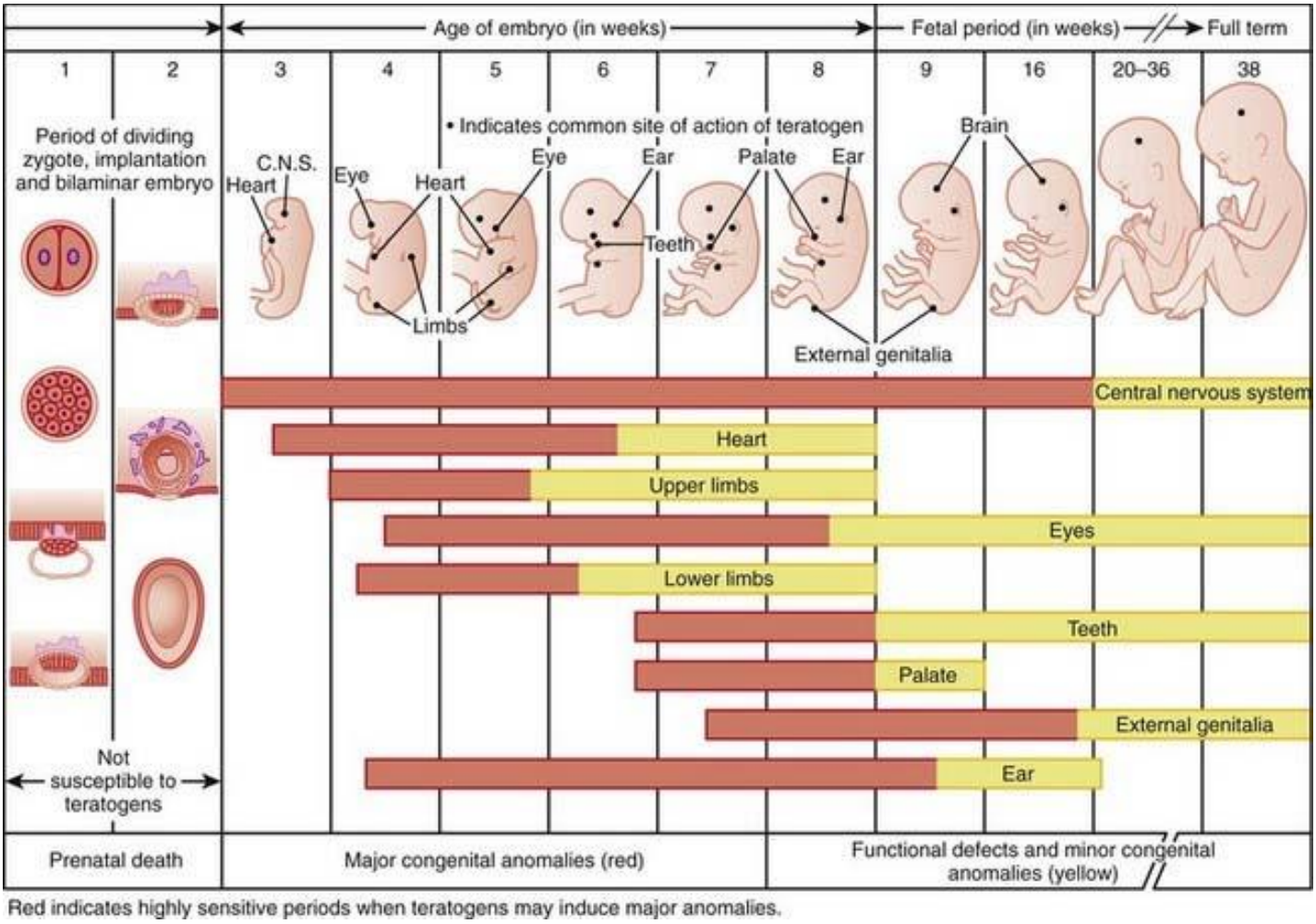


Figure 4. Critical periods in human development.

Source: https://clinicalgate.com/impact-of-age-on-pharmacology/

From Conception to Birth: An Outline of Early Brain Development

Whilst many ETS clinician's will have a very good working knowledge of early brain development from birth, the period of gestation is particularly unique and warrants further investigation. It also serves to give clinicians insight into why the exposure to alcohol, illicit and prescription substances and other potential teratogens Including exposure to excessive or toxic stress in utero can have significant, if not life changing impacts for a child.

First Trimester

The development of the brain begins in the first few weeks after conception (Figure 5). Most of the structural features of the brain appear during the embryonic period (about the first 8 weeks after

[1] Any 'agent' that can disturb the development of an embryo or foetus. Teratogens may cause a birth defect in the child. Or a teratogen may halt the pregnancy outright.

fertilization); these structures then continue to grow and develop during the foetal period (the remainder of gestation).

The first key event of brain development is the formation of the neural tube. About two weeks after conception, the neural plate, a layer of specialized cells in the embryo, begins to slowly fold over onto itself, eventually forming a tube-shaped structure. The tube gradually closes as the edges of the plate fuse together; this process is usually complete by four weeks after conception. The neural tube continues to change, eventually becoming the brain and spinal cord.

About seven weeks after conception the first neurons and synapses begin to develop in the spinal cord. These early neural connections allow the foetus to make its first movements, which can be detected by ultrasound and MRI even though in most cases the mother cannot feel them. These movements, in turn, provide the brain with sensory input that spurs on its development. More coordinated movements develop over the next several weeks.

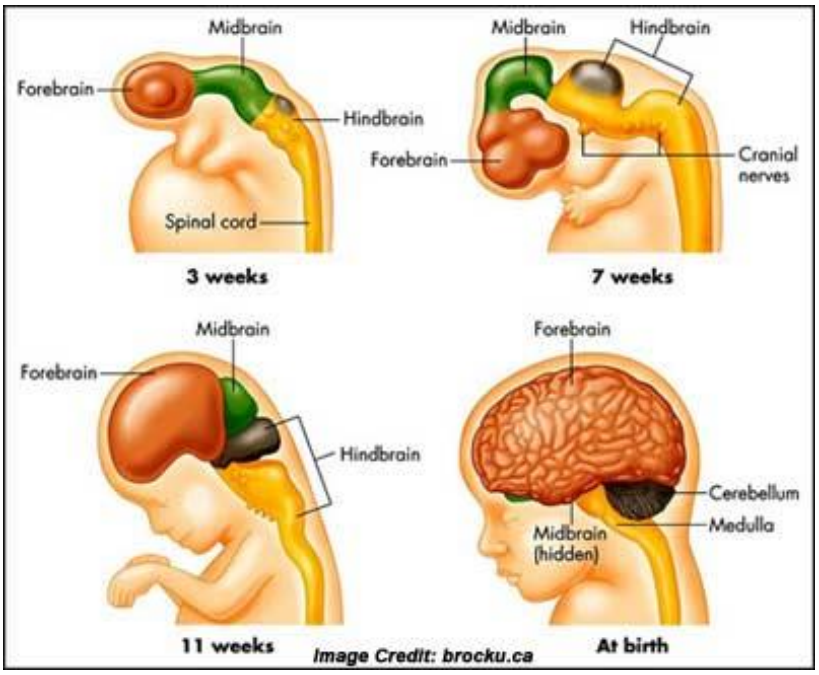


Figure 5. Brain Development from conception to birth.

Source: https://www.consumerhealthdigest.com/brain-health/seafood-and-brain-development.html

Second Trimester

Early in the second trimester, gyri and sulci (figure 6) begin to appear on the brain's surface; by the end of this trimester, this process is almost complete. These are basically fancy Latin words to describe the 'furrowed' or convoluted folded areas of the cerebral cortex. The cerebral cortex is growing in thickness and complexity and synapse formation in this area is beginning.

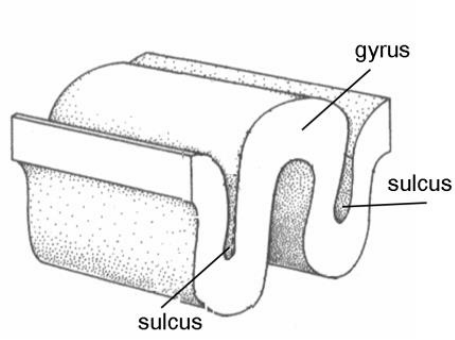


Figure 6. Image of Gyri and Sulci.

Source: http://www.meritnation.com/ask-answer/question/what-are-gyri-and-sulci/biology/556071

Myelin begins to appear on the axons of some neurons during the second trimester. This process – called myelination – continues through adolescence. Myelination allows for faster processing of information: for the brain to achieve the same level of efficiency without myelination, the spinal cord would have to be almost 2.8 meters in diameter. Myelination can be thought of as an insulating and protective coating (myelin sheath) around the axon of nerve cells. If the development of the myelin or the sheath damaged as a result of teratogens or other agents following birth, the messages between nerves (processing of information etc.) can be reduced/impacted upon considerably (Figure 7).

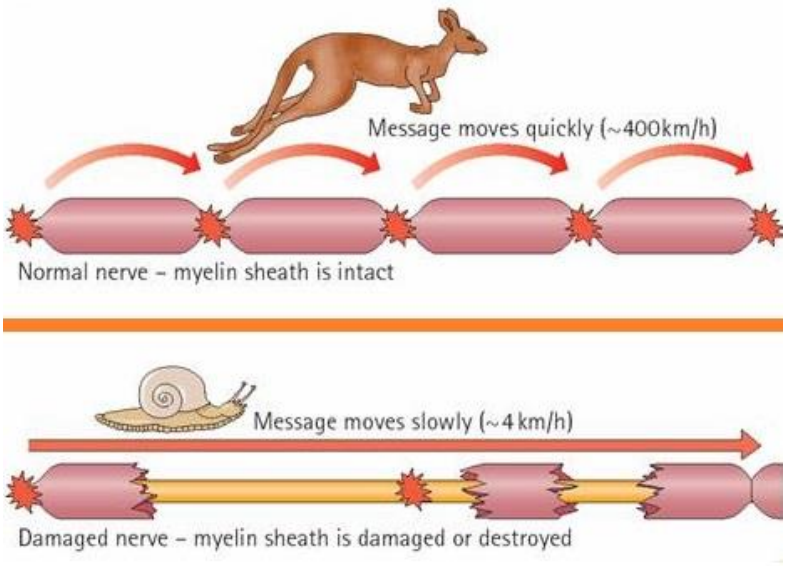


Figure 7. Myelin sheath information processing – intact and damaged.

Source: https://msmosceal.files.wordpress.com/2014/01/picture4.jpg

Third Trimester

The early weeks of the third trimester are a transitional period during which the cerebral cortex begins to assume many duties formerly carried out by the more primitive brainstem. For example, reflexes such as foetal breathing and responses to external stimuli become more regular. The cerebral cortex also supports early learning which develops around this time. The third trimester of pregnancy is particularly important for the foundational development of the mid brain and stress response system. A significant brain growth spurt occurs during this period, making the developing brain especially sensitive to the effects of stress. Research indicates that high levels of maternal corticotropin-releasing hormone during the third trimester can negatively affect optimal foetal brain development.

Reflect

Given what we know about the role of brain development throughout gestation, what could be some implications to infants born premature, before the important structures and tasks are formed?

Explore

For further detailed information about normative child development, and more, click on following links:

- Raising Children Network: Newborn, 0-3 months
- Raising Children Network: Infant, 3-12 months
- Raising Children Network: Toddler, 1-3 years
- Raising Children Network: Pre-schoolers, 4-5 years

Infant & Early Childhood Development in Aboriginal and Torres Strait Islander Culture

'Optimal' infant development is undoubtedly the goal that most parents strive for when raising their children. But what is 'optimal' development, and how might this differ or relate between Western and Aboriginal and Torres Strait Islander ideals? According to Peterson (2010), optimisation involves applied interventions to maximise individuals' opportunities to develop their physical and psychological potential to the full. This generally relates to cognitive, physical, emotional and social constructs. Despite considerable diversity between indigenous communities, clans and people throughout Australia, Aboriginal and Torres Strait Islander perspectives on healthy infant development are far more holistic and community based. The Aboriginal and Torres Strait Islander cultural competence framework (Victoria Department of Human Services & Victorian Aboriginal Child Care Agency, 2008) states that culture and the maintenance of culture is central to healthy infant development and identity formation in Aboriginal communities.

Furthermore, an Aboriginal and Torres Strait Islander child's development is based on:

- Seeing the whole child, not just the child's educational, physical or spiritual needs in isolation
- The child's relationship to the whole family, and not just their mother or father
- The child's relationship to the whole community, not just to the nuclear family
- The child's relationship to the land and the spirit beings, which determine law, politics and meaning

(Victoria Department of Human Services & Victorian Aboriginal Child Care Agency, 2008).

Hence, when examining potential risk and protective factors to infant development in an Aboriginal and Torres Strait Islander population, one must consider 'optimal' development in a holistic framework.

The separation of Aboriginal and Torres Strait Islander children from families and communities which has occurred throughout the period of colonisation in Australia, has been linked to the concept of intergenerational trauma in indigenous people (Ryan, 2011).

The effects of colonization on the Aboriginal and Torres Strait Islander people has made it challenging for them to maintain their traditional ways of caring for their children. Most Aboriginal and Torres Strait Islander families have experienced removal of their children or displacement of entire families into reserves, missions or other institutions and most families have been affected over one or more generations (Tracey, 2014).

The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004-2005 reported that stressful life events adversely affecting families occur at a ratio of 1:4 for Aboriginal and Torres Strait Islanders compared to that of other Australians (Australian Bureau of Statistics, 2006). The findings also confirmed that 'grief and loss' was the largest single factor to impact the wellbeing of Aboriginal and Torres Strait Islander people (ABS, 2006). Research further suggests that this unresolved grief and trauma significantly impacts a parent's emotional availability and parenting, and subsequent attachment security (Lyons-Ruth et al., 2003).

Yeo (2003) posits that the safety of secure attachment in Aboriginal and Torres Strait Islanders has been eroded by the impact of the 'stolen generations', damaging the confidence of indigenous adults to parent their children, having shared a history of not receiving adequate parenting and nurturing (Ryan, 2011; Jordan, Sketchley, Bromfield and Miller, 2010). Thus, inadvertently, exposing their

infants and children to theirs and others trauma. Hence, the intergenerational cycle of adverse developmental outcomes continues to permeate Aboriginal and Torres Strait Islander populations.

