Investing in Young Children’s Mental Health: Promoting School- and Life-Readiness

By Martha Farrell Erickson and Christopher L. N. Watson

Four-month-old Jackson lies crying in his crib, wet, hungry and increasingly agitated by the voices of his parents, who argue loudly nearby. When his mom, Stacy, starts to cry, Jackson’s dad, Curt, stomps outside, slams the screen door and shouts over his shoulder, “There’s no way in hell I can work enough hours to pay all these bills while you just sit home with this kid!” Stacy slumps onto the couch and continues to sob, remembering how excited she and Curt had been when their tiny baby finally came home from the hospital after all the uncertainty around his premature birth. But now the sleepless nights, the mounting bills, and their powerlessness to calm this tiny, fussy baby are taking their toll; Stacy feels like she just wants to go to sleep and never wake up.

How will Jackson’s mental health, now and in later years, be shaped by what he is experiencing in this stress-filled household? What does he, an underweight, hard-to-soothe baby, bring to the equation that will determine his capacity to manage emotions, relate positively to others, and explore and learn from the world around him? And, most important, where are the windows of opportunity for Jackson and his...
parents to get the support and help that will see them through this challenging time and on to better outcomes as individuals and as a family? These are the kinds of questions and challenges that define the field of infant and early childhood mental health.

Many people are surprised by the notion that young children – let alone infants – can possess “mental health.” Even more incredible to some is the assertion that our youngest children can develop mental health problems that contribute to poor outcomes in the future, or that babies can become so distraught that they literally stop eating. The reality is that the foundations of mental health are established in the first years of life. The “health” in mental health includes the critical skills children need to participate in learning activities and thrive in all areas of life, including the regulation of emotions and behavior, the development of trust and empathy, the establishment of a healthy degree of autonomy, and the development of self-efficacy. These foundational strengths develop through ongoing interactions with parents and other caregivers and are shaped by factors within the child, parents (including parental mental health), family, neighborhood, and larger society. All subsequent learning and development build on these foundations. Thus, investing in young children’s mental health is, in fact, one of the most important ways to promote school readiness and reduce educational disparities.

Carol Siegel, a Field Faculty member of the Center for Early Education and Development (CEED) at the University of Minnesota, writes in CEED’s Tip Sheets series (Siegel, 2004), “infant mental health is a developmental process” (p. 1). She notes that it results from the interplay between children’s inborn characteristics and the environment in which they are raised – especially their interactions with significant caregivers. Most parents provide their children with “good enough” care. That is, they attend to their children’s physical needs and support their social and emotional development. But in some circumstances parents cannot or do not provide adequate care. Sometimes this is due, at least in part, to the child’s inability to interact effectively with their parents due to a disability, medical condition or other inborn characteristic. In those cases, the child may have difficulty clearly signaling needs or responding to parents’ efforts to connect. Parents, in turn, may be grieving the loss of the hoped-for child and struggling with the ambiguity of the future. The development of mental health depends on both parent and child participation. An “attachment”
between child and adult is the result of this interactive process. Attachment theory is about “how infants use adults to teach them how to survive...until they can do it for themselves,” writes Anne Gearing (another CEED Field Faculty member) in a previous issue of Early Report (Gearing, 1996, p. 1). “We know this survival is psychological as well as physical; children need sustenance, protection, and regulation to feel safe and to be able to grow and increasingly take care of themselves.”

The ability, and necessity, of children “using” adults to learn to survive on their own is demonstrated at each developmental stage in early childhood. In the baby, it is at play when the infant cries for food or comfort, and the adult responds. This action-reaction sequence repeated time after time teaches the child several key concepts, among them: “when I cry someone cares enough to come to me”; “when I am upset I can count on getting help to calm down”; and “I'm important! I have all right or return to the adult for “recharging.” Whatever life brings into the child’s world is buffered by the reassuring presence of the caring adult.

The preschooler learns to use adults to provide a consistent and predictable schedule of activities, mediate conflicts with peers, and solve problems. Although he or she sometimes rebels against rules and other limits, the preschooler derives security and a sense of calm and safety from the boundaries set by adults.

To support young children’s mental health, families need easy access to a variety of services and support, from basic information on child development for new parents to very intensive interventions for families experiencing more serious issues. Many mental health problems are preventable. Even non-preventable disorders can be ameliorated – and children’s long-term prospects for learning and development can be improved – through early identification and intervention. A variety of people and systems surrounding the family can help.

The “health” in mental health includes the critical skills children need to participate in learning activities and thrive in all areas of life – including the regulation of emotions and behavior; the development of trust and empathy; the establishment of a healthy degree of autonomy; and the development of self-efficacy.
The focus of all infant mental health work is to support healthy relationships between young children and their primary caregivers. As mental health work is extended up through the preschool years, it expands to support the child in relationships with other caregivers, teachers, and peers. It is not about relying on medications or other behavior management solutions in isolation. The goal is to provide opportunities for children to successfully interact with, learn from, and connect with, others. As the saying goes, “It’s all about relationships.” We all become contributing members of our communities through our relationships with our families, friends, and co-workers.

There is no single system that touches the lives of all young children, so efforts to support mental health must be directed to the many people and systems that interact with young children and their families, including childcare providers, preschool teachers, primary care physicians and nurses, social service providers, and employers. Thus, we need systematic ways to engage and educate those groups in how to promote healthy social-emotional development, recognize risk, and encourage families to get the help they need. Because mental health professionals often have inadequate education in early development and parent-infant relationships, there also is a pressing need to build the capacity of mental health professionals to serve young children and their families and provide consultation to other “frontline workers” who serve them, including nurses, childcare providers and teachers.

To succeed in promoting young children’s mental health, we need to get serious about developing, disseminating, and sustaining evidence-based prevention, intervention, and treatment approaches.

Three key opportunities for investment include:
1. Rigorous evaluation of intervention strategies through university-community research partnerships.
2. Timely and efficient dissemination of research findings and information on best practices.
3. Continuous high-quality training, consultation and support for service providers to ensure program fidelity and service quality.

References


Martha Farrell Erickson, Ph.D., is Co-chair of the President’s Initiative on Children, Youth & Families, and is Director of Harris Programs with the Center for Early Education and Development, University of Minnesota, Minneapolis. She may be reached at 612/625-3058 or mferick@umn.edu.

Christopher L. N. Watson, M.S., M.A., is Director of Professional Development with the Center for Early Education and Development, University of Minnesota, Minneapolis. He may be reached at 612/625-2898 or watso012@umn.edu.
Natalia Yzaguirre doesn’t like to think about what her life and her relationship with her daughter, who is now five, would have been like without STEEP™ and her home visitor Kathi Bloomquist.

