

Winona State University

OpenRiver

Counselor Education Capstones

Counselor Education - Graduate Studies

5-1-2019

Infant and Early Childhood Mental Health: Relationship-based Interventions for At-risk Families

Britney Brennan
Winona State University

Follow this and additional works at: <https://openriver.winona.edu/counseloreducationcapstones>

Recommended Citation

Brennan, Britney, "Infant and Early Childhood Mental Health: Relationship-based Interventions for At-risk Families" (2019). *Counselor Education Capstones*. 91.

<https://openriver.winona.edu/counseloreducationcapstones/91>

This Capstone Paper is brought to you for free and open access by the Counselor Education - Graduate Studies at OpenRiver. It has been accepted for inclusion in Counselor Education Capstones by an authorized administrator of OpenRiver. For more information, please contact klarson@winona.edu.

Running head: IECMH RELATIONSHIP-BASED INTERVENTIONS

Infant and Early Childhood Mental Health: Relationship-based Interventions for At-risk Families

Britney Brennan

A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Spring 2019


Winona State University
College of Education
Counselor Education Department

CERTIFICATE OF APPROVAL

CAPSTONE PROJECT

Project Title

This is to certify that the Capstone Project of
Britney Brennan
Has been approved by the faculty advisor and the CE 695 – Capstone Project
Course Instructor in partial fulfillment of the requirements for the
Master of Science Degree in
Counselor Education

Capstone Project Supervisor: 
Dawnette Cigrand, PhD

Approval Date: September 29, 2019

Abstract

This paper explores the literature regarding relationship-based interventions for building caregiver capabilities in at-risk families to improve Infant and Early Childhood Mental Health (IECMH). An overview of IECMH establishes the importance of early intervention in preventing more severe mental health issues across the lifespan, followed by a discussion of caregiver roles in early childhood development, presentation of IECMH issues, and the complexity of risk factors for maladaptive outcomes. A case is made for relationship-based interventions performed within the home, such as Parent-Child Interaction Therapy (PCIT) and Attachment and Biobehavioral Catch-Up (ABC), as most efficacious in reducing barriers and achieving desired outcomes.

Table of Contents

Introduction	6
Infant and Early Childhood Mental Health (IECMH)	7
Conceptualization of Client Issues	8
Early Intervention	9
Review of Literature	11
Caregivers in Early Childhood	11
Early Relationships	11
Secure Attachment	12
Insecure-Avoidant	12
Insecure-Ambivalent	12
Insecure-Disorganized	13
Early Experiences	13
Ongoing and Cumulative	13
Stimulation	14
Plasticity	14
Organization	15
Toxic Stress	15
IECMH Outcomes	16
At-Risk Families	18
Intergenerational Effects	18

Maternal Sensitivity	19
Coercive Parenting	20
Parent Help-Seeking	21
Relationship-Based Interventions	22
Parent-Child Interaction Therapy (PCIT)	23
Home-Based PCIT	24
PCIT Training and Delivery	24
Efficacy	25
Attachment and Biobehavioral Catch-Up (ABC)	26
Efficacy	26
Randomized Clinical Trial	27
Results	27
Implications	28
Limitations	28
Conclusion	29
References	30

Infant and Early Childhood Mental Health: Relationship-based Interventions for At-risk Families

Early childhood is a period of rapid development and high capacity for change in the brain as it makes more than 1 million new neural connections every second, building the foundation for future learning and development to occur throughout the lifespan (World Health Organization, 2016). According to Zero to Three (2017), infants with responsive, consistent, nurturing caregivers and safe, economically secure environments are more likely to have strong emotional health, which is the essential foundation supporting growth and well-being in physical development and health, cognitive skills, language and literacy, social skills, and the child's approach to learning and school readiness. When emotional health in early childhood is compromised, all other key aspects of development are unable to optimally function, with far-reaching impacts across the human lifespan in which children are more vulnerable to poor health, poor educational outcomes, and criminal justice involvement (Zero to Three). Zero to Three estimates 9.5% - 14.2% of young children experience emotional, relational, or behavioral disturbances in early childhood, with an increased risk of disturbances that develop into disorders for children living in families coping with poverty, parental loss, substance abuse, mental illness, or trauma exposure. Further, recent neuro-scientific evidence published by the World Health Organization (WHO, 2016) revealed approximately 250 million, or 43%, of children in low- and middle-income countries are unable to reach their full developmental potential. Jadwin (2019) discovered that preschool and prekindergarten educators and administrators in Minnesota have noticed an increase in underdeveloped social-emotional skills in students within the classroom demonstrated through escalated behaviors including verbal and physical aggression, one of the

most common behavioral issues in preschool-age children. It is challenging for children to be socially and academically successful if they do not acquire the basic skills of labeling and expressing emotions, self-regulation, focus, problem-solving, communication and relationship building at a developmentally appropriate level (Jadwin, 2019).