Therefore, for many Aboriginal and/or Torres Strait Islander children with ETS, their parents or kin may have been unable to implement the template of a positive cultural role model due to 'the dominant parenting style' (i.e. western parenting norms) and the impact of intergenerational trauma.

3 - Bonding and Attachment of Austr

Read

Please read the following article Yeo, S. S. (2003). *Bonding and Attachment of Australian Aboriginal Children*. Child Abuse Review, 12, 292-304.

Reflect

What are the parenting 'norms' in your family and culture, and what are some of the parenting 'norms' in Aboriginal and Torres Strait Islander families?

Key Message

- The impact of the stolen generations has eroded the confidence of many Aboriginal and Torres Strait Islander adults to parent their children, after not receiving adequate parenting and nurturing themselves.
- Intergenerational trauma, grief and loss continues to permeate Aboriginal and Torres Strait Islander populations.

Watch

Deepen your understanding of differences and similarities in various cultures ideas and practices related to infant development, watch "Babies" by Thomas Balmès (2010) DVD. Trailer: https://www.youtube.com/watch?v=QkytlvAEE2k&list=PLGeG8kEZAWkoJgK8HfMa11M-I_Nq3bMde

Developmental Red Flags

For a number of reason, outlined throughout this document, developmental delays are often common in children who have been neglected. The Child Development Program, Child and Youth Community Health Service, Children's Health Queensland Hospital and Health Service in conjunction with Brisbane North Primary Health Network have developed the 'Red Flags Early Identification Guide (for children aged birth to five years): Second Edition'. This guide is a health resource for professionals (including general practitioners, child health nurses, allied health professionals and early childhood educators) working with families, to help identify developmental concerns early, so families can receive support from the right professionals at the right time.

4 - Red Flags Early Identification Guide

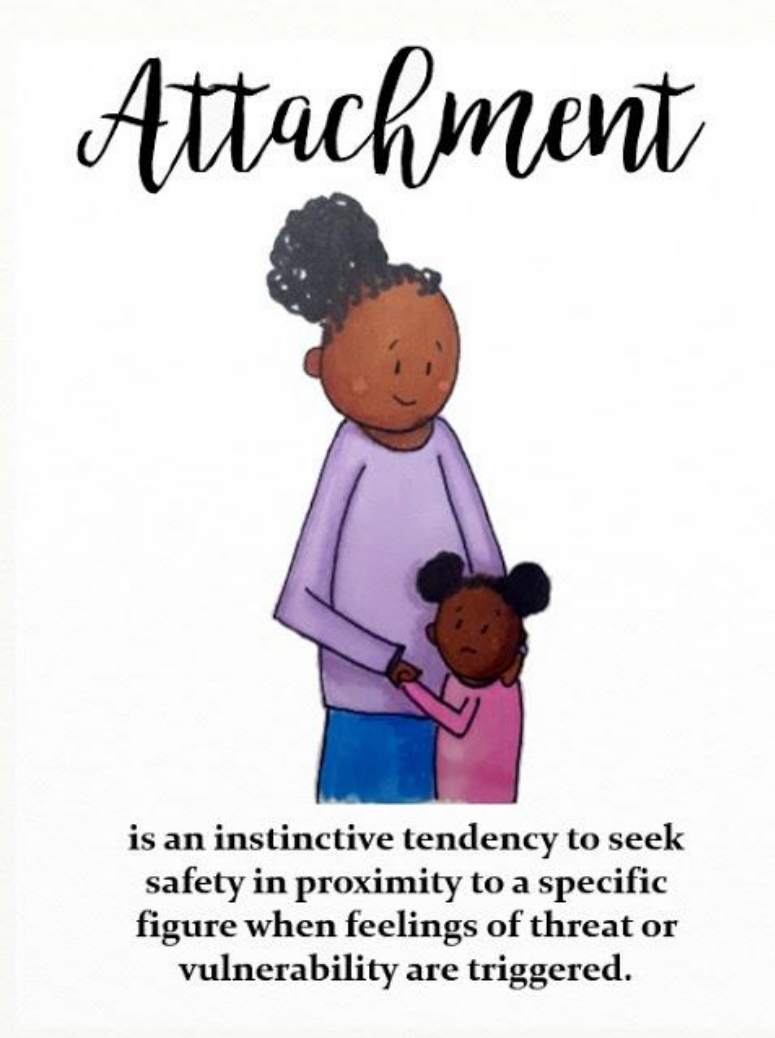
Read:

'Red Flags Early Identification Guide' (for children aged birth to five years): Second Edition (July 2016)

Developed by The Child Development Program, Child and Youth Community Health Service, Children's Health Queensland Hospital and Health Service in conjunction with Brisbane North Primary Health Network.

Attachment

We cannot explore IECMH without delving into the world of Attachment.



Source:http://bearinminddoodles.blogspot.com/2016/05/attachment-impact-of-early-relationships.html

Connection with other human beings and forming a bond is a fundamental need of humans, beginning early in life and continuing throughout the lifespan. Attachment is not only relevant to infants but impacts our lives from the 'cradle to the grave' because:

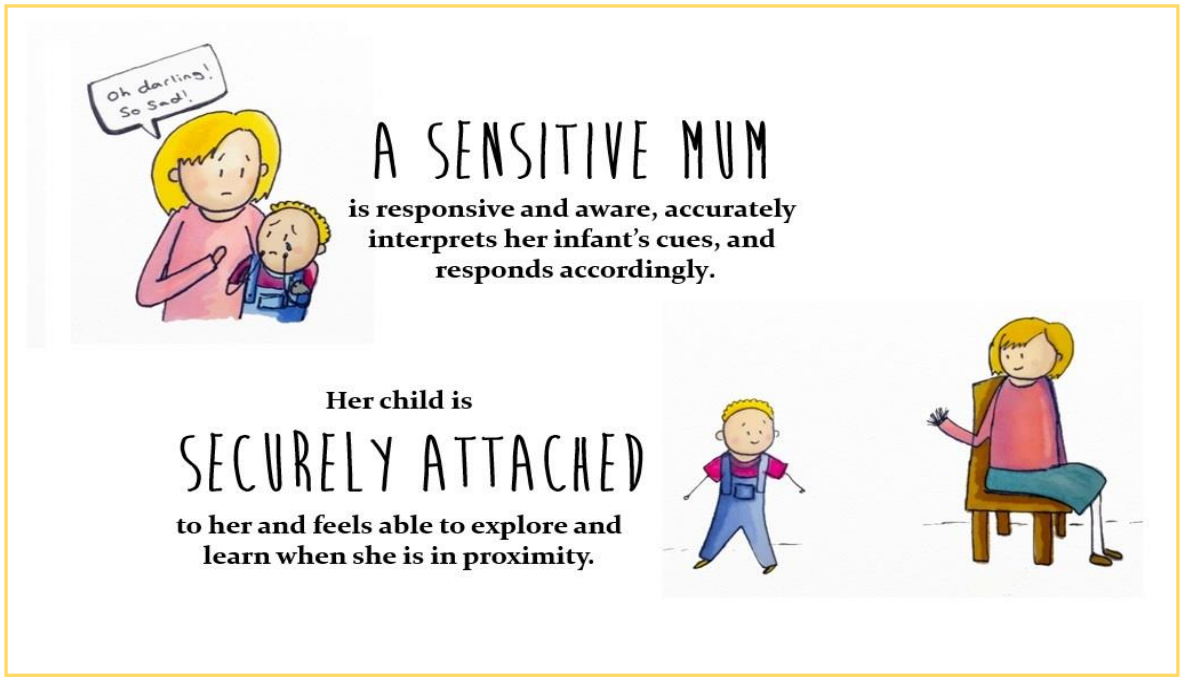
- being connected to others ensures survival both physically and emotionally
- it allows the brain to stay in a relatively calm state
- the process of attachment creates relational templates that effect how we view and experience relationships and how we view the world throughout the lifespan.

'Secure Attachment'

Patterns of secure attachment is characterised by infants clearly and directly communicating their needs and feelings to their care providers. They have confidence in their caregiver's willingness and ability to meet their needs. They are able to move all the way around the circle, moving from exploration (top of the circle/secure base) to coming in (bottom of the circle/safe haven) for comfort and/or protection as needed.

When a caregiver offers a meaningful, attuned and sensitive response to an infant (i.e. responding to their cues through talking, gesturing, facial expressions etc.), connections and neural pathways are reinforced in an infant's developing brain. These "serve and return" interactions form crucial foundational templates for development including language, behavioural control, motor skills, memory and emotional control and mastery.

Approximately 60% of infants demonstrate a secure relationship with their primary caregiver/s.



Source:http://bearinminddoodles.blogspot.com/2016/05/attachment-impact-of-early-relationships.html

Child:

- uses the caregiver as a 'safe base' to explore the environment
- seeks the caregiver out in times of distress
- easily soothed

Caregiver:

- consistently responsive and sensitive to the infant's signals
- consistently responds appropriately to the infant's 'needs'

Developmental Outcome:

- The infant has increased confidence in their caregiver's willingness and ability to meet their needs.

Insecure patterns of attachment are characterised by relationships where the infant cannot rely on their caregivers to consistently meet there needs. Below is a quick re-cap of Insecure Attachment patterns in infants: Ambivalent and Avoidant.

Insecure – Ambivalent (Resistant): "wearing your heart on your sleeve"

A child that has an insecure ambivalent attachment relationship with their primary caregiver tends to be characterised by a preoccupation with the caregiver and maintaining the caregiver's attention. The attachment pattern is developed when caregivers provide inconsistent care. At time the caregiver is sensitive and responsive, and other times they are absent or hard to engage – not reaching the ideal 30% of sensitive interactions. Often these children can be difficult to comfort and can appear clingy. As a result, the infant/child is less likely to explore their environment (top of the circle) and stays close emotionally and / or physically to the caregiver.

Source:http://bearinminddoodles.blogspot.com/2016/05/attachment-impact-of-early-relationships.html

Child:

- Dominance of Attachment over Exploration

Caregiver:

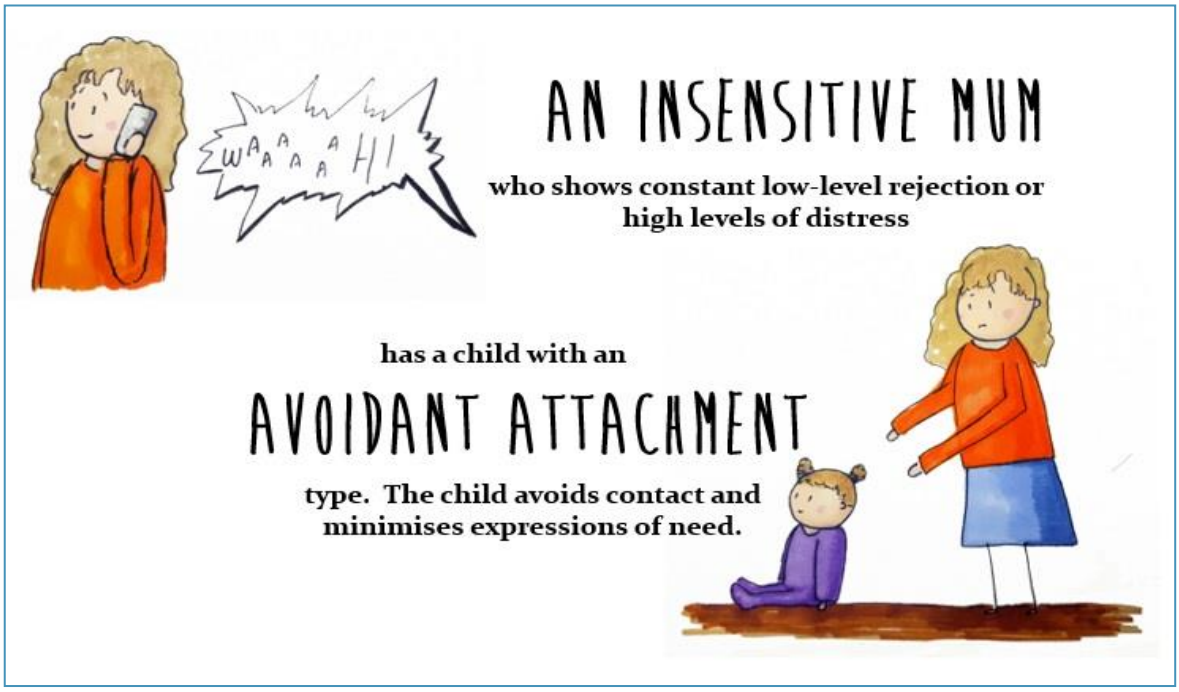
- Caregiver under-involved when infant distressed and had an expressed need; over-involved or intrusive when infant attempts to explore
- Inconsistently responsive to the needs of the infant
- Caregiver unavailability/inconsistency stems from responding more to their own needs, as opposed to infant's needs

Developmental Outcome:

- Heightened Attachment behaviour serves the infant by keeping caregiver close
- Reassures caregiver that the child will stay close and not leave.

Insecure – Avoidant: "Close but not too close"

A child that has developed an insecure avoidant attachment relationship with their primary caregiver tend to be focused on exploration and the environment (top of the circle) because they are less confident that their caregiver is available to respond to their need for connection and comfort (bottom of the circle). This attachment pattern is developed when caregivers are repeatedly unable to respond to infant's emotional needs and may become uncomfortable when the infant expresses emotions such as distress, fear and / or anger. Instead of responding to the child's needs, the caregiver dismisses, ignores or punishes the child/s needs and feelings. The child may also hide (miscuing) their attachment needs in order to maintain a relationship with the parent.