Clean of methamphetamines not even a year when she became pregnant with Raven, the 24-year-old had a very difficult pregnancy, rife with health issues and a deep depression, exacerbated when her doctors took her off antidepressants in an effort to control gestational diabetes. Then after a harrowing labor and delivery, she was discharged with no support system and few if any infant-care or parenting skills. She was soon at her wits end with her newborn and felt she had nowhere to turn.

Days after she was released from the hospital, she returned with her screaming infant, who was diagnosed with an ear infection. Yzaguirre, weeping uncontrollably herself, was asked gently by the attending nurse if she’d ever heard of STEEP™ and whether she might like to try it. She agreed, and within hours someone was at her home.

“I didn’t have a close woman in my life,” says Yzaguirre. “My mother didn’t really raise us; I was raised by my dad. So I didn’t really know how to be a mom, and I didn’t really have a mom. I needed somebody physically, mentally, and emotionally, and then I met Kathi [Blomquist] and I thought, with relief, finally someone’s here to help me!”

Over the next three years, Yzaguirre and Blomquist formed a deep relationship that filled that gap in Yzaguirre’s life. She says it was an incredible safety net to know that Blomquist was only a phone call away, day or night, “She’s my hero. She’s a great person, warm and generous, and I could always call on her if I needed help, or wanted to tear my hair out, or was in a panic and didn’t know what to do.”

Not only did Blomquist help by being a maternal figure Yzaguirre could rely on, she also used a very powerful tool during her bi-weekly home visits. By videotaping the interactions between mother and baby, Blomquist enabled Yzaguirre to see her own relationship with Raven evolve and grow deeper and stronger. Seeing their relationship more objectively, without the interference and stressors of everyday life – trying to get laundry done...
or get out the door – was invaluable. The videos taught her how she might have handled a situation differently and also reinforced that there were many things she was doing well.

“There’s video of us at the park, and I noticed how much I kissed her and cuddled her. The videos made me realize how fast Raven was growing and that I needed to appreciate every moment.”

The other powerful piece of the STEEP™ puzzle was the bi-weekly meeting where Yzaguirre met other women who had similar misgivings and fears about their parenting skills, “Other people would say to me, ‘Why aren’t you happy? You should be happy – you’ve got a new baby!’ I thought there was something wrong with me until Kathi introduced me to the group where moms from all walks of life were all feeling the same things I was feeling.” The group sessions were a nice way to refresh, reenergize, not have to pay for childcare. Both Yzaguirre and Raven looked forward to them a great deal: “I liked that the kids learned how to interact with each other and got social skills and that we learned to be better parents all at the same time.”

Yzaguirre says STEEP™ gave her many other life-changing gifts besides a healthy, loving relationship with Raven. She says without it, she would never have had the strength to stop the cycle of co-dependency and neglectful parenting in her primary relationship and family of origin. With the backing of Blomquist and her STEEP™ group, she left her meth-addicted boyfriend. “Being in STEEP™ made me realize that I could do it without a spouse. I went back and forth, thinking I needed a family unit, probably not the healthiest thing for her, more unhealthy than healthy. Just seeing other women doing it and the support from them gave me the strength to walk away from him and keep myself clean.”

STEEP™ indirectly taught Yzaguirre the importance of picking a mate with good parenting skills and the ability to have a healthy relationship, something she has in her current relationship, “Finding Tom later, it wasn’t me just jumping into another bad relationship – he’s a great parent and a very loving, kind man.”

While STEEP™ helped her appreciate her father and the sacrifices he made to raise her and her sister more deeply than ever, she also gained the strength she needed to stand her ground on her style of parenting. “I finally knew how I wanted to do it – I was given the tools to learn that, so I could say to my dad, ‘I love you, but I’m going to do things my way, not your way.’”

All in all, Yzaguirre believes that without STEEP™, she would have been doomed to repeat the mistakes of her parents. “I think our bond is way stronger, and we had a better relationship because of STEEP™. I had someone there to help me parent, and I can’t say how grateful I am.”

For more information about training for the STEEP™ program, visit http://education.umn.edu/CEED/coursesandtrainings/trainings/steepsib.htm or call 612/625-3058.

Molly Kelash is Principal of Kelash Communications, Minneapolis.
Screening and Early Identification in Infant and Early Childhood Mental Health

By Glenace Edwall

In the summer of 2003, the President’s New Freedom Commission on Mental Health issued the report, *Achieving the Promise: Transforming Mental Health Care in America*. The report contained six goals, which the federal government pledged to work with states and communities to implement, led by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services. While many provisions throughout the report are relevant to the service delivery system for children’s mental health, Goal 4 has become widely known as the “children’s goal.” This status derives from the goal’s insistence on attending to health promotion, early identification, and effective intervention for children beginning at the earliest ages. Goal 4 straightforwardly states that “Early mental health screening, assessment and referral to services [should be] common practice” (p. 17), and more specifically notes practices of importance for infant and early childhood mental health:

- Promote the mental health of young children; and
- Screen for mental disorders in primary health care, across the life span, and connect to treatments and supports.

This federal position is very similar to recommendations of the 2002 Minnesota Children’s Mental Health Task Force, contained in the report *Blueprint for Children’s Mental Health*. At both federal and state levels, parents and parent organizations were clarion advocates for early identification, clearly relaying their stories of needless suffering, increased family stress, school failure and worsening functional abilities when their children’s needs went unidentified. In response to the Minnesota report, the 2003 legislature agreed to provide guidelines and resources to screen children at very high risk of mental health disorders, those in the child welfare, and juvenile justice populations. For other children, attention to early identification of mental health needs has been based on voluntary and collaborative efforts in various sectors, with particular emphasis on the critical role of the health care system.

Following a brief description of the nature of mental health challenges in young children’s development, this article will discuss Minnesota initiatives to increase healthy outcomes for our infants, toddlers and preschoolers and their families.

**Mental Health in Early Development**

*Achieving the Promise* (President’s New Freedom Commission on Mental Health, 2003) cited literature that is familiar to a wide range of early childhood professionals and families:

- Early childhood is a critical period for the onset of emotional and behavioral impairments, with about 1 in 200 children already receiving formal mental health services.
- Rates of expulsion from preschools and child care facilities on the basis of
severely disruptive behaviors and emotional disorders are rapidly increasing.

- Emerging neuroscience is demonstrating the interaction of physiological and environmental factors in shaping brain development and related behavior. This research is helping to identify ways in which early intervention can prevent some disorders, ameliorate others, and keep serious problems from worsening.

- Poor academic performance and school failure are highly likely correlates of early emotional and behavior disorders. These variables are in turn related to a downwardly spiraling set of consequences including juvenile justice system involvement, poor employment opportunities, and higher health care costs.