These risk factors and outcomes only begin to scratch the surface on positive and negative impacts of this critical period in life, both short and long-term. This paper introduces a basic description of Infant and Early Childhood Mental Health (IECMH) before reviewing the literature regarding the importance of caregiver roles in promoting early childhood development and the dynamics faced by at-risk families. This paper then explores IECMH outcomes using relationship-based interventions to build caregiver capabilities in at-risk families and discusses implications for parents, educators, and professionals.

Literature Review

Infant and Early Childhood Mental Health (IECMH)

IECMH is a comprehensive term referring to the emotional health of children from birth to 5-years-old in addition to the “full continuum of services and supports necessary to promote healthy development, prevent mental health problems, and treat mental health disorders” (Zero to Three, 2017, p. 1). More specifically:

IECMH is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture (Zero to Three, 2017, p.1).

In regard to the full continuum of services, promoting IECMH might include programs to educate caregivers about their essential role in providing responsive, nurturing environments,

while prevention efforts might focus on identifying, screening and supporting young children at risk for developing mental health problems by consulting with childcare settings, pediatric offices, home visiting programs, and other early childhood programs (Zero to Three, 2017). Early childhood provides a window of opportunity for improving health and equity over the lifespan with optimal development serving as a buffer against adversity (World Health Organization, 2016).

Conceptualization of IECMH client issues. Infancy and early childhood are a critical period of development for the brain as the child adjusts to life outside of the womb and learns about the world around them. When negative experiences occur during this critical period, it can adversely affect the brain’s architecture, creating enduring connections that may lead to emotional, behavioral, or relational disturbances and eventually mental health disorders if left untreated (Zero to Three, 2017). As social, emotional, and physical development are unfolding, young children may not yet have the words or skills to communicate their difficulties.

0 to 3 Years of Age	3 to 5 Years of Age
Chronic eating or sleeping difficulties	Engaging in compulsive activities (e.g. play enacted in a specific order, hand washing, repeating words silently);
Inconsolable “fussiness” or irritability	throwing wild, despairing tantrums;
Incessant crying with little ability to be consoled	withdrawn or shows little interest in social interactions;
Extreme upset when left with another adult	displays repeated aggressive or impulsive behavior;
Inability to adapt to new situations	difficulty playing with others;
Easily startled or alarmed by routine events	little or no communication;
Inability to establish relationships with other children or adults	lack of language; loss of language demonstrated earlier
Excessive hitting, biting, or pushing of other children or very withdrawn behavior	being anxious and fearful in most situations

Table 1: Behaviors of Concern in Children 0 to 5 Years Old (Zero to Three, 2017, p. 3).

However, behavioral expressions in early childhood can cue adults into signs and symptoms of disturbances and mental health disorders. Behaviors that may warrant concern in infants and toddlers from birth to 3 years old and 3 to 5 years of age are delineated in Table 1.

Early intervention. When mental health concerns are identified early in life, early intervention services can change the course of emotional, behavioral, or relational disturbances and disorders, placing at-risk children on a path for healthy development (Zero to Three, 2017). Early intervention and accurate identification of mental health disorders in young children requires a diagnostic system that is developmentally specific to children birth to 5 years old, the *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (Zero to Three, 2017). Treatment of disorders include specialized interventions for infants, toddlers, preschoolers and their families provided by mental health professionals with advanced training in IECMH (Zero to Three, 2017).

The impacts of early prevention and treatment in IECMH go well-beyond young children and their significant adults, demonstrating the power to make societal differences. Due to the early onset of emotional and behavioral disorders, direct and indirect cost estimates total \$247 billion annually when disorders are left untreated, affecting federal and state spending on healthcare, education, child welfare, criminal justice, and economic productivity (Zero to Three, 2017). However, research validates that the full continuum of IECMH services, including promotion, prevention and treatment, is more cost-effective and beneficial than treating emotional difficulties and their associated impacts on learning and health later in life, once they have become more serious (Zero to Three, 2017). Caregiver roles in promoting early childhood development are crucial, so children's development can be affected by the dynamics within at-

risk families. From the time the child is born, the amount of support or stress they receive is likely to set the pathway for development.

Caregiving in Early Childhood

All humans have basic physiological and safety needs such as food, water, warmth, rest, shelter, stability, and freedom from fear in addition to psychological needs such as love, belonging and esteem (Yadolla Saeednia, 2010). These are key tasks driving human behavior across the lifespan, with caregivers providing support to children in meeting those needs. The research literature emphasizes the ways in which caregivers promote or impede children in meeting their needs and achieving developmental tasks.