Source:http://bearinminddoodles.blogspot.com/2016/05/attachment-impact-of-early-relationships.html

Child:

- Close, but not too close, don't cross the intimacy line
- Dominance of Exploration over Attachment
- Hiding or Masking of Feeling

Caregiver:

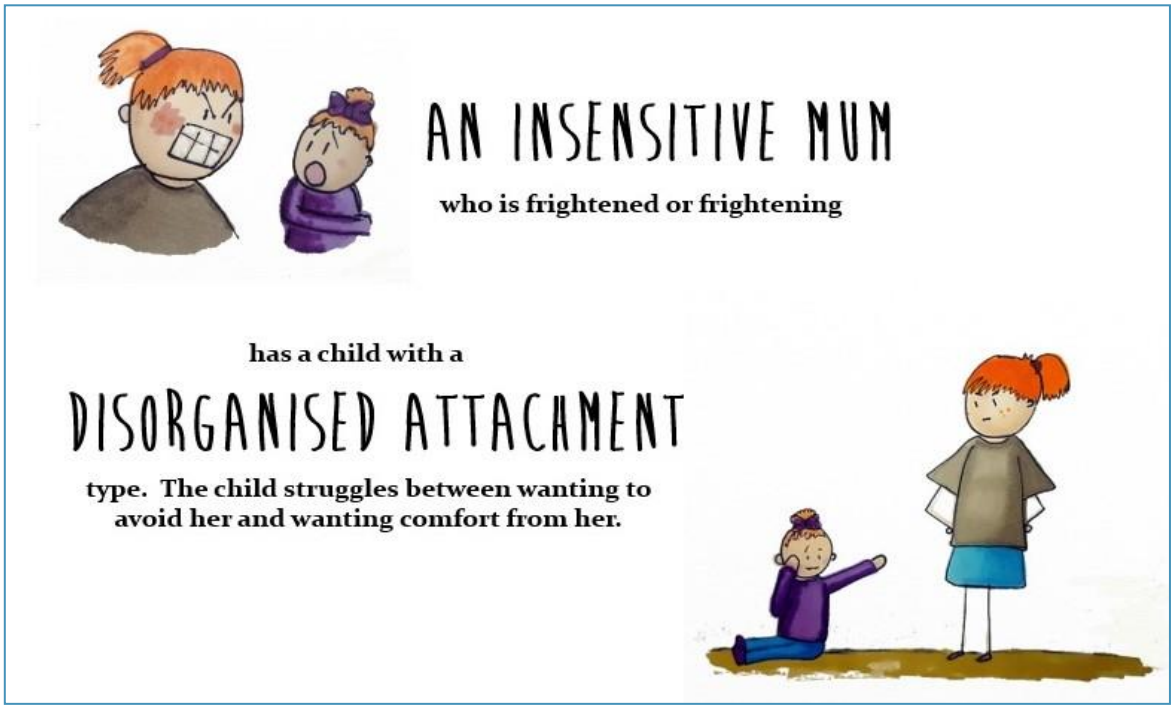
- Caregiver models emotions in a restricted range
- Caregivers purposely do not respond to negative or 'difficult' emotions such as emotional collapse or tantrum
- May withdraw from helping during difficult tasks
- Often unavailable during times of emotional distress.
- Praise and positive affect is linked to exploration rather than interpersonal exchanges
- Consistently unresponsive

Developmental Outcome:

- Infant is less confident that their caregiver is available to respond to their need for connection and comfort
- Avoidant behavior serves the infant by keeping caregiver distant as they are not uncertain how to respond to/trust caregivers attempts of connection and comfort.

Disorganised Attachment

A child that has a disorganised attachment with their primary caregiver is often faced with the irresolvable paradox of the caregiver being both the source of the child's fear and the source of safety (the safe haven). This paradox leaves the child feeling chronically afraid and alone with no-one to turn to. The infant will often show a combination of ambivalent and avoidant patterns of relating to the caregiver. At times they appear independent, but then will be demanding and clingy at other times. They can appear to approach their caregiver, but finding it hard to do so they can be seen to freeze or appear dazed: "I need you, but you can be frightening or frightened, that think I have no one to turn to and I don't know what to do".



Source:http://bearinminddoodles.blogspot.com/2016/05/attachment-impact-of-early-relationships.html

Child:

- Acting towards their caregiver with a self-reliant, compliant or caretaking manner
- Acting in a controlling manner in an attempt to gain safety and predictability
- Violent anger alternating with feelings of helplessness

Caregiver:

- Frightening & emotionally unreadable

Developmental Outcome:

- The infant has no confidence in their caregiver's willingness and ability to meet their needs.

ETS 7 Key Attachment Principles

For more information in attachment, please enroll and complete the Evolve Therapeutic Services Foundations to Attachment course available via iLearn[2]. The training package outlines 7 key attachment principles. These principles explore both normally developing children and children developing under adversity. The 7 principles (Figure 8) include:

1. Experiences Build brain architecture
2. Safe haven and Secure base
3. Caregiver sensitivity patterns of attachment
4. Patterns of attachment
5. Internal working models
6. Attachment disruptions are traumatic
7. It's never too late for attachments

Figure 8. ETS 7 key attachment principles.

[2] iLearn is one of Queensland Health's Learning Management Systems (LMS), that hosts a large number of role specific mandatory education and clinical education packages for the Department of Health and the Hospital and Health Services. iLearn can be accessed 24 hours a day, 7 days a week remotely or via Queensland Health computers, and can be accessible on multiple electronic devices.

Alternative Criteria for Attachment Disorders of Infancy and Early Childhood

Many leading attachment theorists, such as Charles Zeanah Jnr and Alicia Leiberman, have recognised the limitations of the DSM-IV-TR and ICD-10 criteria and proposed broader diagnostic criteria. As such an alternative model of attachment disorders has been proposed by Charles Zeanah Jnr. and colleagues - one that more closely reflects both developmental research into attachment and clinical descriptions of "secure base distortions." The work of Charles Zeanah Jnr. and colleagues has refined descriptors of attachment disorders in infancy and early childhood, to illustrate some of the subtle yet distinct differences displayed by infants from the classic diagnostic criteria of 'Reactive Attachment Disorder' or 'Disinhibited Attachment Disorder'. The descriptors offer an assessing clinician a detailed synthesis that reflects developmental and clinical research.

> "This disorder occurs in the context of deprivation or maltreatment, including persistent and severe parental neglect or documented physical or psychological abuse. The disorder may develop when a child has limited opportunity to form selective attachments because of frequent changes in primary caregiver(s) or the marked unavailability of an attachment figure, as in institutional settings." (Zero to Three, 2016 p.17).

Charles Zeanah Jnr. and colleagues model delineates three types of attachment disorders: (1) **Disorders of Nonattachment** (similar to DSM and ICD), (2) **Secure-Base Distortions**, and (3) **Disrupted Attachment Disorder**. Where the psychiatric perspective of a one-person (one-child) pathology characterizes the first of these categories, the second and third are intended to capture pathology that may exist within a two-person context, pathology that is relationship (attachment) specific.

1. Disorders of non-attachment

This is categorised by infants who have not developed a clear preference for an identified attachment figure. Common where infants have experienced severe neglect and/or multiple changes of caregivers.

1. With emotional withdrawal
    a. Infant is emotionally withdrawn, unreactive and avoidant of social interaction or seeking comfort
2. With indiscriminate sociability
    b. Infant seeks interaction and comfort from available adults including strangers, showing no preference for an identified attachment figure (diffuse attachment relationships). May protest and become distressed on separation and/or make inappropriate behaviours to incite comfort-seeking. Common with infants from institutional caregiving.

2. Secure Base Distortions

1. Attachment Disorder with Self-Endangerment
2. Clinging/Inhibited Exploration
3. Attachment Disorder with Vigilance/Hyper-compliance
4. Attachment Disorder with Role Reversal

Although validation for the disorders of attachment known as secure-base distortions is not well established these relational pathologies may be more closely related to what clinicians encounter in referred populations. In fact the behaviours described in this category are reminiscent of childhood disturbances described by Fraiberg, Adelson, and Shapiro as early as 1975. The presentation of these symptoms is observed almost exclusively in the context of a specific attachment relationship.

The ***Self-Endangering*** sub-type refers to behaviours in which the child impulsively engages in exploratory behaviours unfettered and un-modulated by the opposing activation of attachment behaviours (e.g. proximity seeking, checking back). Aggression toward the self or caregiver is often present, as is significant risk-taking or self-endangering behaviour (e.g. running away from the caregiver in a public place, running into traffic, climbing to dangerous heights). Such children frequently come from homes where interpersonal violence has occurred and their behaviour suggests an attempt to activate the protective instincts of a caregiver who may be preoccupied, dissociative, passive, or unavailable in some other manner.

The ***Clinging/Inhibited Exploration*** sub-type describes a child for whom the attachment system is hyper-activated, to the detriment of the exploratory system. These children stick close to the parent but particularly when in unfamiliar settings. It remains unclear at what point such behaviour constitutes an actual disorder rather than a temperamental disposition.

The sub-type of ***Vigilance/Hyper-compliance*** describes a pattern in which the child is hyper-vigilant regarding the caregiver, hyper-compliant with caregiver requests, and emotionally constricted. The child impresses as frightened of displeasing or provoking the caregiver. This pattern has been previously described as “frozen watchfulness” in the literature on child abuse.

In the ***Role Reversal*** sub-type the child is observed to be preoccupied with the caretaking of the parent. In a manner that is developmentally inverted, the child seems to take on the responsibility of managing the parent’s emotional wellness, providing nurturance, empathy, even protection. In studies of children at age 6, role reversed controlling behaviours, frequently with an aggressive or threatening quality, were associated with disorganized-disoriented attachment classifications in infancy.

3. Disrupted Attachment Disorder

This type of attachment, which is not covered under other approaches to disordered attachment, acknowledges the centrality and profound impact that results from an abrupt separation or loss of a familiar caregiver to whom attachment has developed. The young child's reaction to such a loss is parallel to the grief reaction of an older person, with progressive changes from protest (crying and searching) to despair, sadness, and withdrawal from communication or play, and finally detachment from the original relationship and recovery of social and play activities. The deleterious effects often after the death of a parent and of the attachment disruptions inherent in foster care context.

Read

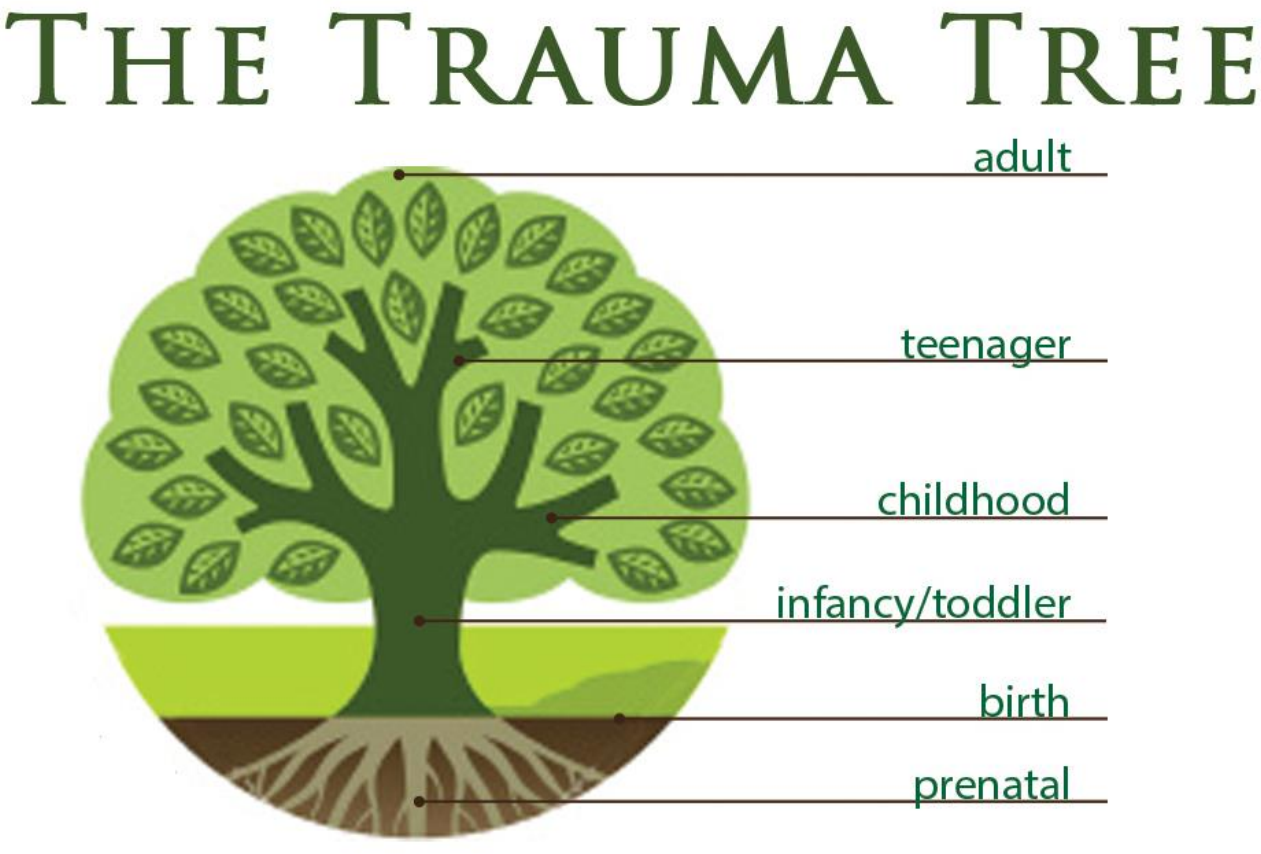
For more information on attachment Disturbance in Infancy, please read Schechter, D. S., & Willheim, E. (2009). Disturbances of Attachment and Parental Psychopathology in Early Childhood. *Child and Adolescent Psychiatric Clinics of North America*, *18*(3), 665–686.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690512/

A brief summary of some behavioural signs of disturbed attachment in young children (adapted from Boris & Zeanah, 2005), is outlined below.