The report concludes that “mental disorders that occur before the age of six can interfere with critical emotional, cognitive, and physical development, and can predict a lifetime of problems in school, at home, and in the community” (p. 58). The impact is unmistakable: “No other illnesses damage so many children so seriously” (p. 58).

**Great Start Minnesota: An Assuring Better Child Development (ABCD) project**

In August 2003, the Children’s Mental Health Division of the Minnesota Department of Human Services (DHS) received one of five ABCD II grants from the Commonwealth Fund, administered under the auspices of the National Academy for State Health Policy. The ensuing project, titled Great Start Minnesota, was based on pilots at Children’s Hospitals and Clinics of Minnesota – St. Paul, and CentraCare Pediatrics Clinic in St. Cloud. At both sites, screening for socio-emotional development was integrated into well-child visits for children ages six months to five years of age. The pilots engaged a variety of strategies to make screening understandable and useful for families, to align it with diverse cultural understandings of child development, and to fit it to the work flow of these busy clinics. The project has been highly successful, with spontaneous spread of interest to other clinics and health care systems. The ABCD grant also created a stakeholder group which has allowed integration of many activities of systems and agencies serving young children and their families, including adoption of common screening instruments, a unified training system, and development of referral resources for clinic use.

**Training Issues**

It is a commonplace that there has historically been little overlap between early childhood and mental health service systems. Health and mental health professionals generally receive little training in early childhood mental health development, and early childhood services have been focused on physical and cognitive
development. New awareness of critical developments in mental health during the preschool period have made both groups aware of the need for training, and have opened opportunities to integrate training, create common developmental understandings, and jointly plan service development. The Children’s Mental Health Division at DHS has been organizing a three-day training, delivered regionally throughout the state, to increase awareness in a broad range of professionals of early childhood mental health issues and then to specifically prepare mental health professionals who are licensed for independent practice in how to conduct a developmentally and culturally appropriate diagnostic assessment when a child has had a positive screening result. These trainings have had several hundred trainees in the past two years.

DHS has also been working with the Minnesota Department of Health, the state Head Start organization, Part C state and local staff, and the physician associations of our ABCD pilot sites on other trainings. Continuing Medical Education training days have been held in the metro area and in northern Minnesota, and an additional training for physicians is planned for spring 2007. The Head Start Association has held three consecutive summer institutes on early childhood mental health, focused on creating seamless systems of screening, diagnosis and referral through integration of the activities of Head Start staff and community resources.

Role of Pediatricians

Pediatrics has been a key professional group in the development of the ABCD pilots and related activities. The Commonwealth Fund, in fact, targeted its

The Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH)

Through a generous grant from the Bush Foundation, The Minnesota Association for Children’s Mental Health is pleased to announce a new division focused on Infants and Early Childhood. This new association will promote the social and emotional well-being and optimal growth and development of infants and young children within the context of the infant/child and parent/caregiver relationship. The University of Minnesota’s Infant and Early Childhood Mental Health Certificate Program certificate program will complement the work of the new association and will advance the development of professional competencies.

For more information, please contact Candy Kragthorpe, Director of the Minnesota Association for Infant and Early Childhood Mental Health at ckragthorpe@macmh.org or 651/644-7333.
ABCD funding toward the development of screening procedures in pediatric clinics, because of the natural fit of this activity with standard pediatric practices of developmental surveillance and anticipatory guidance. Families indicate that they are most comfortable bringing concerns about their children’s development to their pediatricians or primary care providers, and a number of tools are available or in development to help pediatricians with this task. Particularly noteworthy among these is the newly revised Bright Futures curriculum, which includes components which can guide conversation among physicians, families and early childhood professionals about mental health development and disorders.

Pediatrics as the setting for socio-emotional and mental health screening has an added benefit for children and families, as well. When mental health is a routine aspect of health care, stigma is lessened and opportunities for early intervention are increased. Both of these factors are important in reducing the impact – or resolving – a developing mental health problem, including its impact on a child’s readiness for learning.

Early Childhood, Mental Health, and Medications

As SAMHSA has noted in its publications on screening, screening does not establish a diagnosis or a label, and it is not the basis for prescribing medications. Instead, screening for early childhood mental health in the primary care context produces relatively few positive results, and these are opportunities for a family, with the guidance of their pediatrician, to pursue a more in-depth diagnostic assessment to determine whether there is a remediable problem. Even in the event of a mental health diagnosis, best practices for young children are all directed at remediating the child’s developmental challenges through skill building, environmental modifications, or additional supports for the family. Anecdotally, screening in the child welfare system in an urban county has actually led to children being able to stop medications, once their difficulties were correctly identified and psychosocial interventions were successful.

Reference


Glenace Edwall, Ph.D., is Director of the Children’s Mental Health Division, Minnesota Department of Human Services, St. Paul. She may be reached at 651/431-2326 or glenace.edwall@state.mn.us.
Environments Support Early Essential Relationships

By Barbara Murphy

Young children in our country can spend thousands of hours in childcare settings, away from home, in the first five years of their lives. Over the past several decades, a great deal of research has looked at the effect of quality of care on children’s development, but it is only in the last 10 years that researchers have begun to consider the effects of the physical environment specifically. One such pioneer researcher was Anita Rui Olds, a developmental psychologist turned architect. After years of studying children in childcare settings, she concluded that the majority of childcare settings were operating as institutions instead of as homes-away-from-home, which is what children need. Olds understood that the physical space in which children spend most of their day has a powerful effect on the development of mind, body, and spirit (Olds, 2000). Other recent research on children’s development shows that children grow and learn best in the context of relationships with the people and places that reflect their families, cultures, and communities, and that they must feel comfortable and secure for healthy development and learning to occur. Because many children spend the majority of their waking hours away from their homes and families, early childhood programs need to create environments that help children maintain connections with their homes and families while they form new relationships with adults and peers and become part of a larger community. When environments are cozy and homelike, they support strong connections among the people there, as well as a sense of belonging and security.

Creating early childhood environments that have a home-like feel is very do-able. The arrangements and provisions in the physical environment create the context for the social-emotional climate and quality of interactions among the people there. Some practical considerations that promote relationship building in early childhood settings are:

• Create entryways, hallways, and other areas of the building that give an initial impression of welcome. Pay careful attention to the warmth and comfort of these communal spaces in terms of organization and aesthetics, which will convey a sense of openness, belonging, and invitation to connect with others.

The physical space in which children spend most of their day has a powerful effect on the development of mind, body and spirit.

• Purchase furnishings that foster relationship building, such as adult-sized couches or loveseats where adults and children can sit together comfortably, as well as child-sized chairs, tables, and shelves where children can sit together and manage themselves independently.

• Install lighting that is homelike, utilizing natural or indirect sources. Warm colors, interesting textured fabrics, plants, water, fish, and gardens have
all been shown to create an atmosphere where people feel emotionally and physically at ease.