Early relationships. In considering children's early relationships, it is necessary to understand human attachment, an enduring pattern which serves as a roadmap for navigating relationships with others across the human lifespan. The attachment behavioral system is a survival mechanism which likely evolved from the tendency of infant survival to increase with proximity to caregivers by ensuring infants were safe and received needed care (Kim, Woodhouse, & Dai, 2018). In other words, human nature predisposes infants and young children to form attachments with significant caregivers, using them as a "*secure base* from which they can explore and to which they can return as a *safe haven* when needed for protection and comfort" (Kim et al., 2018, p. 1320). The attachment system is activated when children are stressed, distressed, tired, or in danger, leading children to signal their caregivers for assistance by crying, moving closer to them, or indicating a desire to be held (Kim et al.). When children are calm and regulated, they are more likely to explore the environment in various ways, promoting development as they learn and grow their understanding of the world (Kim et al.). Exploration, and thus development, is "only possible, however, when the attachment figure is

available for the child to return to for help or comfort when needed” (Kim et al., 2018, p. 1320). Empirical evidence has established that infants become attached to caregivers by 12 months of age and quality of attachment depends on caregiver responsiveness and sensitivity toward the child’s signals (Kim et al.). Infants develop organized strategies for dealing with stressful or threatening events using one of the four attachment strategies described below.

Secure attachment. Healthy, or secure, attachments develop when “sensitive caregivers notice, properly interpret, and then respond promptly and appropriately to their children’s cues” (Kim et al., 2018, p. 1320). Infants with this pattern are able to use caregivers as a secure base for rich exploration of their environment, tolerate brief separations from attachment figures and demonstrate happiness upon reunification, and are easily soothed if distressed (Kim et al.).

Insecure-avoidant. Insecure attachments develop when infants do not receive consistent, responsive, sensitive, and nurturing care (Kim et al., 2018). These children are often ineffective in using caregivers as a secure base for exploration and have likely experienced caregivers as consistently unavailable for comfort (Kim et al.). Because they have learned to expect little comfort from caregivers, these children immediately stop showing distress upon reunion, avert their eyes, do not greet caregivers after separations, and appear to lack comfort-seeking (Kim et al.).

Insecure-ambivalent. This pattern results when caregivers have been inconsistently available to their children, resulting in difficulty soothing upon reunions and a tendency to remain emotionally dysregulated (Kim et al., 2018). As mentioned above, children in this category are also ineffective in using caregivers as a secure base for exploration.

Insecure-disorganized. Infants and young children with this attachment pattern respond in inconsistent, unusual or atypical ways upon reunion with caregivers after separation (Kim et

al., 2018). This pattern may develop when caregiver behaviors have been frightening or frightened (Kim et al.). Children may demonstrate fearful facial expressions, begin approaching caregivers before pivoting away at the last moment, suddenly freeze movements, or suddenly fall over for no apparent reason (Kim et al.). Unlike the other three attachment patterns which represent organized child adaptations to their environment, this category is characterized by absence of an organized strategy for responding to stressful events in the child's life and is said to mirror their acute dilemma (Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2005). In this paradoxical situation, the child cannot resolve their experienced stress or anxiety because the parent is simultaneously the source of fear and the only possible protective figure to turn to, leaving the child feeling "fright without resolution" (Bakermans-Kranenbur et al., 2005, p. 193).

Early experiences. Children's relationships and environments play a key role in early childhood, a critical period of rapid development which cannot be repeated. The transaction between young children, their relationships and their environments create experiences which promote or impede healthy development (Sroufe, 2005). In other words, the developmental process is a transaction in which everything is influencing and changing each other in various ways such as thoughts, behavior, and at the genome level (Center on the Developing Child, 2007).

Ongoing and cumulative. Development is a cumulative and continuous process throughout the lifespan, and early experiences impact the quality of the brain's architecture by "establishing either a sturdy or fragile foundation for all of the learning, health and behavior that follow" (Center on the Developing Child, 2007, p. 1). Vast and rapid neural connections are made in the first few years of life, with basic functions such as vision and hearing developing before higher cognitive functions such as language (Center on the Developing Child). After this

period, pruning begins to reduce connections for more efficient brain circuits with later, more complex brain circuits built upon earlier, simpler circuits (Center on the Developing Child).

Genes provide a blueprint of the brain's architecture, but experiences shape the quality of brain development and circuitry (Center on the Developing Child).

Stimulation. Reciprocal, or back-and-forth, interactions between children and their caregivers are crucial to the developmental process (Sroufe, 2005). Young children naturally seek interaction through babble, facial expressions, and gestures, and adults respond similarly by vocalizing or returning a gesture (Center on the Developing Child, 2007). In the absence of reliable and appropriate responses, “the brain’s architecture does not form as expected, which can lead to disparities in learning and behavior” (Center on the Developing Child, 2007, p. 1-2). Genes provide our bodies with instructions on how to work, but our environment, experiences, and stimulation leave a chemical “signature” that determines how and whether genes are expressed or carry out their instructions (Center on the Developing Child).