Behaviour	Adaptive	Maladaptive
Affection	Showing affection across a range of interactions.	Lack of affection interchanges across a range of social settings, or “promiscuous" affection with relatively unfamiliar adults.
Seeking comfort	Seeking comfort from a discriminated adult caregiver.	Lack of comfort seeking when hurt, frightened, or ill, or comfort seeking in an odd or ambivalent manner (e.g., increased distress when the child does not seek comfort).
Reliance on for help	Willingness to seek help from discriminated caregivers when problems are too difficult to solve alone.	Excessive dependence on caregiver or inability to seek and use supportive presence of attachment figure when needed.
Cooperation	Generally cooperative behaviour with caregiver.	Pervasive lack of compliance with caregiver requests and demands as a pervasive feature interaction, or fearful overcompliance to caregiver instructions (“compulsive compliance”).
Exploratory behaviour	Uses attachment figure as a secure base from which to venture out and explore novelty in environment.	Failure to check back with caregiver in unfamiliar settings after venturing away or nearly complete unwillingness to leave caregiver to explore.
Controlling behaviour	Little evidence of controlling behaviour directed toward caregiver.	Oversolicitous and/or age-inappropriate caregiving behaviour by the child toward the caregiver, or excessively bossy or punitive controlling of caregiver by the child.
Reunion responses	If distressed, seeking comfort from attachment figure, or if not distressed, establishing a positive reconnection through nonverbal or verbal communication of positive affect or describing what transpired to child to separation.	Failure to re-establish interaction after separation including active ignoring/avoiding behaviours, intense anger, or obvious lack of affection, or failure to resolve distress engendered by separation, or any evidence of disorganized attachment behavior.
Response to strangers	Initial reticence about social engagement, which is more marked in unfamiliar settings.	Immediate engagement without initial wariness, extensive physical contact without referencing caregiver, willingness to leave caregiver (and go with stranger) without protest.

Section Two: Infant Mental Health in a Child Protection Context – Relevance for Evolve Therapeutic Services



Infancy is a period of great opportunity contrasted with great vulnerability. Infants are also undoubtedly our most vulnerable members of society for a multitude of reasons; biological and developmental immaturity, limited autonomy, complete reliance on their caregivers to provide a safe, secure, supportive, nurturing and nourishing environment and maximising their opportunities to optimal development. Their experiences – relationships, and the things they see, hears, touches, smells and tastes – stimulate their brain, creating millions of connections. Following conception, this is when the foundations for health, learning, health and behaviour throughout life are laid down..

The proportion of children subject to a notification, by age group, Queensland, 2016-17 indicates that the 0-4 age group was the highest represented, with 32% of all notifications[2].

According to Department Child Safety, Youth and Women data year ending 30th June 2017, the highest percentage of children subject to substantiated physical abuse were the 0-4 year cohort, with 36.1% of all cases [3].

According to the Queensland Child Death Case Review Panel Annual Report 2015-16, children aged under 12 months were the highest represented group in Child Death cases accounting for 32% of cases reviewed (Department of Communities, Child Safety and Disability Services (2017).

These figures continue to highlight that infants and toddlers are for a number of reasons disproportionately represented in the out of home care system within Queensland.

Of additional concern is recent research indicating that, almost one in three infants, who are reunified with their biological parents, will return to foster care (Wulczyn, Chen, Collins & Ernst, 2011 from Chinitz et al., 2017).

Outcomes for infants and toddlers in out-of-home care have historically been poor. They have significantly higher rates of medical, developmental and behavioural problems than their peers who are not in out of home care resulting from pre- and post-natal stressors on the developing brain and neuroendocrine systems (Shonkoff, Boyce & McEven, 2009 from Chinitz et al., 2017).

Impact of Trauma on Optimal Development

The literature is overwhelming - exposure to trauma (e.g., abuse, neglect, exposure to violence) affects every dimension of an infant's psychological functioning (i.e., emotional regulation, behaviour, response to stress and interaction with others) (Perry, 2002). Focus on the formative role that earlier experiences and exposures can have on later periods of development, both within and across individuals, has been a central tenet of developmental sciences for much of their history, as has understanding that neither health nor development commences just at birth (Prechtl, 1984).

Jordan and Sketchley (2009) eloquently remind us of the effects of trauma across all developmental domains:

> "Very young infants may be overwhelmed with intense negative emotions, manifesting in incessant crying, inability to be soothed, feeding problems, sleep disturbances, hyper-arousal

[3] https://www.csyw.qld.gov.au/child-family/our-performance/intake-phase/notifications

[4] https://www.csyw.qld.gov.au/child-family/our-performance/investigation-assessment-phase/substantiations

> and hyper-vigilance, and intense distress during transitions. Toddlers may experience intense separation anxiety, wariness of strangers, social avoidance and withdrawal, and constricted affect and play. They are likely to have reduced tolerance of frustration and problems with emotional regulation evident in intractable tantrums, non-compliance and negativism, aggression, and controlling behaviour. Extreme anxiety may be expressed as new fears, constricted and repetitive play, hyper-vigilance, reckless and accident-prone behaviour, and fear of body damage. Toddlers may regress and have somatic complaints (Drell, Siegel, & Gaensbauer, 1993; Zeanah & Sheeringa, 1996). These traumatic responses can lead to unmanageable stress in the infant–parent relationship (Lieberman, 2004)."

It can be difficult to detect the signs of emotional neglect in children who are not yet able to talk. Wotherspoon & Gough (2008) and others have outlined the following broad summary of the impact/effects of maltreatment, abuse,

and neglect on infants and toddlers. This is by no means an exhaustive list, but highlights some symptoms that might point toward emotional neglect (that might also be caused/attributed to other factors):

- Inconsolable crying or excessive tantrums that can't be explained by colic or illness
- Unusual passivity or listlessness, such as lack of eye contact or interest (paradoxically, babies who have been emotionally neglected are sometimes described by caregivers as very "good" babies – it is an important role of the Evolve clinician to be aware of "good" babies and mistaking their quiet compliance for mental wellbeing. Advocacy and educating other professionals and key partner agencies around identifying the subtle "less obvious" symptoms is a valuable and critical aspect of Infant Mental Health
- Altered sleep patterns, such as excessive sleeping for the child's age, or failure to establish a developmentally expected sleep/wake pattern
- Feeding or digestion problems
- Self-soothing behaviour such as rocking, chewing, head banging, or other odd or repetitive behaviour.

Stress & Defence Behaviours in Infancy and Early Childhood

Eliciting information around the level of distress an ETS consumer is experiencing can be obtained through a variety of ways (self-report, feedback from the care system, neuro-vegetative functions, performance, changes in general presentation and functioning etc.). When faced with the same challenges with an infant client (especially pre-verbally), many clinicians are unsure what 'signs' tell us that the infant is 'OK' or 'Not OK'. Many distress signals in infants can be challenging to identify unless they are so bizarre and/or overt in nature that the physiological and behavioural presentation can be overwhelming (for example, primitive responses such as growling, rocking, head-banging).

It is important for ETS staff to be reminded about some of the more common indicators of distress and trauma in infants, which are observable through our physiological states. Almost like an optical illusion, once the 'invisible' becomes 'visible', the clinician is able to readily identify distress and trauma in infants through careful observation and cross-domain collateral information (i.e. carers, parents, day care staff) to assist with assessment.

The following stress/defense behaviours in infancy and early childhood are indicators of processes in the Nervous System (specifically Sympathetic, Parasympathetic and Vagal).

Parasympathetic Nervous System – Ventral Vagal "Social Engagement" "OK"

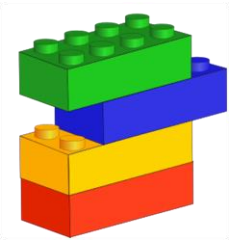
- Ability to relate and connect
- Circulation to non-vital organs
- Digestion and intestinal motility
- Immune response and resistance to infection
- Connected, safe and oriented to the environment
- Animated facial expressions including activated/involuntary orbicularis oculi muscular contraction (around eyes).

Sympathetic Nervous System – "Fight, Flight" "Not OK"

- Increased heart rate and blood pressure
- Irregular respiration
- Circulation to vital organs
- Changes in skin colour (cyanosed, mottled)
- Hyper-tonicity (fisting, arching)
- Frequent active gaze aversion
- Loss of bowel and bladder motility
- Spitting up, straining, yawning, hiccoughing
- Tremoring, startling
- Irritation, frustration
- Inconsolable crying
- Sleeplessness
- Decrease
- immune response.

Parasympathetic Nervous System – Dorsal Vagal "Freeze" "Not OK"

- Fuel storage & insulin activity
- Increased release of endorphins to help numb pain and raise pain threshold
- Numbness, shut-down
- Dissociation
- Hypo-tonicity (floppiness)
- Tachycardia and high blood pressure
- Pupils may be very small or dilated
- Skin tone may be pale and/or flushed
- Hyperventilation.



Explore

5 - 123 Care - A Trauma Sensitive Toc

"123 Care: A Trauma Sensitive Toolkit for Caregivers of Children". This resource was developed by Neighborhoods Matter/Weaving Bright Futures to provide a one page overview of potential triggering events and observable behavioural trauma responses (flight, flight, and freeze).

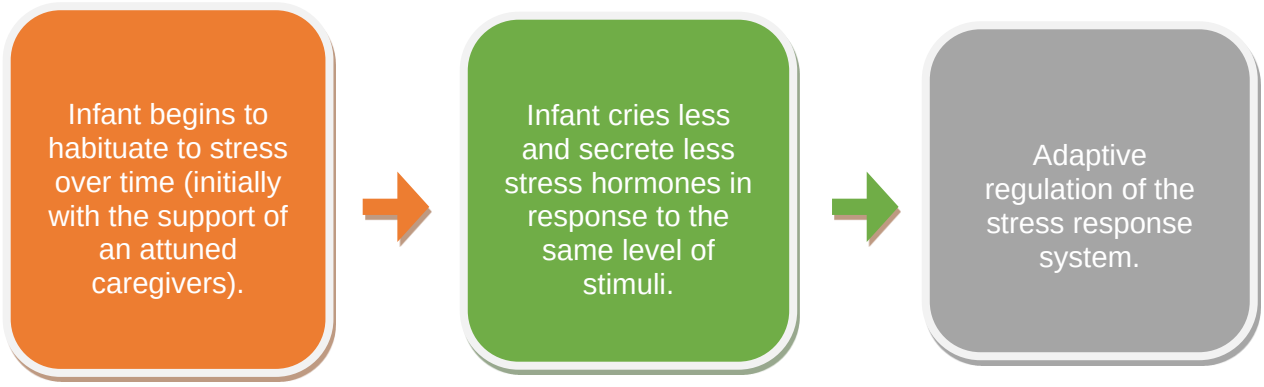
Source: https://srhd.org/media/documents/Poster2017x111.pdf

Like many of those referred to ETS, infants may often only come to the attention of staff with disruptive 'externalising' behaviours. In infants, the most obvious externalisation of distress (and arguably most challenging) is the infant who cries excessively.

Normative Stress Habituation in Infancy

Despite many caregivers smiling through gritted teeth, infant and young children's crying and tantrums are developmentally expected, and an important part of their social and psychological development.

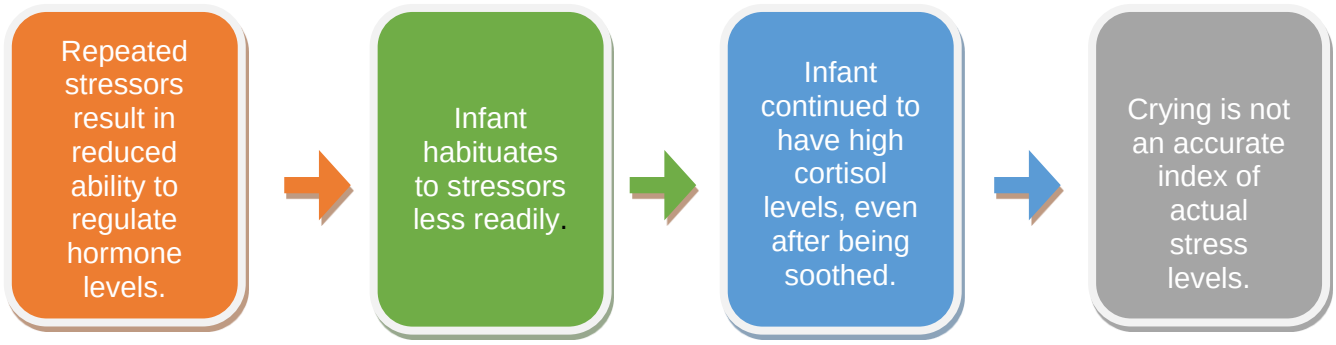
The expected normative stress habituation cycle in infants is as follows:



Impaired Responses to Stress in Infancy

In comparison, those infants and young children who are repeatedly exposed to stress without an attuned caregiver to support their habituation, develop maladaptive process of regulation of their stress response system.

As such, it can be difficult to interpret when an infant is actually distressed, as the emotional collapse can often manifest as 'freeze' behaviours including withdrawal (especially in young infants). Many infants will subsequently be mislabeled as 'good babies' or 'quiet babies', despite having excessive and toxic levels of stress, which can inadvertently contribute to the structure and function of the brain and peripheral organ systems, and overall physiology, behaviour and health.



In promoting and advocating for infants to be referred to Evolve Therapeutic Services, this is an important process to understand and raise awareness with referring Child Safety staff, as traumatised infants will often be overlooked in favour of older children with externalizing behaviours.

Specific concern related to the infant cohort: Failure to Thrive (FTT)

Failure to Thrive (FTT) is a term used to describe children under 5 years of age who have poor weight gain. Generally, FTT is described as weight less than the 3rd centile on 2 or more separate occasions, or weight which crosses two centile lines over time.

The following factors have been identified in the literature as contributing to an ***increased likelihood of an infant being diagnosed*** with FTT:

Parental Factors	Infant Factors	Environmental Factors
• Substance misuse • Family Violence • Poor parenting skills and knowledge • Untreated or poorly managed mental health issues and stress • Parental history of abuse • Poor infant-parent bond	• Premature or low birth weight • Chronic illness or disability • Feeding difficulties or food aversions • Behavioural or developmental problems	• Lack of pro-social and practical supports • Poverty • Isolation (Block & Krebs, 2005)

Whilst the above indicators or factors have been identified as contributing factors, they are not exhaustive.

The factors listed can ***increase the risk of infant neglect*** and FTT due to:

- Parent/s poor understanding of an infant's needs and cues, and how to respond to them
- Parent/s inability to provide appropriate nutrition and stimulation
- Parent/s previous experience of being parented/poor parental role models/absent parenting 'template'
- Increased stress when parents are unable to meet or understand the infant's basic needs
- Parent/s frustration when attempting to deal with difficult feeding issues or difficultly feeding due to illness or disability.