• Create adequate, attractive, well-organized storage areas, which would eliminate the clutter that accumulates in so many early childhood programs.

• Fill classrooms with interesting and inviting materials and activities that reflect the individual identities, as well as the families and cultures, of the children, such as family photo boards, displays of children's work and objects from home.

• Plan that some of the equipment and materials would require or suggest use by more than one person and encourage collaboration and connection among children. The environment would be rich with open-ended materials that are suited to developmental needs of the children.

• Finally, staff the environment with adults who are knowledgeable about children and are friendly, warm, and nurturing as well as respectful of all children and families.

Further Information


Barbara Murphy, M.S., is Early Childhood Specialist and Associate Director with the Shirley G. Moore Laboratory School, University of Minnesota, Minneapolis. She may be reached at 612/624-9035 or murph028@umn.edu.

Check out the CEED Web Site for More Issues of Questions About Kids
http://education.umn.edu/ceed/publications/questionsaboutkids/

Questions About Kids is a series of handy fliers that answer questions frequently asked by parents and early childhood educators. They are available on the Web at http://education.umn.edu/ceed/publications/questionsaboutkids/, and titles include the following:

• Am I spoiling my baby?
• Do dads really matter?
• How do I get to know my newborn?
• How can I survive these temper tantrums?
• Can a mom’s depression affect her toddler or baby?
• How can I get my baby to sleep through the night?
• What does it mean when my young child is assessed?

The Questions About Kids Series is available in Hmong, Somali, and Spanish.
Questions About Kids

What is Meant by “Infant Mental Health?”

Infant mental health refers to an infant’s intellectual, physical, and emotional growth and development. Unlike the term adult mental health, which usually describes a defined outcome, infant mental health is a developmental process. It is based on children’s inborn characteristics, such as their temperament, their interactions with their caregivers, and the environment in which they are raised. This means that children’s development depends on their parents and other caregivers to provide a “good enough” environment. British pediatrician and psychoanalyst D.W. Winnicott coined the term “good enough” when he described an environment where parents respond consistently enough and well enough to their children. From those consistent responses, children learn to expect care, comfort, and pleasure in their achievements. And “good enough” means exactly that — good enough. No parent responds to babies’ cries each time, nor should they. It would not be good for babies to have their every uncomfortable feeling soothed from the outside, because then they would not learn how to wait, to tolerate some discomfort, and to soothe themselves.

Over time, as babies are cared for, responded to, and encouraged to grow and develop. They form the expectation that the world is a safe, interesting place and the people in it are responsive and kind. As they grow, babies who have a positive expectation of the world around them develop more satisfying relationships with other adults and children, are better able to handle everyday stresses, and show greater curiosity and interest in learning.

How Do I Learn to Provide a “Good Enough” Environment for My Baby?

Most parents naturally give babies the attention and responsiveness that they need. It feels natural because we learn how to hold, comfort, and delight in our babies from our parents. Parenting is not instinctive — it is learned from our experiences as children. Some parents were not given consistent positive attention, encouragement, and empathy when they were children. It is very difficult to “naturally” transmit these qualities to the next generation when they were not provided to you. However, babies and parents are predisposed to connect with each other, and you can learn to provide a “good enough” environment for your baby to get your relationship off to a secure start.

Connection

More than anything, babies need to connect with their parents. As newborns, they need contact through touch and sound as much as they need food. Many parents are confused if their babies still cry even though they are fed and changed. Sometimes parents are afraid that holding a baby just because the baby “wants attention” will lead to spoiling. When a baby cries and a parent responds, the baby learns that there is a connection and begins to expect to be cared for. That is what happens when the baby stops crying just by hearing your voice or your footsteps, or by being picked up. Contrary to the fears about spoiling, holding and comforting a baby helps the baby feel secure and comfortable. Will the baby expect you to hold him or her when upset? Yes, and that means your baby has connected you with care and comfort. You have succeeded!
Education
Educate yourself about your baby’s developmental needs and stages. This knowledge helps you respond to your baby’s needs when your “instinct” does not. For instance, if your baby begins to fuss even though fed and dry, you will know that babies get bored, as all people do, and need new stimuli for learning and entertainment. Knowing what your child can do during different developmental stages can help control your frustrations.

Empathy
Emotional understanding builds a strong relationship between parent and child. Start when they are babies and toddlers. Children whose parents acknowledge their feelings, even when they do not give in to their demands, are easier to comfort and satisfy than children whose feelings are ignored. One way to build emotional understanding and empathy is to try to understand an event from the child’s point of view. That helps your child believe that you are on their side. It does not mean that you give in to your child’s wishes or change your plans, but children do much better when their wishes are acknowledged even if they are not granted. A small amount of reassurance and acknowledgment can help your child learn to adjust to disappointment without falling apart (“You didn’t like it when I said no to ice cream. I know you really wanted that ice cream. Now let’s go ride on the swings.”).

Emotional understanding also helps children learn that their feelings and behavior are connected. Even with your baby or toddler, the more you acknowledge that your child’s behavior and feelings are connected, the more your child will feel understood. Over time, they can learn that feelings and behavior are separate — that it’s possible to be mad but still not throw a fit.

A “Good Enough” Environment Over Time
Parenting groups, friends, family, counseling, and books and articles about parenting can help you maintain the relationship you want with your child as they grow. Parenting presents new challenges as children develop. Staying connected with a young baby requires different parenting techniques, education, and empathy than staying connected with a two-year-old or a teenager. Luckily, parenting groups for parents of older children offer contact with people who have survived or even flourished during the parenting years. Many are more than willing to share ideas with others. Creating a supportive environment for yourself with experienced parents, friends, and family members will help you provide a “good enough” environment for your child.

For More Information
For more information, please see the Web sites below. Each site will provide links to additional Web sites and materials about parenting and child development —
- http://www.zerotothree.org/ztt_parents.html
- http://www.pbs.org/wholechild/

Carol Siegel, Ph.D., Clinical Director, Infant/Toddler Program, Washburn Child Guidance Center, Minneapolis, Minnesota

Questions About Kids is on the Web at —
http://www.harristrainingcenter.org
http://education.umn.edu/ceed
A View From the Ground: Lessons for Early Childhood Mental Health From Greater Minnesota

by Sara Carlson

The field of early care and education is riding a wave of change and support unlike ever before in Minnesota, but many challenges still remain. Perhaps the most pressing need during these critical first years is the development of positive social and emotional skills as a solid base upon which all other skills are built. However, an understanding of how interconnected social-emotional development is to all other early learning is lagging. That lag is felt acutely across Greater Minnesota, where the shortage of mental health professionals and services is compounded by the lack of clinical training focused on very young children. This is the story of three Greater Minnesota programs that are bridging the void in their communities and the common lessons they provide.