Plasticity. The brain is most flexible, or plastic, early in life to allow for a plethora of experiences, environments and interactions (Center on the Developing Child, 2007). As the brain matures, developing more specialized, complex functions through the process of pruning, it is less flexible or capable of reorganizing and adapting to new and unexpected challenges (Center on the Developing Child). In other words, plasticity makes it easier and more effective to influence the developing brain architecture than to rewire parts of its circuitry in adulthood (Center on the Developing Child, 2007).

Organization. The brain is highly coordinated and interrelated with other bodily functions, and one of its fundamental responsibilities is to organize human behavior (Sroufe, 2005). Emotional well-being and social competence provide the foundation for emerging

cognitive abilities, remaining closely intertwined throughout the lifespan, as all three constitute the foundation for overall human development (Center on the Developing Child, 2007). In this sense, organization is regulation.

Toxic stress. Chronic, unrelenting stress in early childhood damages the architecture of the developing brain by reducing neuron connections (Center on the Developing Child, 2007). Positive stress produces moderate and short-lived physiological responses to uncomfortable experiences which are necessary for healthy development (Center on the Developing Child). However, strong, unrelieved activation of the body's stress management system results from toxic stress due to experiences such as extreme poverty, repeated abuse, or severe maternal depression (Center on the Developing Child). Children have the capacity to assess dangerous situations, engage in emotional and physical reactions as well as protective actions (National Child Traumatic Stress Network [NCTSN], 2012). However, traumatic experiences elicit strong biological responses that can persist and alter the normal course of neurobiological development resulting in impairments in memory and emotional and behavioral regulation (NCTSN). Without the buffering protection of adult support and healthy attachment during early childhood, this stress activation is built into the body through the developing brain architecture (Center on the Developing Child).

IECMH outcomes. Early childhood development and attachment clearly play vital roles in IECMH. Tronick and Beeghly (2011) focus on the ways in which infants make meaning of their experiences and themselves in relation to the world to better understand the development of resilience or maladaptive outcomes during infancy and early childhood. The infant-caregiver relationship serves as a regulatory system but also shapes infant engagement with the world, consequently affecting the meanings infants assign to their experiences which in turn impact how

infants choose to interact with the world in future experiences (Tronick & Beeghly). Meaningful exchanges and growth-promoting interactions occur with reliable, responsive caregivers, allowing infants to develop secure, organized and coherent understandings of the world and their relationships in the moment, contributing to resilient outcomes in the long-term (Tronick & Beeghly). Infant success in making new meanings leads to feelings of wellbeing, pleasure, and joy while promoting positive engagement with the world (Tronick & Beeghly). A sense of wholeness and continuity develops as the infant-caregiver dyad create shared meaning of feeling connected and in relationship with each other (Tronick & Beeghly). Further, with the accumulation of successful dyadic matching, or the ability to repair interactive errors or misunderstanding of signals and cues, infants develop an implicit knowing that their dysregulated emotional state can be transformed into a positive state (Tronick & Beeghly). Tronick and Beeghly argue that moment-by-moment experiences of positive affect allow infants to develop a positive mood or affective core which enables them to enter new situations with positive feelings while building resilience.

In contrast, infants with harsh, unresponsive caregivers may learn to minimize engagement in order to safely maintain proximity with caregivers (Tronick & Beeghly, 2011). While adaptive in the short-term, this avoidant behavioral style may increase risk of maladaptive outcomes in the long-term such as a tendency to form insecure attachments in future relationships (Tronick & Beeghly). A chronic lack of consistent and appropriate social interaction with caregivers can lead to prolonged dysregulation and negative self-representations such as “I am helpless” or “My actions do not work in getting me help” (Tronick & Beeghly, 2011, p. 109). Without the shared meaning-making of the infant-caregiver dyad, infants show reactions consistent with sadness, anger, withdrawal, disengagement, anxiety and fear as they are unable to

make organized, coherent meaning of their experiences, resulting in dysregulation as their sense of self becomes threatened (Tronick & Beeghly). Tronick and Beeghly argue that prolonged mismatching, unsuccessful reparation, and a general failure to reestablish positive states in the infant-caregiver dyad lead to mental health problems by undermining the infant's trust in others. For example, infants of depressed mothers who are chronically exposed to negative maternal mood states may learn that the dyad's way of being together is characterized by helplessness and hopelessness, creating meanings such as "We can be sad together" rather than having infrequent or conflicted interactions with the caregiver (Tronick & Beeghly, 2011, p.115). When these atypical forms of meaning-making persist, development goes awry as infants are unable to master age-appropriate tasks such as developing self-regulation, forming attachments with caregivers, or establishing autonomy, increasing the risk of pathological outcomes (Tronick & Beeghly).