It is important to recognise that whilst there are sometimes underlying medical and or genetic vulnerabilities to an infant having FTT, FTT is usually considered more than just a case of a 'small child', and the complicating psychosocial risk factors including links to developmental and psychological delays mean that a FTT diagnosis should be considered salient in the ETS clinician's mind when gathering collateral information.

6 - Failure to Thrive.pdf

Read

For more information regarding Failure to Thrive, please see this document

Source:
https://pdfs.semanticscholar.org/37ea/08970bdf06574a98cfc91b55cddf0a2f2798.pdf

The table below compares normal brain development and the impact of trauma and neglect on development. It provides a useful reference for what you might see or observe in the children that could signify an issue that may need follow up or referral.

Age	Normal development	Indicators of trauma and neglect	Impact of trauma and neglect
0-12 months	• Anticipates relationship through facial expression • Focuses on face - gazes • Changes vocalisations to communicate • Smiles • Turns in direction of a voice • Initiates interactions • Participates in interactions • Communicates with expressions, gestures and some words • Begins to regulate emotions • Uses carer for comfort and can self soothe • Reaches for objects • Laughs • Notices strangers, likely to be wary • Anxious when separated from caregivers • Sits unsupported • May roll over or stand • Objects if toy is taken away • Able to recognise and imitate emotion	• Avoidance or lack of eye contact • Arching back, inability to be soothed or unable to relax • Disruption to eating and sleeping • Limp, displays no interest • Loss of eating skills • Increased tension, irritability, and reactivity - easily startled • Uncharacteristic crying • Increased clinginess • Lack of usual responsiveness • Loss of motor skills • Heightened indiscriminate attachment behaviour (goes easily to strangers) • Can appear numb - emotionless • Tactile disturbances • Loss of acquired language skills • Fight/flight or freeze response • Severe nappy rash • Being hungry • Infant doesn't meet physical and development milestones and there is no medical cause	Malnutrition • Failure to grow at the rate expected for age • Behaviour changes, irritability, anxious and listlessness Failure to thrive • Poor growth • Caused by multiple factors including psychological, behavioural and parent-child interaction factors • It can lead to long term adverse effects including developmental delay/damage

Age	Normal development	Indicators of trauma and neglect	Impact of trauma and neglect
1-3 years	• Enjoys communicating • Seeks comfort from familiar objects and people • Expresses more intense emotions • Doesn't like to be separated from familiar people • Walks • Develops language • Likes structure and routine • Likes to help • Can play alone and likes to explore • May be toilet trained	• Behavioural regression • Unable to relax, very reactive • Disruption of sleep and eating pattern • Avoids eye contact • Unable to be soothed • Aggression • Tactile disturbances • Unusually anxious when separated from caregivers • Heightened indiscriminate attachment behaviour (goes easily to strangers) • Can appear numb - emotionless • Loses language skills • Sexualised play • Insecure or disorganised attachment • Hyperactivity • Unable to manage emotions • Increase in resistance to parent's directions • Cognitive delays • Lack of communication • Memory deficits • Unkempt and unclean hair • Involved in serious accidents	• Language delay • Delayed physical development • Delayed socio-emotional development • Impaired attachment and may be indiscriminate in their social interactions • Emotional difficulties • Passive, withdrawn or aggressive behaviour • Shows less affection toward mother • May engage in more active exploratory behaviour

Explore

For further information refer to the 'Child development and Trauma' series developed in 2012 by the Department of Human Services, Victoria Australia, click on following links:

- Child Development and trauma guide - Introduction
- Development trends 0-12 months
- Development trends 1-3 years
- Development trends 3-5 years

Eight Things to Remember About Child Development

When considering the unique challenges faced by many infants and young children who have experienced early trauma and/or abuse and neglect, the Harvard Centre of the Developing Child has identified 8 things to remember about child development. These are:

1. Even infants and young children are affected adversely when significant stresses threaten their family and caregiving environments. ***Adverse foetal and early childhood experiences*** can lead to physical and chemical disruptions in the brain that can last a lifetime. The biological changes associated with these experiences can affect multiple organ systems and increase the risk not only for impairments in future learning capacity and behaviour, but also for poor physical and mental health outcomes.

2. Development is a highly interactive process, and life outcomes are not determined solely by genes. The environment in which one develops before and soon after birth provides powerful experiences that ***chemically modify certain genes*** in ways that then define how much and when they are expressed. Thus, while genetic factors exert potent influences on human development, environmental factors have the ability to alter family inheritance. For example, children are born with the capacity to *learn* to control impulses, focus attention, and retain information in memory, but their experiences as early as the first year of life lay a foundation for how well these and other ***executive function*** skills develop.

3. While attachments to their parents are primary, young children can also benefit significantly from relationships with other responsive caregivers both within and outside the family. Close relationships with other ***nurturing and reliably available adults*** do not interfere with the strength of a young child's primary relationship with his or her parents. In fact, multiple caregivers can promote young children's social and emotional development. That said, frequent disruptions in care and high staff turnover and poor-quality interactions in early childhood program settings can undermine children's ability to establish secure expectations about whether and how their needs will be met.

4. A great deal of brain architecture is shaped during the first three years after birth, but the window of opportunity for its development does not close on a child's third birthday. Far from it! Basic aspects of brain function, such as the ability to see and hear effectively, do depend critically on very early experiences as do some aspects of emotional development. And, while the regions of the brain dedicated to higher-order functions—which involve most social, emotional, and cognitive capacities, including multiple aspects of ***executive functioning***—are also affected powerfully by early influences, they continue to develop well into adolescence and early adulthood. So, although the basic principle that "earlier is better than later" generally applies, the window of opportunity for most domains of development remains open far beyond age 3, and we remain capable of learning ways to "work around" earlier impacts well into the adult years.

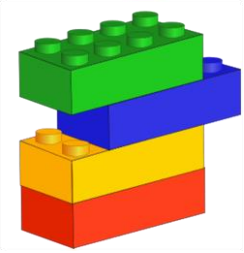
5. Severe neglect appears to be at least as great a threat to health and development as physical abuse—possibly even greater. When compared with children who have been victimized by overt physical maltreatment, young children who experienced prolonged periods of ***neglect*** exhibit more serious cognitive impairments, attention problems, language deficits, academic difficulties, withdrawn behaviour, and problems with peer interaction as they get older. This suggests that sustained disruption of serve and return interactions in early relationships may be more damaging to the developing architecture of the brain than physical trauma, yet it often receives less attention.

6. Young children who have been exposed to adversity or violence do not invariably develop stress-related disorders or grow up to be violent adults. Although children who have these

experiences clearly are at greater risk for adverse impacts on brain development and later problems with aggression, they are not doomed to poor outcomes. Indeed, they can be helped substantially if ***reliable and nurturing relationships with supportive caregivers*** are established as soon as possible and appropriate treatments are provided as needed.

7. Simply removing a child from a dangerous environment will not automatically reverse the negative impacts of that experience. There is no doubt that children in harm's way should be removed from dangerous situations immediately. Similarly, children experiencing severe neglect should be provided with responsive caregiving as soon as possible. That said, children who have been traumatized need to be in environments that restore their sense of safety, control, and predictability, and they typically require therapeutic, supportive care to facilitate their recovery.

8. Resilience requires relationships, not rugged individualism. The capacity to adapt and thrive despite adversity develops through the interaction of supportive relationships, biological systems, and gene expression. Despite the widespread yet erroneous belief that people need only draw upon some heroic strength of character, science now tells us that it is the reliable presence of at least one supportive relationship and multiple opportunities for developing effective coping skills that are the essential building blocks for strengthening the capacity to do well in the face of significant adversity.



Explore

Explore the Centre of the Developing Child '8 Things to remember about child development' resource further. This is a great resource to use when providing a summary of the impact of trauma on Infant and Early Childhood Development for Caregivers and Professionals.

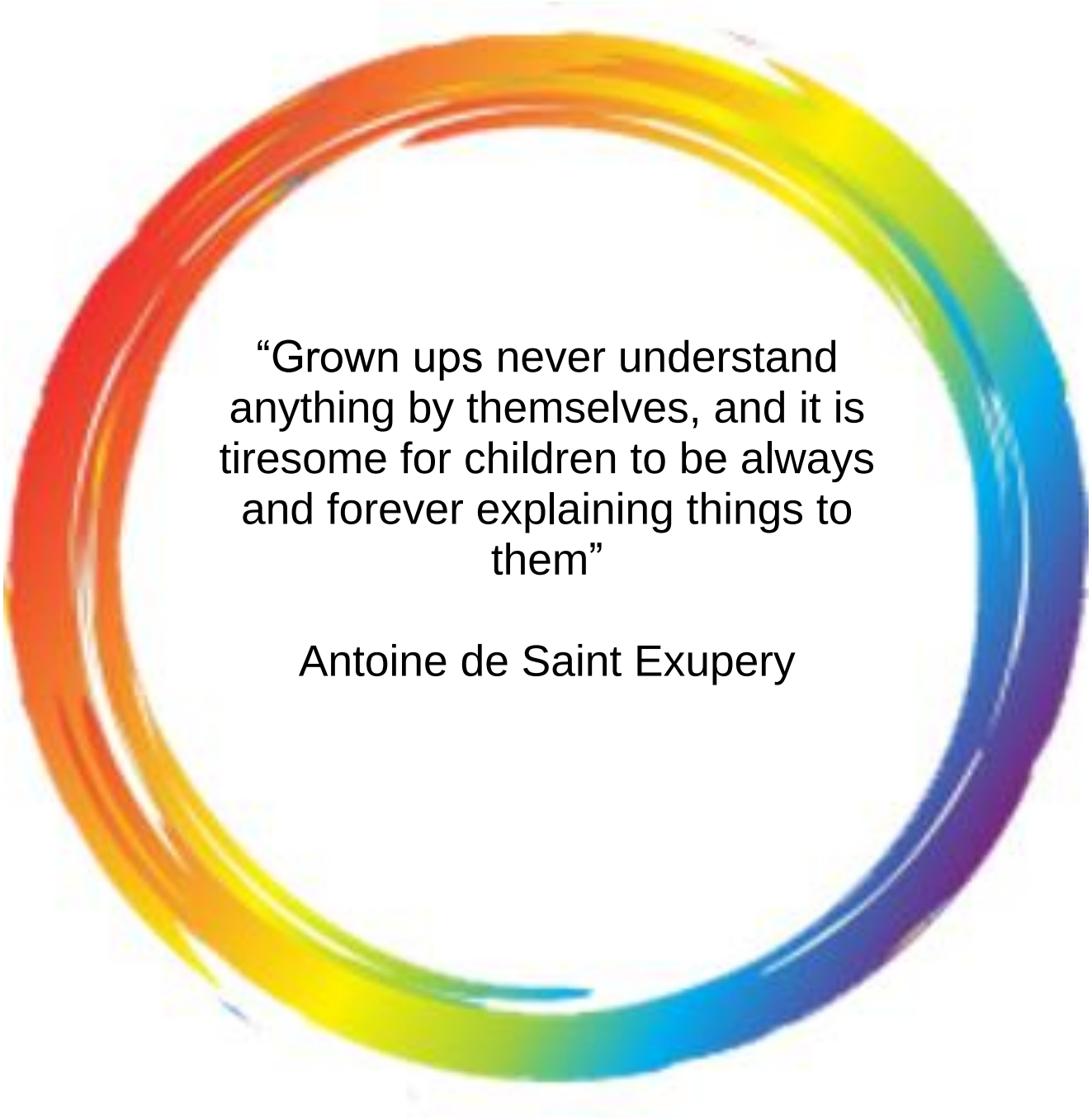
Source: www.developingchild.harvard.edu

Taking all of this information/issues/concerns outline thus far onto consideration, in 2017 the "A family-centred recovery orientated practice framework for infant and early years mental health: Evolve Therapeutic Service (ETS) State-wide Infant Mental Health Practice Framework Contextualising Document" was launched. This is a guiding resource to inform the practice framework for infant mental health within a tertiary mental health child protection setting, to enhance ETS workforce knowledge development and to enhance and inform ETS service provision when responding to infants and young children with a compromised trauma history. This document was informed by the Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) 'Practice Framework for Infant Mental Health' framework.

7 - ETS IMH Practice Framework Contexti

Read:

To enhance understanding of the practice framework for ETS when working with infants, young children, their carers and families, read the 'A family-centred recovery orientated practice framework for infant and early years mental health: Evolve Therapeutic Service (ETS) State-wide Infant Mental Health Practice Framework Contextualising Document"


“Grown ups never understand anything by themselves, and it is tiresome for children to be always and forever explaining things to them”
Antoine de Saint Exupery

Infant & Early Childhood Mental Health Assessment in ETS

The following will be covered within this section:

- Assessment of Infants
- Tools (psychometric measures/screeners/validated/normed/developmental)
- Infant Toddler MSE
- Diagnostic Formulation using DC: 0-5
- Observational Assessments
- Structured and semi-structured interviews with key caregivers
- Detailed developmental history incl. intergenerational patterns and trauma
- Systemic assessment of the infant-toddler (consider marix/who is the key caregiver/multiple attachment figures esp. in foster care).

Principles of Assessment in IMH

One of the most perplexing aspects for even the most experienced child and youth clinicians is 'what am I assessing?' This becomes even more obscure when an infant has multiple primary attachment figures, as in the case of ETS infants who are in the process of reunification with their biological caregiver. As such, the inevitable question becomes 'who am I assessing?' Granted, it is easy to become deceived by the allure of assessing a primary caregiver's capacity to meet the emotional and physical needs of an infant.

Infant Mental Health is explicitly relational in its focus, hence any diagnostic or classificatory system which explores or attempts to qualify difficulties should include attention to not only child psychopathology (intrinsic factors) but equally, between child and caregiver psychopathology (Zeanah & Lieberman, 2016). "Infant development is a consequence of the interaction between innate characteristics of the infant, the caregiving and interpersonal environment – the transactional model of development" Sameroff & Fiese (2000). Perhaps the most important question to continuously ask yourself then is - "What is the infant experience in this dyad?".

A comprehensive I-ECMH Assessment should comprise of the following:

- Observational Assessments
- Developmental Assessments
- Psychometric Assessments
- Interviews using IMH frameworks such as the Working Model of the Child Interview
- Infant Toddler Mental State Examination (ITMSE)
- Formulation & Diagnosis using an appropriate classificatory tool (DC: 0-5)

Read

8 - The clinical assessment of infan

Mares S, Graeff-Martins A. S (2012). The clinical assessment of infants, preschoolers and their families. In Rey JM (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.