Duluth Public Schools Use the BEAM Approach

Marilyn Larson, director of Head Start and Early Childhood Programs for the Duluth Public Schools, is hard at work creating change in her area. The growing number of children with difficult-to-manage behaviors, classroom safety concerns, and high emotional needs, has required a new approach and new partnerships.

One year ago, armed with a grant from the South St. Louis County Collaborative, Larson and leaders from the Arrowhead Equal Opportunity Agency Head Start and Hermantown-Proctor Schools partnered with the University of Minnesota Center for Early Education and Development (CEED) to address social-emotional needs of young children in their programs. They used the BEAM (Bridging Education And Mental Health) approach to engage the multi-agency staff in four days of joint training centered on re-tooling perceptions and responses to challenging behaviors. While all partner agency staff received the full training program, the Duluth Head Start and Early Childhood programs (Early Childhood Family Education, Early Childhood Special Education, and School Readiness) were so excited by the possibilities that they took the approach further, refining their entire set of programs to focus on relationships as the primary classroom and family building tool. Study groups, led by trained coaches, guided
further exploration of topics, strategies, techniques, and discussions among staff as the concepts were tested in classrooms. Teachers learned and supported one another in these groups, earning in-service credits that would build their professional portfolios and help them gain better understanding of concepts like antecedents and nurturing emerging child-adult relationships to reduce classroom stressors and enhance supplemental attachments.

“The staff approach in the classrooms now is that the relationship is the most important thing. It serves as the counterbalance to all of the early academic and cognitive development underway, because children can’t focus on learning colors when they are experiencing emotional distress,” said Larson. She reports that teachers find their classrooms easier to manage now and that staff regularly engage in discussions about what a behavior might really be indicating, as opposed to feeling overwhelmed. Although the initial grant funding is past, the lasting philosophical changes remain embedded across their programs and serve as incentive to move ahead into the next phase of the project: building the clinical professional base to treat identified children. “This is critically important work given the stressors faced by today’s families,” says Larson, who has high praise for the BEAM approach. “It’s been transformational – for our staff, our children and our community.”

**Renville County SUCCEEDs with Unique Partnership**

The public health nurses of Renville County in Minnesota have also embraced the concept that transformational philosophy leads to lasting change in practice. In 2002, their local children’s mental health collaborative, PACT 4 Families, assembled 21 early childhood educators and public health nurses from four counties to implement Project SUCCEED (Supporting and Understanding Children’s Cognitive and Emotional Early Development).

Under a three-year federal grant, they formed a team of service professionals working with at-risk children and families during the early years, even prenatally. During the specialized training each team member received, largely via CEED and University Field Faculty, acceptance of doing “therapeutic work” versus “therapy” emerged, and the transformation began. Attachment theory, relationship-based practices, curriculum and reflective consultation aided team members in building a common set of tools they could put into practice.

“This was so innovative,” says MaryKay Sinner, a public health nurse in Renville County. “Teachers and nurses as teams – training together, consulting together, educating together. Even now after the grant is over, we cannot go back to the way it was before, and everyone, especially families, benefit from that experience.” Enthusiasm and results bring new partners to the program, including Head Start, social services case managers, and more early childhood and public health staff who now participate in more training, such as monthly reflective consultation groups with a trained clinician. “We have more confidence in what we do for kids and families,” shares Jean Younger, also a public health nurse in
Renville County. “SUCCEED gave us permission to do what we’ve always known we needed to do. We support the parents in ways that equip them to make more progress on not only their own issues, but in tackling the generational cycles of attachment and behavioral challenges. That is true lasting change.”

**A New Curriculum in Crookston**

Dr. Jodi Boerger, Psy.D., a clinical child psychologist at Northwestern Mental Health Center in Crookston, knows something about the clinical mental health shortages facing Greater Minnesota. In seeing children birth to age six in a five-county area, she faced a mounting caseload of very young children and the increasing need for clinical consultation to educators, public health nurses and in-home therapists directly serving these at-risk children.

Facing this reality, the Rainbow Connection curriculum was created by Dr. Boerger and is being piloted with children at-risk-of or exhibiting social-emotional difficulties. “Rainbow Connection is an attachment and play-based curriculum that can be used for prevention and early intervention in a developmentally appropriate way,” says Dr. Boerger. The initial phase of implementation is currently underway via approximately 50 trained staff from public health, social services, and Head Start, as well as in-home mental health in consultation with Dr. Boerger. Additional plans include testing the material for efficacy and reliability of the model.

While the hard data is still to come, the early anecdotal evidence is encouraging. Dr. Boerger says, “The medical providers are responding now in ways they haven’t before, the staff have new tools to use with very young children, and we’re seeing improved parent/child relationships as a result. Home-based therapy referrals are exploding, which is driving our mental health center to respond to a whole new clientele – we’re bridging the gap between mental health and community agencies, and that is exciting.”

**Common Lessons**

Similar best practices that are worthy of careful reflection exist within these three programs. There is great hope for their replication across the state with emerging partners, including the University, that
build both clinical and professional capacity via technology-aided training and consultation. Hallmarks for programs of change include:

- Relationships with children and their families are central to promoting healthy development.
- Collaborative training opportunities help staff build skills and form supportive networks.
- Consultation with mental health professionals result in shifts in practice.
- Building relationships between professionals offers opportunity for change beyond funding.

Common lessons from these and other Greater Minnesota pioneers offer strategies upon which others can build. By working together to blaze new trails, communities can nurture the healthy social and emotional development of young children to provide them with a solid base for success in school and in life.

**More Information**

For more information, visit the Bridging Education and Mental Health Web site at http://education.umn.edu/ceed/projects/beam/default.html.

**Contributors**

Marilyn Larson is Director of Head Start and Early Childhood Programs with the Duluth Public Schools, MN. She may be reached at 218/733-2084 or marilyn.larson@duluth.k12.mn.us.

Jean Younger is a Public Health Nurse with Renville County Public Health in Olivia, MN. She may be reached at 320/523-2570 or jean_y@co.renville.mn.us.

MaryKay Sinner is a Public Health Nurse with Renville County Public Health in Olivia, MN. She may be reached at 320/523-2570 or marykay_s@co.renville.mn.us.

Jodi Boerger, Psy.D, is a Clinical Child Psychologist with Northwestern Area Mental Health Center in Crookston, MN. She may be reached at 218/281-3940 or jboerger@nwmhc.org.

Sara Carlson is Program Officer with the Southwest Initiative Foundation. She may be reached at 320/587-4848 or sarac@swifoundation.org.