Early experiences with important caregivers become internalized as cognitive schemas, or internal working models (IWMs) of self and others, which influence expectations and perceptions of relationships, how emotions are regulated and expressed, and how individuals behave in interpersonal contexts (Kim, Woodhouse, & Dai, 2018). IWMs transmit early attachment experiences by unconsciously influencing functioning in later relationships (Kim et al.). With sensitive, responsive care from attachment figures, infants develop IWMs of the self as worthy of love and care in addition to the caregiver as someone who can be relied on in times of need (Kim et al.). However, infants do not expect that rejecting or unavailable caregivers will be there when needed and develop negative representations of themselves and others, in addition to ineffective strategies for coping with distress (Kim et al.).

At-Risk Families

Children at-risk for developing emotional, behavioral, or relational disturbances and disorders in early childhood experience a number of challenges within their family systems including but not limited to poverty, parental loss, substance abuse, mental illness, trauma exposure, lack of consistent, responsive caregivers, and lack of safe, secure environments. Researchers have identified maternal depression, maternal substance abuse, and domestic violence as particularly harmful to the healthy development of young children, especially when combined with the stress of living in poverty and lack of supports (Azzi-Lessing, 2013). Further, frequent community violence, inadequate housing, and shortage of social and recreational resources increases level of isolation for families living in very low-income neighborhoods (Azzi-Lessing). The presence and interaction between multiple risk factors creates a cycle of extreme stress, and parental capacity to focus on their children's learning and development is severely diminished when such risk factors are unaddressed and unresolved (Azzi-Lessing).

Intergenerational effects. Kim and colleagues (2018) suggest that infants and young children internalize both sides of the parent-child relationship, later influencing thoughts, feelings, and behaviors with their own children. Meta-analytic data show strong associations between caregiver attachment based on their own experiences growing up and their infant's attachment status, highlighting the tendency of parents to pass on their own representations of attachment to their children (Kim et al., 2018). Further, maladaptive interaction patterns within a mother's family of origin and a mother's own early childhood adversity are known to transmit risk across generations, accounting for associations with deficits in parenting, as quality of caregiving is influenced by childhood as much as it is influenced by contemporary adult experiences (Spieker, Oxford, Fleming, & Lohr, 2018). Parental childhood trauma disrupts the development of cognitive, emotional, and behavioral capacities necessary for healthy and

nurturing parenting, especially if severe, persistent, and if it occurred during critical stages of early development (Ammerman, Shenk, Teeters, & Noll, 2013). For instance, “a mother with early emotional trauma and a strong need to maintain physical or psychological distance from her infant to protect herself from further dysregulation” may fail to accurately notice, interpret, and respond to her infant’s distress as signaling a need for sensitive response in the moment (Spieker et al., 2018, p. 8). Parental childhood trauma is associated with caregiver emotional dysregulation, inadequate reading of emotional cues, disrupted attachment, parenting stress, depression, and low levels of social support (Ammerman et al., 2013).

Maternal sensitivity. Maternal depression impacts maternal sensitivity by resulting in mothers who are less attuned to and in-sync with their infants, are less playful and more irritable, and show less positive and more negative or neutral affect during infant-caregiver interactions (Spieker et al., 2018). However, it appears that a depressed mother’s response to infant distress is more disturbed than times of nondistress (Spieker et al.). While substance exposure and attachment patterns are indicative of adverse outcomes, maternal sensitivity and involvement have been found to be significantly more predictive of attachment patterns than substance exposure, indicating that biological risk is not as powerful as social risk in human development (Bergin & McCollough, 2009). Insecurely attached children have an increased risk of experiencing attention deficit hyperactivity disorder symptoms, poor verbal and cognitive ability, immature play, behavior problems, and poor physical growth (Bergin & McCollough).

Ammerman et al. (2013) examined the effects of parenting stress, defined as “the gap between the demands of parenting and available personal resources and the negative mental appraisals that emerge in response to this discrepancy” (p. 234). Factors which interact in complex ways to contribute to and maintain parenting stress include high demand (e.g., financial

hardship), development of ineffective coping strategies, maternal states (e.g., depression), and contextual vulnerabilities such as low levels of social support (Ammerman et al.). Correlated risks for parental stress include poverty, single parenthood, child behavior problems, low psychological resources and depression, which is a strong predictor of the persistence of parental stress (Ammerman et al.). Ammerman et al. also found that parenting stress interfered with attention and sensitivity to children's needs, disrupted goal-directed behavior, and contributed to parental maladjustment in relationships and overall functioning, especially in new mothers who face new demands and care requirements. Parenting stress is linked to harsh parenting practices, child maltreatment, and developmental delays in young children during the most vulnerable years for negative consequences of impaired parenting (Ammerman et al.).