The Assessment Process

This involves the integration of collateral information from a variety of sources, including:

- Questionnaires and Psychometric/Objective Assessments.
- Clinical interviews with caregivers (biological/kin/foster), other key family members, day care/kindy staff, GP.
- Intergenerational history, detailed perinatal and neonatal/medical information of both infant and biological Mother and biological Father (if available).
- Observational assessments of infant,
- Observational assessments of infant-caregiver interactions in free play/unstructured and structured activities.
- Formal Developmental Assessments.

Interviews and collateral information

Accuracy of information being reported by multiple sources, including biological parents, is ideal when completing an I-ECMH assessment, yet conflicting or inaccurate reports of information can offer important insights. The parent's perspective of the infant's history, temperament, role in family unit, traits, and interpretation of perinatal/neonatal information call tell us a plethora of clues about a dyad/family unit.

Key Message

- Inaccurate or inconsistent reports from biological parents and family can tell us important information about the child. Namely 'What is the infant/child's experience of being in this family unit?'
- Hypotheses, wondering, and *supported reflective supervision* around the clinical interview *utilising a psychodynamic lens* are ***critical*** for the clinician in formulation.

Recommended assessment tools and formats

Observational Assessments - How to observe the 'unobservable'.

Infant and Early Childhood observational assessments are a critical component of any IMH assessment. However, conducting observational assessments is a specialised skill, and best practice states that formal observational assessments require mental health clinicians to complete recognised training and supervision.

Formal training and supervision is critical as infant and early childhood observations are more complex than observations that occur with older children and young people. This is in part due to needing to be aware of the very subtle, often covert, behavioural/emotional changes in the infant/caregiver and the interaction between these subtle changes and potential internal/external reactions. Further it is due to clinicians more importantly needing to be mindful of the unconscious (and sometimes conscious) responses that can be inevitably experienced as a clinician when conducting observations and working with infants. Many clinicians can find this confronting and unsettling, as it may raise visceral memories of our own early years, or a sense of helplessness and feeling unable to figuratively 'rescue' the infant. Thus, needing to access supervision from someone who is experienced in, and trained in infant observations.

Guidelines for use of observational procedures in clinical settings (Miron, Lewis & Zeanah, 2009):

- Standardised assessment settings and procedures.
  - PROS: Consistency - administered in the same format, setting and materials.
  - CONS: Flexibility – does not allow for flexibility of needs of a dyad (e.g. cultural, developmental delays). Higher interrater reliability and validity, but should be used with caution when making clinical inferences about a dyad.
- Include both structured and unstructured activities in observational assessments.
  - Structured – useful for eliciting specific behaviours of interest.
  - Unstructured – flexible, less likely to constrain behaviour of caregiver.
- Ensure efficiency of the assessment procedure used – mimic behaviours of caregiver-child in "real life".
- Ensure developmental and cultural appropriateness of the procedure to the extent possible (keeping in mind the notion of 'optimal' and 'good enough').
  - Most observational procedures have been developed for and by Caucasian American populations, hence implications when generalising to other cultures.

    - The observer needs to consider the child's caregiving network systemically (not focus on one caregiver).
    - It is important that the observer explores the caregiver's beliefs about child development and parenting when interpreting behaviours.
- Ensure ease of interpretability of observations.
- Videotape/record procedures when and where possible.
    - PROS: Provides an opportunity on review to detect behaviours which may have not been picked up 'live'.
    - CONS: Most observational procedures have coding which require training to obtain reliability.

Mares, Newman& Warren (2011) highlight the importance of observing the "quality" of the interaction and relationship between an infant and their caregiver. They offer some suggestions on what to consider when observing interactions:

- Parental sensitivity to the infant.
    - The parent/caregiver is responsive to the infant's cues rather than being intrusive or insensitive. They are also able to identify and attuned to the infant's emotional state, and organise responses appropriately.
- Infant responsiveness to parental care and attention.
- The 'fit' between them.
    - Interactions are more often seamless, in that both parties are active participants in these interactions and communication. Both parties build or repair ruptures together, to restore optimal and tolerable levels of arousal.
- Infant and parent safety.

When observing an interaction or relationship dyad, the clinician is encouraged to note the language and communication used with or when talking about their infant. Mares, Newman, Warren (2011) suggest some examples could include:

- Offhand remarks and nick names.
- Stories (when a carer may consciously or unconsciously be talking about other people or situations but is describing something about the infant or their interactions with the infant.
- Non-verbal communication between parents/caregivers and between infant and caregiver (specifically facial expressions and touch).
- What the carer says to the infant, what they say about the infant, and how these compare.

Key Message

A safe and mutually regulating relationship between an infant and their caregiver is dependent on the caregiver's capacity to be empathic, perceive the mind of their child, reflect on their own experience of being parented and their inner state. Furthermore, the caregiver should be able to acknowledge what Mares, Warren & Newman (2011) term the infant as an "experiencing being" that is, to be with rather than do things to their child.

Infant Observation (Tavistock Method)

Esther Bick is largely credited with developing Infant Observation protocols (now often referred to as the Tavistock Method – originally referred to as *'Psychoanalytical Infant Observation'*. This, coupled with the work of Bowlby, Ainsworth, Main and James and Joyce Robertson's seminal videos documenting infant separations, have long been a part of formal Psychodynamic and Infant Mental Health post-graduate specialty training for Psychotherapists and mental health professionals alike.

Bick's model is centered around some key premises:

- Free floating attention - that is encouraging in therapists the capacity for this special kind of 'attention; scanning one's mind when observing, being close enough to experience (and relate to) others, and far enough away to have space to reflect.
- Being available for the 'intense emotional impact' of being within a family with a newborn baby.
- Learning to watch and feel before jumping in with theories, to learn to tolerate and appreciate how mothers care for their babies and find their own solutions'.

This has since morphed into much of what infant mental health clinicians utilize in 'reflective practice' or reflective supervision. For example, it would not be uncommon for an infant observation/IMH supervisor to frequently remind their supervisees to ensure they reflect on your own visceral responses and thoughts around how the interaction flows between caregiver and infant.

Reflect

Reid (2013) has made the following statement about Infant Observation: *"It strips away much of what we thought we knew and exposes the ignorance and prejudices in each of us. To observe well, the observer has to relinquish their current professional identity".* How does this notion sit with you? Reflect on your own thoughts and responses and whether you feel this is something that would feel natural or vulnerable.

This can be a confronting, alarming and, at times, challenging process for the clinician, as many of us have been trained to not consider our own thoughts, feelings and responses to our clients. In other words, we 'do' therapy with our clients, as opposed to being a part of the experience of the difficulties. It is critically important that the clinician continually wonder about the infant's experience (particularly pre-verbal infants) of 'being', and how caregivers own internal representations of caregiving, family roles, expectations and desires/'phantatsies' directly affect the dyad's burgeoning relationship. This is also where the psychodynamic themes of parallel processes, transference, counter-transference and projection become important throughout this process, and highlight why /how Psychoanalytic theories have influenced IMH as we know it today.

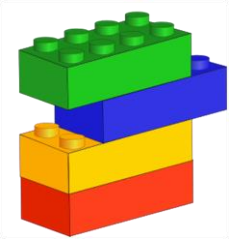
Key Messages

Infant observation is about seeing what there is to be seen, not to look for what a clinician think should be there. What you see is equally important as what you feel.

Infant observation is primarily about containment – one of the most useful theoretical concepts developed to aid us in understanding what our clients need throughout their lives in order to function effectively.

Observing young infants in particular can be an alarming experience for clinicians, as it strips the professional of usual competences designed to protect us from the unknown.

The observation process can be in itself emotionally and intellectually draining. Good infant supervision is essential!



Explore

Please review some of the infant behavioural cues that tell us whether an infant is okay or not okay that we touched on in earlier chapters. These are helpful reminders when completing an observational assessment of an infant (particularly a pre-verbal infant).

Infant Behavioural Cues (what we can see)

Approach / Self-Regulatory Behaviours

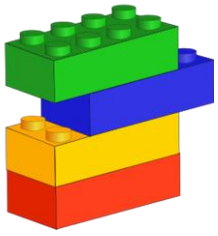
- Autonomic Stability
  - Pink undertone, stable skin colour.
- Motoric Stability
  - Smooth well-modulated posture, regulated tone.
- State-Stability & Attentional Regulation
  - Clear, robust sleep states, easily consoled, 'shiny-eyed' alertness & animated facial expressions.

Stress and Defence Behaviours

- Autonomic & Visceral Stress Signals
  - Irregular respiration, skin colour changes (mottled, cyanotic), spitting up, hiccoughing, straining, yawning, tremoring, startling.
- Motoric Signals
  - Hyper or Hypo-Tonicity (fisting, arching, floppiness).
- State-Related Stress Signals
  - Frequent active gaze aversion, inconsolability, sleeplessness and restlessness.

The Clinical Interview – Biological Family and Caregivers

Many clinicians may already have a template that they use when gathering collateral information on an infant or young child, to prompt important medical data and developmental milestones. It is important to use these templates / questions even in the IECMH space – if not more important given the knowledge you have gained from this document so far.



Explore

Explore/share with your colleagues some of the important perinatal, infant and developmental information that you gather when obtaining collateral during an assessment. Discuss why the maternal obstetric history, antenatal care, labour/delivery and infant's condition at birth can have important consequences and outcomes for the infant or young child.

Reflect

The psychological aspects of pregnancy and birth can have a profound impact on the relationship between a biological parent and their child. Questions to consider asking include, "Was this pregnancy planned/wanted?" and the parents' hope, dreams and wishes for their 'imagined baby' (including their gender). Answer to these questions can provide ETS clinician's important insights into the psychological representation of an infant in a family, and how this may have affected the burgeoning attachment between both parties.

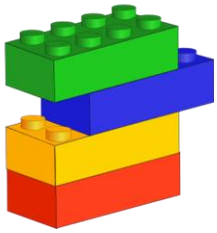
For those referred to ETS, what questions would you consider asking in order to enhance your understanding of the psychological representation of the infant for the biological parent when they child was born? Would these questions change if you asked them for a child that was aged 1 or 3? If so what would they be?

The Infant Toddler Mental State Examination (ITMSE)

When completing an initial assessment for an infant or young child, it is useful to use the ITMSE, as it provides both the clinician and reader with a richer description of the infant and how they present.

Reflect

After reviewing the ITMSE, reflect on what similarities and differences you noted between a CYMHS MSE and the format used in an ITMSE. Do you think the ITMSE is a helpful tool to use when assessing an infant/toddler/young child? If so, why?



Explore

Please look at the Infant Toddler Mental State Examination (ITMSE) attached below. One provides a basic overview, whilst the other provides more context and examples.

The following attachments are de-identified examples of how an ETS clinician might write up the ITMSE.

Whilst the usual data set within CYMHS teams designed to monitor and screen extend to the Strengths and Difficulties Questionnaire (SDQ), and clinician reported Health of the Nations Outcome Scales - Children and Adolescents (HoNOSCA), there is no defined screening tool to capture the psychological, social-emotional, developmental and adaptive behaviours of children aged 0-3 years. Acknowledging the importance of not only having effective tools to screen for more serious mental health and developmental concerns, but also to inform clinicians about treatment planning goals and progress, two options are discussed briefly below.

Some validated instruments available for measuring infant mental health include the Brief Infant-Toddler Social-Emotional Assessment (BITSEA) and Ages & Stages Questionnaire Social & Emotional Scales (ASQ-SE).

Brief Infant Toddler Social Emotional Assessment (BITSEA)

The BITSEA is an effective routine screening test of infants aged 12 to 36 months, which explores social-emotional, competency and developmental challenges. The BITSEA is a brief, screening tool drawn from the longer ITSEA

Benefits of BITSEA:

- Assesses competencies that may positively influence treatment outcome
- Family-centred assessment — relies on parent/caregiver input and level of concern
- Can be administered as a structured interview or take home questionnaire
- As part of a comprehensive assessment, the BITSEA can help identify children at risk for autism, anxiety disorders, depression etc.

The psychometrically sound BITSEA is highly targeted to the subtle growth and developmental stages of infants with norms presented in 6-month age bands. Validation studies include ABAS-II and Greenspan Social-Emotional Growth Chart.

The Ages and Stages Questionnaire: Social Emotional (ASQ:SE-2)

The ASQ:SE2 is a questionnaire designed to screen young children for social emotional issues between the ages of 1 month and 72 months of age. It provides screening of the following areas: self-regulation, compliance, adaptive functioning, autonomy, affect, social-communication and interaction with people.

Click on the PDF to view an example of the questionnaire:

12 - ASQSE2 24 Month Questionnai

In addition to these tools, the Neonatal Behavioural Assessment Scale (NBAS) is useful for screening neuro-behavioural and developmental concerns in neonates aged a few hours post birth to 2 months of age (from a stabilized minimum gestation of 35 weeks). Items are designed to explore an infant's social-interactive and neurodevelopmental capabilities and difficulties including orientation to human voice, other sounds muscle tone, reflexes and self-soothing. The tool is especially useful when assessing or screening a neonate following suspected illicit substance exposure in utero.

The Transactional Model of Development & Assessment in IMH

The Transactional Model for infants and young children is based on the premise that an infant's developmental trajectory is the consequence of interactions between individual and environmental characteristics.

It considers the following:

- **Constitutional Factors** (within the infant)
  - Innate resilience, genetics, medical diagnoses, temperament etc.
- **Environmental Factors**
  - Poverty, oppression, strong communities, neighbourhood or family violence, ability to access services, pollution etc.
- **The caregiver-infant relationship.**

The transactional model offers a risk/buffer model that balances an individual infant/young child's needs, versus the caregiver's resources.

Child's Needs comprise of the following:

- Physical Care & Safety
- Empathic Attention
- Attachment Relationship
- Emotional & behavioural self-regulation
- Developmental
- Role Model
- Cultural
- Educational

Parent Resources comprise of the following:

- Responsive Caregiving & Protection
- Reflective Function
- Bonding – resolved attachment
- Emotional availability
- Strategic behaviour management
- Ability to transmit community values

Transactional Model – Risks

Risk factors are "characteristics which have a deleterious effect on the child's developmental path" Sameroff (2000). They are also (1) Cumulative (the addition of each risk factor increases the likelihood of a poor outcome) and Interactive (risk factors interact in ways that can overwhelm the child's natural resilience).