**CEED Trainings for Parents and Professionals**

http://education.umn.edu/ceed/coursesandtrainings/

CEED provides training services to parent groups and to professionals in early education, health care, social services, and mental health fields. CEED tailors trainings to group and organizational needs, be it a full-day presentation for 100 or a two-hour training for staff at a child care center. Trainings can incorporate an array of training materials such as manuals, videos, demonstrations or instructional interactive CD-ROMs.

Training topics include but are not limited to:

- Addressing the Needs of Children Who Engage in Challenging Behavior
- Bridging Education and Mental Health
- Introduction to Infant Mental Health
- Parent-Infant Pathways
- Relationship-Based Teaching with Young Children
- Steps Toward Effective, Enjoyable Parenting (STEEP™)

For a full list of topics and a training request form, visit http://education.umn.edu/ceed or call 612/625-2252.
CEED's Infant and Early Childhood Mental Health Certificate Program

By Christopher L. N. Watson

The Center for Early Education and Development (CEED) at the University of Minnesota is taking the lead in establishing intensive and comprehensive training programs aimed directly at increasing the capacity of professionals to support families and other professionals in the area of infant and early childhood mental health. The University of Minnesota’s Infant and Early Childhood Mental Health Certificate Program, scheduled for launch in fall 2007, will be a two-year, dual-track training program offered for CEUs or graduate-level academic credit. One track will be focused on the needs of mental health clinicians who want to learn about or enhance their knowledge of treating younger children. The second track will be geared toward “frontline” community providers (home visitors, early interventionists, public health nurses, child protection workers, etc.) seeking increased knowledge of the mental health needs of young children and their families.

Interest in mental health training among early childhood professionals is high, as evidenced by the more than 400 e-mails CEED has received in response to the initial announcement of the new certificate program. Among those expressing interest were professionals not only from Minnesota, but also Alaska, Arizona, California, Connecticut, North Dakota, South Dakota, Washington, Wisconsin, Canada and New Zealand. Interested persons represented a broad range of professions or disciplines, including early childhood special education, public health nursing, school psychology, early care and education, Head Start, social work, physical therapy, speech and language therapy, parent education, occupational therapy, medicine, and psychology.

So, how and when did CEED become involved in the mental health of infants and young children? In 1993, representatives of Minnesota state agencies and interested local providers began to discuss mental health and Part C (early intervention services supported through the federal government within the Individuals with Disabilities Education Act). Through these informal initial discussions, participants sought a common understanding of the infants and young children within Part C for whom there are mental health concerns. It became apparent that in Minnesota there was neither a common definition of infant mental health nor an infrastructure to address the mental health of infants and toddlers (let alone those who were also served by Part C). Yet the needs of young children were great along the entire continuum, from universal needs for healthy relationships and general health to needs for intensive
therapeutic intervention for some infants and toddlers and their families.

CEED’s work in the area of infant and early childhood mental health began with the Minnesota Infant Mental Health Project, a cross-agency initiative coordinated by CEED and funded by the Minnesota Departments of Health, Human Services, and Education. During the project’s existence from 1996 to 2004, project staff conducted a statewide needs assessment, set forth recommendations for service provision, held trainings and public forums, and produced the online course authored by Susan Schultz, entitled "Introduction to Infant Mental Health." The online course is offered periodically throughout the year and continues to provide professionals with a beginning understanding of infant mental health theory, research and practice.

Interest in mental health training among early childhood professionals is high, as evidenced by the more than 400 e-mails CEED has received in response to the initial announcement of the new certificate program.

Concurrent with CEED’s work in this area, the Irving B. Harris Training Center for Infant and Toddler Development at the Institute of Child Development (ICD), University of Minnesota, provided infant mental health training for a wide range of community providers and supervisors, building on ICD’s wealth of research on early development and preventive intervention with young children and families in high risk circumstances. To a large extent, the Harris Center’s infant mental health work drew on lessons learned from the implementation, evaluation and adaptation of the STEEP™ (Steps Toward Effective Enjoyable Parenting) program with different populations of high risk children and families. Developed in 1986 by Drs. Byron Egeland and Martha Farrell Erickson, STEEP™ reaches out to parents even before their first child is born. Guided by attachment theory and research, STEEP™ works on the premise that a relationship with a sensitive, responsive parent helps a baby develop trust, confidence, motivation and the ability to regulate emotions and behavior. Through home visits and group sessions, STEEP™ facilitators work alongside parents to help them understand their child’s development, learn to respond sensitively and predictably to their child’s needs, and make decisions that ensure a safe and supportive environment for the whole family. One of the core strategies in the STEEP™ program is Seeing Is Believing®, a unique practice that helps parents increase their sensitivity and responsiveness to their babies’ cues through videotaping and guided viewing. Seeing Is Believing® promotes perspective-taking by giving parents a chance to see, from the camera’s point of view, what happens between them and their baby. Many public health nurses and other home visitors have incorporated Seeing Is Believing® into their practice, and the STEEP™ program now is implemented with
different populations across the U.S. and in Europe, Australia and New Zealand. Now that CEED and the Harris Center have merged, we more easily can bring our combined resources to this pressing issue in early childhood. With the addition of this new certificate program, Minnesota can rightly claim continuing leadership in providing critical supports and services to families.

More information is available online at the following Web sites:

- STEEP™ and Seeing Is Believing® Trainings at http://education.umn.edu/ceed/coursesandtrainings/trainings/steepsib.htm
- Infant Mental Health Feasibility Study at http://education.umn.edu/ceed/publications/briefsandreports/imhstudy/default.html

Christopher L. N. Watson, M.S., M.A., is Director of Professional Development with the Center for Early Education and Development, University of Minnesota, Minneapolis. He may be reached at 612/625-2898 or watso012@umn.edu.

NEW!

CEED Online Courses for 2007
http://education.umn.edu/ceed/coursesandtrainings/ • 612/625-6617

- Parent-Infant Pathways (PIP)
  Instructor: Jolene Pearson, MS
  Summer session: June 11 to August 13
  Fall session: October 8 to December 10
  New parents are especially eager to understand their infant’s growth and development. The period following the birth of a child offers a special opportunity for professionals to reach new parents with important information and to build relationships. Parent-Infant Pathways captures the key information needed by new parents, has effective strategies and materials to impart this information, and explains how to empower parents and demonstrate support.