Coercive parenting. Caregiver sensitivity results in different emotional responses in children which can be understood through attachment patterns. Scaramella and Leve (2004) provide a model for understanding coercive parent-child interactions which place young children at risk of developing emotional and behavioral disturbances in early childhood due to the mutually reinforcing cycle of intense hostility and negative emotionality. For example, a child may react to a caregiver request with anger and resistance, creating negativity that evokes hostile emotions and responses from parents, which only serve to further intensify emotional reactions in children (Scaramella & Leve). Such interactions are of concern during early childhood because they promote negative, reactive and externalizing child behavior and harsh parenting practices which hinder the development of social competencies (Scaramella & Leve). Some children are naturally more sensitive or emotionally responsive to environmental demands and consequently experience more difficulty learning how to regulate their emotions. When combined with harsh parental response, the child's successful development of regulatory

strategies is further impeded while continuing to reinforce hostile parenting (Scaramella & Leve). Intense negative parental emotions increase children's emotional arousal, interfering with their ability to interpret parental messages causing them to react on emotions rather than content of parent requests (Scaramella & Leve). Any of the previously mentioned risk factors can interact in complex ways, creating stressors and disruptions in at-risk families, setting a pathway of emotional reactivity in some young children and potential harsh parenting practices, fueling a vicious cycle of coercive parent-child interactions and developmental deficits.

Parent help-seeking. A discussion of risk factors provides some understanding of the contexts in which IECMH issues can develop into maladaptive outcomes. However, it is also important to understand how at-risk families connect with early intervention services, as research indicates that less than a quarter of children and adolescents with mental health issues access appropriate professional help (Oh & Bayer, 2015). Different populations vary regarding the factors which influence their decisions to access support including personal attitudes and beliefs about help-seeking (Oh & Bayer). With early intervention services, caregivers have a central role in seeking professional help for behavioral or emotional issues in young children (Oh & Bayer). The literature establishes that parents follow a three-step help-seeking process beginning with recognition that a problem is present, followed by parent consideration of whether help is needed for the issue, and the final stage wherein parents must overcome any attitudinal or physical barriers to help-seeking (Oh & Bayer). This study of parent help-seeking processes for early intervention services found that a key barrier to accessing professional help was caregiver recognition of a significant behavioral issue in their child. Further, the majority of parents experienced difficulty overcoming attitudinal and physical barriers to professional mental health services with many citing beliefs that their child's problem would improve on its own and that

[parents] were strong enough to handle the issue alone (Oh & Bayer). Parents with more positive help-seeking intentions were more likely to access professional care for their child in need than parents who felt ambivalent about seeking help (Oh & Bayer). However, a critical finding of this research demonstrated that parents who recognized their child's behavior as more difficult than average were seven times more likely to access professional help for their child's mental health issue, indicating the importance of increasing caregivers' ability to discern between normal challenging behavior and clinical level behavioral problems.

Relationship-Based Interventions

The literature clearly substantiates the importance of early relationships and experiences in early childhood mental health and development while citing various factors which may contribute to putting some families and young children at risk for developmental, emotional, behavioral or relational issues (Tronick & Beeghly, 2011). However, the research consistently supports secure attachment and positive parent-child relationships as important protective factors in early childhood (Kim et al., 2018). If problems persist and are left untreated, young children are at greater risk for maladaptive outcomes and future mental health issues throughout the life span. Two evidence-based treatments (EBTs) are discussed to determine outcomes and best practices in working with vulnerable families.

Parent-child interaction therapy (PCIT). Disruptive behavior problems affect hundreds of millions of young children and their families with prevalence estimates varying from 4 to 15% (Fowles et al., 2017, p. 1115). Parent-Child Interaction Therapy is a well-established evidence-based treatment for young children ages 2-7 with disruptive externalizing behaviors and their parents which aims to reduce negative and coercive parent-child interactions that often result from parent's lack of knowledge and inappropriate use of discipline (Fowles et al.). PCIT

is informed by social learning theory and attachment theory, using a one-way mirror to observe parent-child dyads and a bug-in-the-ear device to coach parents on how to attend to the child's behaviors consistently and predictably (Thomas & Zimmer-Gembeck, 2012). Parents learn behavior management strategies focusing on positive reinforcement rather than power assertion to reduce oppositional and disruptive behaviors while helping children to regulate emotions and providing parents with developmentally appropriate language and skills (Thomas & Zimmer-Gembeck).

PCIT consists of two phases, a relationship enhancement phase (Child Directed Interaction [CDI]) and a discipline phase (Parent Directed Interaction [PDI]) which typically occurs over 20 sessions (Fowles et al., 2017). The first phase, CDI, aims to enhance parent-child relationships as parents engage in play by following the child's lead, using selective attention to respond to appropriate behaviors with specific skills including behavior descriptions, labeled praise, and reflections while ignoring negative behaviors (Fowles et al.). In the second phase, PDI, parents learn how to give effective commands and provide consistent consequences (Fowles et al.). PCIT is unique and individualized for each family due to its focus on live coaching during therapy sessions and its mastery-based, data-driven approach (Fowles et al.).