Risk factors for emotional neglect can be organized into four domains:

1. **Social environmental risks**, such as social isolation, poverty, or a high-risk community.
2. **Problems with the caregiver/infant attachment:** Parents who have a negative or bizarre view of their baby, who cannot empathize with their baby, or who cannot recognize the baby's cues and respond appropriately, are at considerable risk for emotionally neglecting their infant.

3. **Parental competence:** Parents who are depressed, mentally ill, cognitively delayed, dealing with substance abuse, or who lack basic child care skills, can pose a risk to the healthy development of their children. Parents who have a history of trauma or unresolved loss (including a childhood history of multiple foster care placements) may experience particular difficulties when they are raising children of their own.
4. **Child characteristics:** Children who are vulnerable because of prenatal exposure to substances such as alcohol, low birth weight, premature birth, difficult temperament, or medical fragility, are at risk for problems in healthy development. Children referred to mental health services are 34 times more likely to have risks in all four of these domains than are children who have risks in two or fewer domains.

As such, the resulting IMH assessment and formulation considers the balance between these factors:

- Diagnostic Formulation in IECMH – the DC: 0-5
- The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)

It also utilizes the framework of the Transactional Model within Infant Mental Health (as discussed above).

Why have a different diagnostic system for infants**?**

Traditionally psychopathology has been understood to exist ***within individuals*** rather than ***between individuals.***

The core premise of infant mental health is explicitly relational "they are focused on understanding young children's development and their manifestations of psychopathology ***within the context of their relationships with caregivers".***

Other diagnostic systems (such as DSM-V and ICD-10) fail to capture the unique presentation of infants in the context of their relationships in order to inform treatment planning (especially in infants aged less than 12 months).

How does it differ from a traditional CYMHS formulation and diagnosis?

DC: 0-5 clinical axis model is used in lieu of the traditional CYMHS formulation structure (i.e. 5 P's Model).

> "The use of a multi-axial system for clinical formulation focuses the clinician's attention on the factors that may be contributing to the difficulties of the infant/young child, adaptive strengths and additional areas of functioning in which the intervention may be needed" (Zero to Three, 2016, page 8).

DC: 0-5 recognises that behaviours and emotional expressions are shaped by family cultural values and practices which are often "unconsciously held, but carry enormous parameters of what is expected and practiced in regards to parenting. For these reasons, diagnosing an infant/young child who is experiencing mental health problems must include developing an understanding an appreciation of the family's cultural background and parents socioeconomic conditions, national origin and history, immigration status, ethnic and racial identity, sexual orientation, religious and spiritual practices, and other sources of diversity." (Zero to Three, 2016, page 9).

How is it similar to a traditional CYMHS formulation and diagnosis?

The basic premise of why we conduct mental health assessments and diagnose remains the same - "We assess individuals, but we classify disorders. The primary purpose of classification of disorders is so that professionals – including clinicians, researchers and policy makers – can communicate clearly about descriptive syndromes. Having a shared nosology allows clinicians to link their observations to etiology, pathogenesis, the course of a disorder and expectations concerning treatment. Using the common language of a diagnostic classification system facilitates the connection of individuals to existing services and thus can aid in the mobilisation of appropriate systems of mental health care." (Zero to Three, 2016, page 7).

13 - Diagnostic Classification of MH

14 - DEFINING RELATIONAL PATHOI

Read

Please read the following articles regarding the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5).

A Brief Overview of the DC: 0-5 Multiaxial Structure

Use of the multiaxial system for clinical formulation focuses on the clinician's attention on the factors that may be contributing to the difficulties of the infant/young child, adaptive strengths, and additional areas of functioning in which intervention may be needed (Zero to Three, 2016, page 8).

Axis I: Clinical Disorders

- Neurodevelopmental Disorders
- Sensory Processing Disorders
- Anxiety Disorders
- Mood Disorders
- Obsessive Compulsive and Related Disorders
- Sleeping, Eating & Crying Disorders
- Trauma Stress and Deprivation Disorders
- Relationship Disorders

Axis II: Relational Context

Used to characterise the infant/young child's caregiving relationship context. Use of the axis facilitates the understanding by encouraging systematic characterization of one or more infant/young child relationships and characterization of the broader caregiving environments, including co-parenting, sibling and other important family/kin/caregiver relationships that affect the infant/young child's development.

These are broken down into several parts, which are as follows:

A. Caregiver-Infant/Young Child Relationship Adaptation
    1. Dimensions of Caregiving
    2. Infant/Young Child's Contributions to the relationship
    3. Levels of Adaptive Functioning – Caregiving Dimension

B. Caregiving Environment and Infant/Young Child Adaptation
   1. Levels of Adaptive Functioning – Caregiving Environment

Associated forms related to Axis II are as follows:

15 - TABLE 1. DIMENSIONS OF CA

16 - Table 2 Infant-young childs

17 - TABLE 3. DIMENSIONS OF THI

Axis III: Physical Health Conditions and Considerations

As we know, a comprehensive diagnostic assessment includes exploring physical, developmental, and cognitive contributions to overall mental health. Axis III is designed to capture physical health conditions and considerations that ***have not*** been described in Axis I. This information can be obtained from medical collateral information, parent and caregiver reports and or referral information from Child Safety. This also serves the purpose as part of the comprehensive formulation in highlighting strengths/prophylactic/resilience factors in an infant/young child (e.g. fully immunized), or increasing overall risks.

Axis IV: Psychosocial Stressors

1. The Psychosocial and Environmental Stressors Checklist for the Identified Infant/Young Child

This helpful checklist provides a framework from which the clinician can:

- identify multiple sources of stress experienced by an infant/young child and their family and
- exploring their duration and severity.

As we know the cumulative severity of stressors affects the overall wellbeing of an infant/young child and their family. The greater number of stressors experienced, the greater adverse impact on the infant/young/child is presumed to be. Many of the infant/young children referred to ETS in out of home care will have multiple stressors (e.g. neglect, abuse, poverty, poor quality early learning environment, inadequate, unsafe or overcrowded living conditions).

The checklist covers the following categories of stressors;

- Challenges within the infant/young child's family or primary support group
- Challenges in the social environment
- Educational or child care challenges
- Housing challenges
- Economic and employment challenges
- Infant/young child health
- Legal or Criminal justice challenges
- Other

Associated forms related to Axis IV are as follows:

18 - Psychosocial and Environmental S

Axis V: Developmental Competence

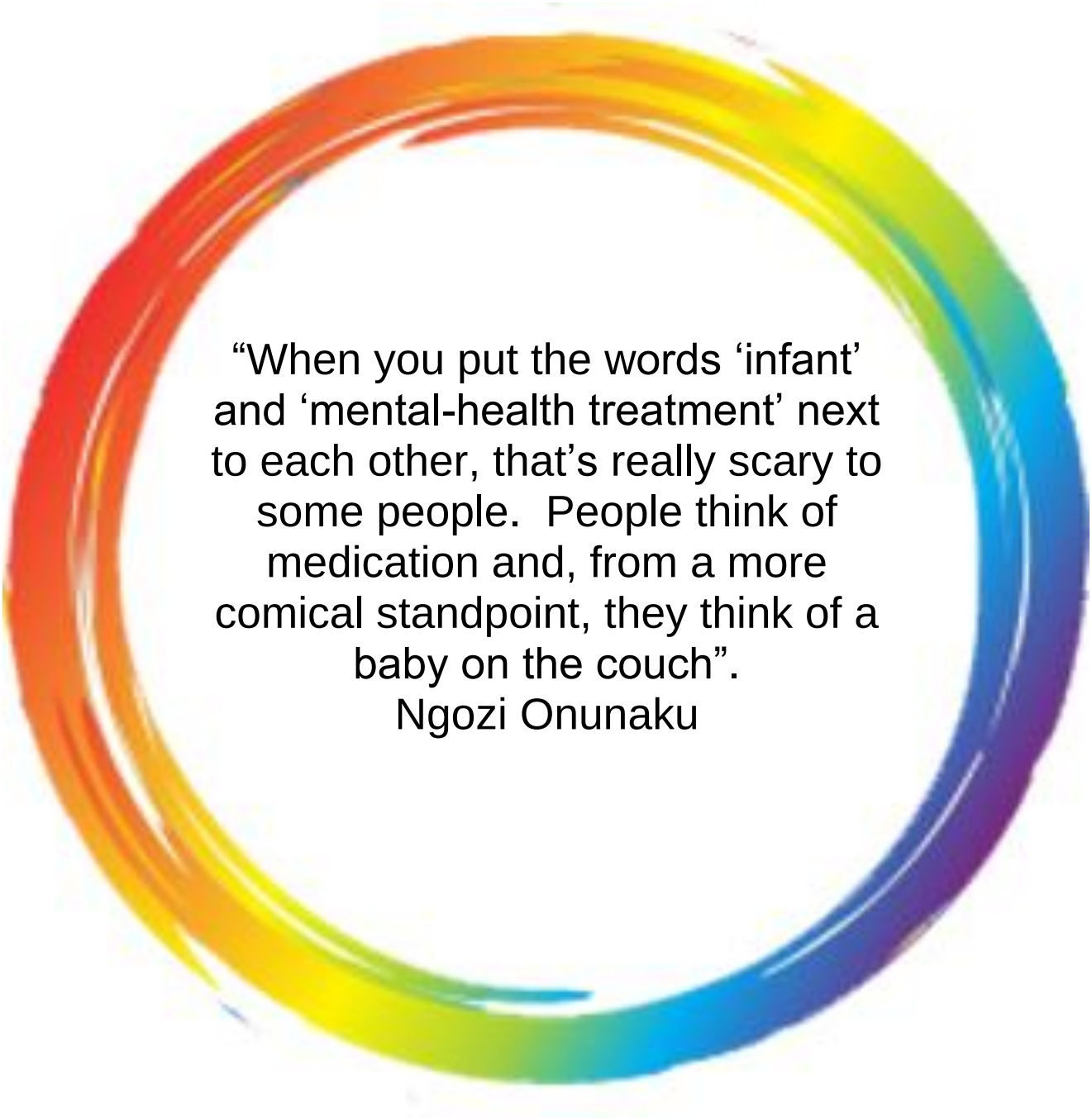
Developmental competence utilizes and integrative model for understanding the infant/young child's developmental competencies in the domains of emotional, social-relational, language-social communication, cognitive and movement/ physical development.

Ratings can be informed by observations of the infant/young child's interactions across environments, caregiver reports, collateral information, developmental screening tools and formal standardized developmental assessments.

It is advisable that the assessing clinician ensure they consider cultural norms and expectations when completing this domain. Consultation with an Indigenous Program Coordinator or Indigenous Mental Health/Community Health worker would be strongly encouraged.

Associated forms related to Axis V are as follows:

19 - Appendix A - Developmental Mile


“When you put the words ‘infant’ and ‘mental-health treatment’ next to each other, that’s really scary to some people. People think of medication and, from a more comical standpoint, they think of a baby on the couch”.
Ngozi Onunaku

Infant & Early Childhood Mental Health Interventions

Consider this scenario - infant referred to ETS has been in out-of-home care (OOHC) with an approved foster parent from the ages of 13 – 18 months. After experiencing significant neglect and trauma in the first 13 months of their life, there are clearly some signs that the infant is displaying signs of trauma.

After a thorough assessment, the ETS Clinician devises a treatment plan in collaboration with the foster carer, to support the felt safety and regulation of the infant. After 2 months of the intervention and signs of improvement, you are advised that the biological Mother has made positive steps to address the previous child protection concerns and reunification is being fast-tracked over the next 4 months.

So who are you going to focus the intervention on? What about the gains being made so far? How do you continue the intervention with the foster carer and start an intervention with the infant and biological Mother? Who is the target dyad?

Unique challenges for infants and young children in OOHC and their carers

When working in IECMH within an Evolve care team, one of the central dilemmas becomes ensuring that the infant is provided with a secure attachment and caregiving relationship with someone who is not their parent, while simultaneously working to ensure that the best possible circumstances are provided for the infant to have an ongoing meaningful relationship or to be united with their parents where this is in the infant's best interests (Jordan & Sketchley, 2009).

The recognition and understanding of infants' subjective experiences of and response to traumatic experiences are crucial in order to ensure that services provided at both the secondary and tertiary intervention levels are designed to meet a traumatised infant's need for the relief of immediate suffering and to prevent long-term impacts, including intergenerational impacts.

Assessment and treatment services for infant mental health problems need to target the infant symptoms, the infant's emotional development and infant–parent relationship, including trans-generational issues that may be undermining the health of the infant–parent relationship.

Many foster parents encounter an inherent role conflict. On the one hand, the infant needs them to be a primary attachment figure, to be emotionally available, preoccupied with the infant and their needs, and committed to them. However, until a permanent plan of reunification with parents or permanent placement is made, the potential duration of this relationship is unknown. The foster parent is facing the issue of loss while simultaneously forming an attachment with the infant (Jordan & Sketchley, 2009).

Reflect

The insolvable dilemma of getting 'close, but not too close' is a reality for many carers of infants. How might a carers own attachment history effect how they manage this internal dissonance?

Separations, Caregiver Disruptions

Although most babies undergo everyday separations from their caretakers (e.g. day care, babysitters, relatives, etc.) their ability to cope with separations declines as the separations exceed their capacity to hope for the caregivers return. For most children placed in foster care, the separation from a caretaker is often sudden and can last for weeks, months, or years (Wotherspoon & Gough, 2008).

In addition to having experienced at least one major disruption in primary-caregiver relationships, infants in OOHC have typically have been exposed to maladaptive caregiving at an early age, often witnessed traumatic events, and they are frequently delayed in their physical and emotional development.

Infants and young children in foster care face multiple risks that leave them especially vulnerable to poor mental health outcomes and comorbidities such as developmental delays and disruptive disorders. These problems are commonly overlaid with frequent and abrupt disruptions in caregiving arrangements that are associated with attachment disorders. As a result, foster children often struggle with effectively regulating their cognitions, emotions, behaviours and physiology (Sameroff, 2000). Placements can often end prematurely when foster carers feel overwhelmed, exhausted and unable to cope with the complex needs that an infant or young child requires.