- Introduction to Infant Mental Health
  Instructor: Scott Harman, MSW, LICSW
  Summer session: June 4 to August 6
  Fall session: September 17 to November 12
  Introduction to Infant Mental Health is designed for professionals interested in an introduction to the field of infant mental health and intervention with infants, toddlers, and their parents. Readings, video, and observational tasks are included to familiarize students with the foundations of infant mental health and direct work with infants and parents. While not a clinical class, this course attempts to introduce the role and function of the infant mental health specialist and the use of relationship and reflection in work with families.
Infant and Early Childhood Mental Health: Best Practice Profiles

Introduction

As with any area of child or family services, we always should aspire to “best practices” in infant and early childhood mental health. But what does that really mean? Ideally a program or strategy should be “evidence-based” – that is, supported by evidence that it produces the desired outcomes for program participants. The gold standard in evidence-based practice is when programs or strategies are demonstrated to be effective in randomized, controlled trials – a costly and often difficult endeavor. But even when a program has been shown to be effective in a randomized study, future implementation must be monitored carefully to ensure program integrity (i.e., that it is being carried out exactly as it was intended) and face careful scrutiny if it is adapted to new populations or new conditions.

Because there are not always evidence-based strategies available (particularly those tested by this gold standard) – and because young children and their families need help now – service providers often need to rely on promising, rather than proven, practices. To be considered “best practices” those should be: 1) guided by well-supported theory; 2) grounded in research that indicates key risk and protective factors shown to influence developmental outcomes; and 3) subjected to ongoing evaluation using the most rigorous methods available. (For a more detailed discussion of how to make sense of evaluation data, see Erickson & Kurz-Riemer, 2002, Chapter 2, pp. 27-52.)

To illustrate, the following brief pieces offer five examples of programs or strategies that are guided by attachment theory (one of the central theories in infant and early childhood mental health) and grounded in relevant research on risk and protective factors. These programs fall along a continuum from prevention to early intervention to treatment. As noted in the descriptions, both the Steps Toward Effective, Enjoyable Parenting (STEEP™) program and infant-parent psychotherapy have been demonstrated effective in randomized, controlled studies. The other programs have been – or currently are being – evaluated with varying degrees of rigor as circumstances and resources allow.

Reference


Contributed by Martha Farrell Erickson, Ph.D., Co-chair of the President’s Initiative on Children, Youth & Families, and Director of Harris Programs with the Center for Early Education and Development, University of Minnesota, Minneapolis. She may be reached at 612/625-3058 or mferick@umn.edu.
STEEP™ at St. David’s Child Development & Family Services

St. David’s Child Development & Family Services in Minnetonka incorporates the format, principles, goals and strategies of STEEP™ into its county-funded preventive-intervention program for “at-risk” infants, toddlers and their families. A successful collaboration between Plymouth Youth Center and St. David’s extends this effort into north Minneapolis. St. David’s STEEP™ programs now serve 60 families across the two sites; adolescent parents head approximately 30 of these families.

Despite considerable funding limitations, St. David’s sustains a commitment to the original STEEP™ design, which is grounded in attachment theory and research and which was demonstrated to be effective in a randomized, controlled trial conducted at the University of Minnesota (see Egeland & Erickson, 2003). Through regular home visitation (beginning during pregnancy) and bi-weekly parent-infant groups, STEEP™ facilitators provide families with concrete assistance, emotional support, developmental guidance, early relationship assessment, child and family advocacy, and therapeutic interactions that help parents confront past and present risk factors that may compromise their ability to care for their children. Throughout the program, parents participate in the Seeing Is Believing® video strategy developed as part of the original STEEP™ program to enhance parental understanding and sensitivity.

The positive effects of STEEP™ are contingent upon the capacity of the home visitor to create supportive and caring relationships with difficult-to-engage families. Reflective supervision, provided regularly and frequently to all STEEP™ facilitators, helps develop and sustain the psychological-mindfulness that enables staff to remain regulated and connected with at-risk families throughout the two- to three-year length of participation. Through regular meetings designed to promote self-awareness, flexibility and observational skills, home visitors develop competence and confidence to use their relationships with families as the vehicles for change. (See “A Beautiful Bond” on page 5 of this issue for one mother’s story of how the STEEP™ program at St. David’s affected her life and that of her child.)

Reference


Contributed by Scott Harman, MSW, LICSW, Field Faculty member with the Center for Early Education and Development, University of Minnesota, Minneapolis. He is based at St. David’s Child Development and Family Services, Minnetonka, MN. He may be reached at 952/939-0396 or sharman@stdavids.net.
Baby’s Space and the Baby’s Space Partnership: Integrating STEEP™ Parenting Support Services and High Quality Childcare

Inspired by other successful adaptations of STEEP™ and propelled by welfare-to-work reform legislation necessitating that more families living in poverty place their children in childcare, the Baby’s Space program, located at Little Earth Neighborhood Early Learning Center in the Phillips neighborhood of Minneapolis, provides high quality childcare and enhanced learning opportunities for children six weeks to five years of age, an important window of opportunity for optimizing children’s development. Founded on the attachment-based principles of STEEP™, the Baby’s Space model reflects the belief that the parent-child relationship is paramount and that the promotion of healthy parent-child relationships requires services that evolve within the needs of the family and their community. The STEEP™ family facilitators offer individual parenting support and advocacy services through home visits, mother-infant groups, family nights, Seeing Is Believing® videotaping, and doula (childbirth coaching) services. The full-day enriched classrooms are staffed by teachers in higher than required staff-to-child ratios. All teachers receive training and consultation in responsive, culturally sensitive, attachment-based care and strategies that promote young children’s mental health and development.

Serving primarily families living in poverty, the Baby’s Space model is currently being replicated in three additional.

---

STEEP™ – Steps Towards Effective, Enjoyable Parenting

Relationship-based Strategies for Working with Infants and Families in High-Risk Circumstances

Instructors: Kathi Blomquist, MS, PHN; and Mary Quinlan, MS

Dates: June 18 to 22, 2007, 9 a.m. - 4 p.m.

Location: University of Minnesota, Minneapolis

Cost: $400; CEUs available (30 clock hours)

This training is for professionals who are interested in learning more about how to work with parents and very young children through STEEP™. Among the specific topics and strategies included in STEEP™ are making relationship-based practice real, from participant recruitment to program termination; using videotaping and guided viewing (Seeing Is Believing®) to promote parental understanding, sensitivity, and responsiveness; planning and leading parent-infant groups; challenging and supporting parents to reflect on their own relationship history and how it influences their attitudes, feelings and parenting behavior; and using reflective supervision (or consultation) to sustain the hope and energy of service providers and ensure effective service for families.

FFI or to register online, visit: http://education.umn.edu/ceed/coursesandtrainings/courses/junesteep.htm. Questions? Contact Sara Zettervall at sarazet@umn.edu or 612/625-2252.
sites in Minneapolis, funded by grants from the McKnight and Bush Foundations through the Baby’s Space Partnership, a project of CEED at the University of Minnesota. An evaluation study, overseen by University of Minnesota faculty members Amos Deinard and Michael Rodriguez, will track the adaptation of the model across these different settings.