Home-based PCIT. Traditionally, PCIT is performed in a clinic, and barriers such as lack of transportation or childcare for siblings prevent families of young children from participating in services (Fowles et al., 2017). However, Fowles et al. adapted the intervention to provide intensive services within the home to minimize such barriers to treatment common among families with limited resources and who ordinarily are less likely to engage in services (Fowles et al.). Home-based delivery has several advantages compared to clinic-based treatment including lower attrition rates, involvement of other individuals aside from the caretaker, and

more individualized attention (Fowles et al.). Specifically, in-home PCIT has ecological validity and allows for more rapid generalization of skills as therapists are able to observe parent/child behaviors and intervene in a natural setting while involving other family members in treatment and using PCIT skills with siblings and in varying situations (Fowles et al.). Further, home delivery is the preferred approach in working with families at risk for physical abuse and neglect due to its ability to increase retention by establishing strong rapport and high levels of support for families (Fowles et al.).

PCIT training and delivery. To be competent to use PCIT, therapists at minimum complete a 40-hour training with a PCIT master trainer according to PCIT training guidelines (Fowles et al., 2017). In Fowles et al.'s study, therapists completed the standard training in addition to receiving supplemental material specific to in-home delivery. Following intake, families received a general clinical evaluation and pretreatment observations using the Dyadic Parent-Child Interaction Coding System (DPICS) in a clinic or home-based setting depending on logistical issues, and all sessions thereafter were completed in-home with the exception of the initial PDI coaching sessions to ensure a level of environmental control (Fowles et al.). In-home coaching did not use electronic communication between therapist and caregiver, and therapists were trained to be as inconspicuous as possible when coding or coaching, sitting away from the child and ignoring any child attempts to communicate (Fowles et al.).

In addition to PCIT, families received wrap-around care including individual case managers for integrating community services (i.e., financial, food stamps, legal counsel) and involving the family in decision-making about service planning (Fowles et al., 2017). Case managers worked closely with the home-based PCIT therapists to create a customized Plan of

Care (POC), with caregivers, family supports, and the treatment team meeting each month to discuss the POC and any necessary adjustments (Fowles et al.).

Efficacy. Parent skills were recorded as CDI-do skills (i.e., those which are encouraged) and CDI-avoid skills (i.e., those which are discouraged; Fowles et al., 2017). To master CDI, parents had to demonstrate 10 labeled praises, 10 behavioral descriptions, and 10 reflections in a 5-minute period while demonstrating less than three questions, commands, and criticisms (Fowles et al.). Overall, results of the study found home-based PCIT to be equal to clinic-based PCIT in outcomes and with lower attrition of high-risk populations (Fowles et al.). In general, intensive home-based participants demonstrated significantly higher use of specified skills at the beginning of treatment and showed less improvement session-to-session as compared to clinic-based participants (Fowles et al.). Both modalities of PCIT lead to significant decreases in child disruptive behaviors with effects that are evident across settings and measurement methods and gains that are maintained over time (Fowles et al.). PCIT also has shown to improve positive parenting behavior and reduces negative verbalizations such as criticism and has been shown to reduce disruptive behavior in children with developmental delays, at risk due to abuse, and racial/ethnic minority populations (Fowles et al.).

Attachment and Biobehavioral Catch-Up (ABC). Attachment and Biobehavioral Catch-Up (ABC) is a 10-session evidence-based treatment for high-risk families shown to be effective in helping children form secure attachments to caregivers while improving children's ability to regulate emotions and physiology (Yarger, Hoye, & Dozier, 2016). ABC aims to improve caregiver quality by promoting identified targets known to play key roles in child development when faced with adversity by encouraging parents to behave in sensitive and delighted ways when the child is not distressed, provide nurturance when the child is distressed,

and reduce frightening behaviors at all times (Yarger et al.). Therapists gradually incorporate intervention targets into sessions by discussing research findings with parents, viewing video demonstrations of other parents and children, and watching video clips of their own previous sessions (Yarger et al.). Therapists record video of parent-child interactions throughout the intervention, serving as coaching tool for improving parenting behaviors and as a demonstration of growth through creation of a video montage upon completion of ABC (Yarger et al.). A key strategy thought to lead to changes in parenting behaviors is in-the-moment feedback from therapists regarding the targeted behaviors of delighting, following the child's lead, nurturance, sensitivity, and non-frightening behaviors (Yarger et al.). Initially, therapists point out parents' naturally occurring behaviors, and once rapport is established, begin using scaffolding techniques to encourage on-target behaviors when parents fail to behave in nurturing, sensitive, and non-frightening ways (Yarger et al.).

Efficacy. ABC demonstrates efficacy with regard to children's HPA axis functioning, attachment behaviors, and executive functioning (Yarger et al., 2016). Children demonstrated higher wake-up cortisol value and steeper slope which are normative for HPA axis functioning in typically developing children and differentiate high- and low-risk children (Yarger et al.). Further, changes in cortisol production have been shown to persist for 3 years after completion of ABC in addition to long-lasting change of children's executive functioning (Yarger et al.). The literature also supports evidence of attachment security and more sensitive parenting in families who complete ABC (Yarger et al.).