It is known that exposure to maltreatment during the first year of life is associated with the development of insecure and disorganized attachment strategies and it has negative consequences for subsequent relationships. Parental loss may be more traumatic for older infants than younger ones. Older infants may be more likely to have moved around to different foster homes and thus to have suffered more disruptions than younger infants.

> The timing of the disruption itself, regardless of previous experience, that affects infants' abilities to reach out to new caregivers.

Foster parents can either overlook the symptoms of an emerging internalizing disorder or become frustrated with externalizing symptoms that do not respond to traditional behaviorist approaches, the transactional model and a developmental framework.

Perhaps even more ominous for the foster child are findings which demonstrate that children exposed to trauma and abuse begin to interact with their environment in ways that further exacerbate risks, in particular by provoking maladaptive responses, even in otherwise competent and well-intended. These maladaptive transactions are believed to have their roots in the relationship template the child has created from prior caregiving experiences, which then influence the foster parenting relationship. When foster parents develop a pessimistic view of the foster child and respond punitively, the template is reinforced and the likelihood of a harmful developmental trajectory and placement disruption is increased—setting off what Patterson (1982) called "cycles of coercion" and potentially foster care drift.

While the foster child's overall social and emotional presentation might have its origins in the early caregiver relationship, the foster parent's response can either maintain or diminish what have become maladaptive behaviors.

Infants entering foster or out of home care are faced with the task of forming attachments to new primary caregivers. Many of these infants have often experienced problematic home environments as well as disruptions in previous caregiving relationships. Hence, it is probable that these previous experiences diminish infant's chances of forming trusting relationships with new caregivers.

Research suggests that the timing of an infant's placement in out of home care is central to their ability to organise attachment around a new caregiver's availability. It has been suggested that the duration of inadequate or harmful caregiving, rather than the timing of the of the new relationship's formation is most important to the child's ability to organise attachment behaviours (Dozier et al., 2001).

Infants and young children in out of home care have experienced at least one major disruption in primary-caregiver relationships, they typically have been exposed to maladaptive caregiving at an early age, witnessed traumatic events and are frequently delayed in their physical and emotional development (Wotherspoon, O'Neill-Laberge & Pirie, 2008).

Developing an Emotional Bond with a Traumatised Infant

In cases where infants suffer from severe attachment disturbances resulting from abuse and neglect, the infant's response to separation from the parent, their particular expression of loss, grief reactions and distorted attachment behaviours may make it difficult for the foster parent to provide sensitive and responsive care (Dozier & Lindhiem, 2006; Goldsmith, Oppenheim, & Wanlass, 2004). To ensure healing for the infant and the stability of the placement, there is a need for foster carers to receive ongoing training and reflective supervision that is focused on how to read the infant's emotional cues, how to develop an emotional connection with a traumatised infant, how the infant's experience of maltreatment and/or prior placement disruption may be impacting on them, and how the foster parent may need to adapt their own intuitive parenting style to accommodate the response

of the particular infant (Melmed, 2004). This piece of clinical work should be a crucial aspect of any ETS clinician's treatment plan when working with infants and young children in OOHC.

Foster Carer's State of Mind

Foster parent's state of mind regarding attachment has been found to be related to a foster child's tendency to seek out a new caregiver when in distress. A caregiver's state of mind in regard to attachment influences how he or she will anticipate, interpret, and respond to attachment related events, including a child's attachment signals and needs.

A high rate of correspondence (72%) between foster infant and foster parent attachment has been found (Dozier et al., 2001), suggesting that the foster parents' states of mind play an important role in the formation of these new attachments.

20 - Dozier - interventions for fos

21 - Attachment for Infants in Foster Car

Read

Please read the articles written Dozier et al., (2002 and 2001) for more information on foster carer state of mind to deepen your understanding.

Evidence Informed Treatment Interventions with traumatised infants and caregivers

The following is a list of evidence-informed treatment interventions with traumatized infants and their caregivers which may be explored further to enhance your infant mental health intervention skills. This list is not exhaustive, yet is very relevant to the ETS population.

- Attachment & Bio-behavioural Catch Up (ABC)
- Watch, Wait & Wonder (WWW)
- Interaction Guidance
- Child-Parent Psychotherapy (CPP)
- Circle of Security Home Visiting (COS-HV4)

Attachment & Bio-behavioural Catch-up (ABC)

Mary Dozier (University of Delaware USA) developed ABC for caregivers of infants 6 months to 2 years old who have experienced early adversity/trauma/abuse and neglect. There are approximately 10 sessions.

The program goals of ABC are:

- Increase caregiver nurturance, sensitivity, and delight
- Decrease caregiver frightening behaviours
- Increase child attachment security and decrease disorganized attachment
- Increase child behavioural and biological regulation.

ABC support:

- Well-Supported by Research Evidence (Level 1 – highest available) from California Evidence-Based Clearing House for Child Welfare (CEBC).
- CEBC Child Welfare System Relevance Level: High.

For more information:

- http://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/
- http://www.infantcaregiverproject.com/

Watch Wait & Wonder (WWW)

Watch, Wait and Wonder Intervention [1999©] was established by Elisabeth Muir, Mirek Lojkasek and Nancy Cohen. This empirically tested intervention [1999, 2002] is used with infants and young children who may have relational, behavioural, regulatory and/or developmental difficulties and parents who may feel troubled in their relationship with their child.

Following assessment, and with the family's support, dyads generally attend weekly for 8-24 sessions [the research averaged 15 sessions]. Most often both caregivers attend regular family review sessions. These decisions typically reflect the primary nature of the infant's relationships at this early stage of development.

For more information:

- http://www.watchwaitwonderdownunder.com/

Interaction Guidance

Interaction Guidance therapeutic treatment model was developed by McDonough (2000), incorporates principles of a family system theory into a multigenerational transactional preventive intervention. The approach:

- Focuses therapeutic treatment on the infant-caregiver relationship rather than on either the infant or the caregiver alone apart from the environmental context.
- Observable interactions between the baby and caregiver serves as the early therapeutic focus and, as such, serve as the therapeutic port of entry.
- Caregiver interactions with the infant are understood both as reflection of family structure and caregiving nurturance and as a reflection of the caregiver's and infants representational world.
- At its core are principles of a focus on strengths and on self-observation as a vehicle for change.

The Interaction Guidance treatment approach was created specifically to meet the needs of infants and their families who previously were not successfully engaged in mental health treatment or who refused treatment referral.

For further information:

- https://www.researchgate.net/publication/232589903_Interaction_Guidance_Promoting_and_Nurturing_the_Caregiving_Relationship

Child-Parent Psychotherapy (CPP), Ghosh-Ippen

CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with their primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the

caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory.

A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors).

Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

CCP Support:

- Scientific Rating 2 – Supported by Research Evidence (CEBC)
- CEBC Child Welfare System Relevance Level: High.

For further information:

- https://www.nctsn.org/interventions/child-parent-psychotherapy
- http://www.cebc4cw.org/program/child-parent-psychotherapy/

Circle of Security Intervention – Home Visiting 4 (COS-HV4) - Jude Cassidy, Cooper, Hoffman, and Powell

COS-HV4 is a version of Circle of Security that includes a mandatory home visiting component consisting of 4 home visits. The program intends to help caregivers understand their infant's behaviors and adjust their responses to the infant's behaviors. Videos are recorded of caregiver and child interactions in the home with the intent of looking for caregiver positive responses to behavioral issues and discusses strategies for addressing challenging situations.

Sessions consist of the following:

- Teaching caregivers the fundamentals of attachment theory (i.e., children's use of the caregiver as a secure base from which to explore and a safe haven in times of distress) by introducing a user-friendly graphic to the caregivers that they can refer to throughout the program.
- Emphasise the importance of a caregiver's sensitive responsiveness to their infant's signals. Identify which infant signals are more difficult to respond to, develop an individualised treatment plan for caregivers, promote the understanding that all caregivers can be insensitive at times and encourage forgiveness in these situations, and view video clips of caregiver and child interactions and review and discuss segments when caregiver reacted sensitively and times caregiver reacted less suitably.
- Exploring not only parenting behaviours but also internal working models. Encourage caregivers to reflect on situations in which they find it difficult to react sensitively and consider some different options in these scenarios.
- Presenting caregivers with a simple structure for considering the ways in which their internal working models influence their cognitive, affective, and behavioural responses to their children, thus helping caregivers gain awareness and understanding of the nonconscious, problematic responses they sometimes have to their children's needs.

The Circle of Security approach provides caregivers with the skills to understand their children's behaviour, and the skills to understand and regulate their own cognitive, affective, and behavioral responses to their children.

COS – HV4 support:

- Scientific Rating 3: Promising Research Evidence (CEBC)
- CEBC Child Welfare System Relevance Level: Medium.

For further information:

- http://www.cebc4cw.org/program/circle-of-security-home-visiting-4/

Emerging interventions for child protection

Parent Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT) was developed for families with children ages three to six showing behavioural and emotional problems such as disobedience, aggression, rule breaking, disruptive behavior, poor attachment with the caregiver and internalizing feelings. It is a treatment for disruptive behaviour in children and is a recommended intervention for 'physically abusive parents'. Therapists coach parents during interactions with their child to help teach them new parenting skills. These skills are intended to strengthen the parent-child bond, decrease harsh and ineffective parenting discipline methods, and reduce the child's negative or maladaptive behaviours. PCIT involves child directed interaction and parent directed interaction. In the child directed interaction parents are taught to give praise after positive child behavior, reflect or paraphrase the child's appropriate talk, describe the child's positive behaviour and avoid using commands, questions, or criticism. During the parent directed interaction, caregivers are taught how to direct the child's behaviour when it is important to obey instructions and caregivers are observed and coached through a one-way mirror at each treatment session

PCIT support:

- CEBC Child Welfare System Relevance Level: Well-Supported.

For further information:

- http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed

Promoting First Relationships (PFR)

Promoting First Relationships (PFR) is a home visiting intervention/prevention program which includes parent training components based on strengths-based practice, practical, and in-depth strategies for promoting secure and healthy relationships between caregivers and young children (birth to 3 years). Features of PFR include:

- Videotaping caregiver-child interactions to provide insight into real-life situations and help the caregiver reflect on the underlying needs of the child and how those needs impact behavior
- Giving positive and instructive feedback that builds caregivers' competence with and commitment to their children
- Focusing on the deeper emotional feelings and needs underlying children's distress and behaviors
- Using handouts and homework to enhance parent insight and learning about child social and emotional development, needs, and concern

PFR support:

- CEBC Child Welfare System Relevance Level: High

For further information:

- http://www.cebc4cw.org/program/promoting-first-relationships/detailed

Theraplay

Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behaviour, overactive-aggressive behaviour, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behaviour and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, *Theraplay* has been used for many years with foster and adoptive families.

Theraplay support:

- CEBC Child Welfare System Relevance Level: Medium

For further information:

- http://www.cebc4cw.org/program/theraplay/

Clinical / Reflective Supervision

> Infant and early childhood work is inherently relational and occurs in the intersubjective space between caregivers, infant, and clinician. This space can be charged with a number of unmet needs of both caregiver and infant, and this in turn can trigger these same 'states' in the clinician (O'Rourke, 2011).

The challenge us a clinicians, and an organisation, is to remain open to being affected by and responsive to these feeling states when our own early and possibly preconscious responses and coping strategies are being stirred. O'Rourke (2011) noted that if these states "remain out of awareness, they can manifest as avoidance and denial, and this can be reflected in the system and result in limited service delivery". This emphasises the significance of clinical supervision in any infant mental health, and more importantly reflective supervision being an integral part of the system of service delivery.

Australian Association for Infant Mental Health Inc (AAIMHI, 2016) notes that "Reflective Supervision is now well established in the field of Infant-Early Childhood work as a tool for supporting practitioners in their therapeutic work with infants, young children and their families, maintaining practitioner skills, and ensuring a quality service is provided."

Reflective supervision is different to traditional mental health clinical supervision. Clinical supervision is a broad term encompassing a range of principles, activities and areas of work practice essentially where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one other individual. This type of supervision often does not traditionally "consider what the practitioner brings to the intervention nor does it necessarily encourage the exploration of emotion as it relates to work with an infant/toddler and family" (AAIMHI, 2016).

Reflective supervision is much more relational based and focuses "on the shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners" (Weatherston & Barron, 2009).

For further information regarding reflective supervision in infant mental health the Australian Association for Infant Mental Health Inc web site (https://www.aaimhi.org/resources/reflective-supervision/) provides a number of useful resources.

22 - Best Practice for Reflective Super

Read

The Michigan Association for Infant Mental Health "Best Practice for Reflective Supervision/Consultation Guidelines".

(http://mi-aimh.org/wp-content/uploads/2017/09/BPGRSC_Alliance-logo_20170130_AM.pdf)

Key Resources Recommended for ETS Teams:

- Zero to Three (2016). Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). Zero to Three, Washington.
- Zeanah, C. H., (Ed). (2009). Handbook of Infant Mental Health, Third Edition. Guilford Press, NY.

Recommended Websites:

- https://www.aaimhi.org/
- https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services/qcpimh/
- https://www.zerotothree.org/espanol/infant-and-early-childhood-mental-health
- https://www.waimh.org/i4a/pages/index.cfm?pageid=1
- https://developingchild.harvard.edu/

Image References

Image	Accessed	Source
	10.09.17	http://www.canberramummy.com/caught-in-the-in-between/
	10.06.2018	https://www.paintingcircle.com/ This image was edited specifically for this document.
	15.10.17	https://openclipart.org/detail/185355/happy-cloud
	15.10.17	https://openclipart.org/detail/248081/reading
	15.10.17	https://openclipart.org/detail/176565/movie-popcorn-bag
	15.10.17	https://openclipart.org/detail/214574/building-blocks
	15.10.17	https://openclipart.org/detail/1027/key
	09.07.2018	http://www.dailymail.co.uk/news/article-3452825/Bobbi-lee-Hille-s-photos-Aboriginal-newborns-pregnant-women.html
	12.11.17	https://thetomatos.com/free-clipart-21284/
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