*Contributed by Michele Fallon, MSW, LICSW, Clinical Director of the Baby’s Space Partnership, Center for Early Education and Development, University of Minnesota, Minneapolis. She may be reached at 612/874-4741 or fallo009@umn.edu.*

**The Families Together Program**

The Families Together Program supports 48 preschoolers struggling with high levels of family stress, including poverty, family violence, child abuse and neglect, chemical dependency, incarceration, homelessness, and mental health problems. Program components include early childhood classes three or four half-days a week; play therapy, occupational therapy, speech and language therapy; and family support. Children participate one to two years.

At Families Together, children often come to school with stress, hurt, and difficult memories from home. Sometimes the memories and hurts are expressed through swearing. A little boy who has witnessed and experienced much physical and verbal abuse recently started preschool. He began yelling angry swear words on the bus. I said, “Sometimes grown-ups say angry swear words to children, and those swear words hurt children’s hearts. Jason remembers some of those hurting words, and we need to help him get those hurting words out of his heart.” I then told Jason we would catch all those hurting swear words in his hat, and throw them out the door of the bus so they wouldn’t hurt his heart anymore. I held his hat in front of Jason and told him he could say all the hurting swear words into his hat. When he was done, the bus driver stopped, and we tossed the hurting swear words from the hat out the door, so they wouldn’t hurt Jason anymore. The swearing was done for the day.

Another response that we teach children when another child swears is to say, “What’s the matter?” Swearing often indicates a child is distressed, not just being “naughty.” One day, a three-year-old girl was swearing at the coloring table. The four-year-old boy next to her said, “What’s the matter?” She answered, “My foster mom’s been hitting me.” The little boy suggested, “Why don’t you tell her to use her words?” The little girl answered, “Not her, she’d just hit you harder.” The little boy nodded, and the two children went back to coloring. A caring, empathetic response is powerful, even when we can’t solve a child’s problems! We teach children to ask “What’s the matter?” when a friend is swearing, rather than the more common preschool coaching of “I don’t like that,” which often makes children feel rejected. Empathy to others distress can be helpful to both children.

For more information, see the Relationship-Based Teaching course Web site at http://education.umn.edu/ceed/coursesandtrainings/courses/rbt.htm.

*Contributed by Julie Nelson, Early Childhood Teacher with the Families Together Program, Lifetrack Resources, St. Paul, MN. She may be reached at 651/227-8471 or julien@lifetrackresources.org.*
Washburn Child Guidance Center’s Preschool Day Treatment Program

Over the years, staff at the preschool day treatment program at Washburn Child Guidance Center in Minneapolis recognized that many of the young children referred for aggressive behaviors had early histories of attachment disruptions. Using an attachment lens, staff realized that self-regulation of arousal was a primary deficit in the children’s functioning, leading them to react to both internal and external distress with panic. Companion to this was the children’s inability to use others – to look to adults at these moments of distress with hope that help might be offered.

In normative development, self-regulation emerges from repetitive experience of distress and repair, as babies expect their parents to come to their “rescue” and learn from these reliable interactions how to feel regulated again. As is characteristic of disorganized and anxious attachment patterns, “more than at-risk” children instead assume that care would add to their miseries. Since positive company and mutual regulation have been missing in these children’s lives, this day treatment program uses this pathway to counter these early and learned expectations. By joining a child in moments of distress (an opportunity amply available within the group treatment experience), staff help the child to experience the possibility of a different outcome or expectation, and over time, to gradually learn to better manage (to self-regulate). As this self-regulation becomes possible, the child is also helped to reflect – to become aware both of internal emotions and the intentions of others – and to be an active and pro-social participant in a social group of peers.

A preliminary evaluation carried out by Trisha Beuhring at the University of Minnesota’s Institute on Community Integration yielded promising results of the program’s effectiveness (Beuhring, 2006).

Reference


Contributed by Anne Gearity, Ph.D., LICSW, Field Faculty member with the Center for Early Education and Development, University of Minnesota, Minneapolis. She is based at Washburn Child Guidance Center, Minneapolis. She may be reached at 612/825-7200 or geari002@umn.edu.

Attachment Theory and Infant Parent Psychotherapy

Infant-parent psychotherapy is an in-depth treatment for parents and young children who are at risk for emotional difficulties, abuse, or neglect. Developed in the 1970s by Selma Fraiberg, M.D., and expanded through the Infant-Parent
Program at the University of California, San Francisco, infant-parent psychotherapy combines traditional psychoanalytic concepts and attachment theory to understand and treat relationship difficulties between parents and children. As demonstrated in a randomized, controlled study designed by Lieberman, Weston, and Pawl (1991), this kind of intervention can significantly improve relationships between parent and child and reduce anxiety and hostility in their children.

What Infant-Parent Psychotherapy Looks Like:

- Provider uses the therapeutic relationship to explore parent’s thoughts and feelings about the infant or toddler, caregiving responsibilities, and relationships, past and present.
- Provider attends and responds to parental histories of abandonment, separation and loss as they affect the care of the infant, the parent’s emotional health, and the developing relationship between parent and infant.
- Provider allows core conflicts and emotions to be expressed; hold, affirm, and contain them.
- Provider stays emotionally available, curious, open, and reflective.

Source

While most parents are warmly attentive and responsive to their children, some parents are indifferent to, bewildered by, or hostile to theirs. Attachment theory helps explain parenting difficulties, the effects on the developing child, and the intergenerational transmission of parenting patterns. Attachment concepts such as the internal working model and adult state of mind help the infant-parent psychotherapist understand how parents’ past experiences of relationships are replicated in their current relationships with their children. Furthermore, research into patterns of insecure attachment clarifies how the child’s expectations of relationships (the child’s developing internal working model) can lead to behavioral and emotional difficulties in young children whose parents struggle to provide “responsive enough” care.

Reference

Contributed by Carol Siegel, Ph.D., LP, Field Faculty member with the Center for Early Education and Development, University of Minnesota, Minneapolis. She may be reached at 612/825-4307 or cfsiegel@gmail.com.
“Risk, Resilience, and Race in Early Childhood: Issues for Research and Action”

April 24, 2007
1 - 4:30 p.m.
Coffman Memorial Union
University of Minnesota

Featured speakers (visit Web site for full list of panelists):

Wei-Jun Jean Yeung, Research Professor, Department of Sociology; Senior Research Scientist, Center for Advanced Social Science Research, New York University

Chris Coleman, Mayor of St. Paul

Byron Egeland, Irving B. Harris Professor of Child Development and CEED Fellow, University of Minnesota

For more information and to register online, visit http://education.umn.edu/ceed/events/roundtable/. Questions? Contact Sara Zettervall at sarazet@umn.edu or 612/625-2252.

For more information about CEED events:
http://education.umn.edu/ceed/events/