Randomized clinical trial. Yarger et al. (2016) sought to investigate how and when change occurs during ABC in conducting a randomized clinical trial of an experimental group receiving ABC intervention and a control group receiving an intervention focused on improving

children's fine and gross motor skills, cognition, and language abilities (Yarger et al.). Both interventions occurred across 10 weekly, hour-long sessions in the home with a parent coach interacting with the parent and child (Yarger et al.). For the experimental group receiving ABC, sessions 1 and 2 introduce the idea that children need nurturance even when they are not providing clear cues; sessions 3 and 4 encourage mothers to behave in sensitive and delighted ways by following the child's lead; sessions 5 and 6 help mothers identify and appropriately respond to children's signals while acknowledging that some play interactions can be frightening and/or intrusive; sessions 7 and 8 support mothers in exploring their own experiences of being parents and how those may be impacting their ability to meet intervention targets; and sessions 9 and 10 provide an opportunity for therapists to consolidate gains and focus more closely on areas where mothers continue to struggle in addition to celebrating accomplishments (Yarger et al.). Weekly homework assignments facilitate further comprehension of intervention targets (Yarger et al.).

Results. Yarger et al. (2016) found that mothers who participated in ABC were significantly more sensitive, less intrusive, and showed a steeper rate of change than mothers in the control group (Yarger et al.). The study substantiated that mothers showed a steeper increase in sensitivity and a steeper decline in intrusiveness during the first half of treatment than during the second half of treatment (Yarger et al.).

Implications

An examination of two empirically-supported, relationship-based interventions, PCIT and ABC, further confirmed their efficacy in achieving the changes they seek to influence in parent-child relationships. Examination of the two interventions supported previous findings in the research indicating that most change in relationship-based interventions occurs early in

treatment. Clinicians may use this as a point of reference for when parenting behavior is generally expected to change and make adjustments to the therapeutic approach if not seen by anticipated timelines (Yarger et al., 2016). Future research should aim at determining the exact number of sessions needed to sustain change in parenting behaviors and whether the second half of treatment is necessary to maintain improvements (Yarger et al.). Further, the literature supports the effectiveness of home-based treatments in reducing barriers to accessing professional support.

More can be done to better target and educate high-risk families in addition to other community supports such as early childhood educators through consultation and wrap-around services. Evidence-based treatments aimed at improving parenting quality are crucial for children who have experienced early adversity as it disrupts negative developmental trajectories and prevents more severe maladaptive outcomes across the lifespan. This constitutes future-oriented thinking which creates healthy societies in a time when mental health issues are on the rise and mental health professionals are in shortage.

Limitations

While the literature makes a strong case for the importance of IECMH and early intervention, it demonstrates a need for further educating caregivers and professionals on the full continuum of services intended to promote healthy development, prevent mental health problems, and treat mental health disorders in young children. This is especially true for society's most vulnerable families whom experience a complexity of risk factors including poverty, trauma exposure, substance abuse, and maladaptive interaction patterns transmitted across generations. Many parents and professionals continue to need support in distinguishing typical challenging behaviors from clinical level behavioral concerns in young children.

Conclusion

This literature review established the importance of IECMH and early intervention services, identified the vital role of early relationships and experiences, explored the pathways and contexts of maladaptive outcomes, and discussed the efficacy of two relationship-based interventions, Parent-Child Interaction Therapy (PCIT) and Attachment and Biobehavioral Catch-Up (ABC). Secure attachment and positive parent-child interaction patterns support resiliency in response to life stressors in IECMH. These are particularly important in at-risk families exposed to a plethora of risk factors as relationship-based interventions such as PCIT and ABC can provide the impetus to change maladaptive interaction patterns, preventing their transmission across generations of families while working towards healthier societies.

References

- Ammerman, R.T., Shenk, C.E., Teeters, A.R., & Noll, J.G. (2013). Multiple mediation of trauma and parenting stress in mothers in home visiting. *Infant Mental Health Journal, 34*, 234-241. doi: 10.1002/imhj.21383
- Azzi-Lessing, L. (2013). Serving highly vulnerable families in home-visitation programs. *Infant Mental Health Journal, 34*, 376-390. doi: 10.1002/imhj.21399
- Bakermans-Kranenburg, M.J., Van Ijzendoorn, M.H., & Juffer, F. (2005). Disorganized infant attachment and preventive interventions: A review and meta-analysis. *Infant Mental Health Journal, 26*, 191-216. doi: 10.1002/imhj.20046
- Bergin, C., & McCollough, P. (2009). Attachment in substance-exposed toddlers: The role of caregiving and exposure. *Infant Mental Health Journal, 30*, 407-423. doi: 10.1002/imhj.20221
- Center on the Developing Child. (2017). *Early childhood mental health*. Retrieved from <https://developingchild.harvard.edu/science/deep-dives/mental-health/>
- Center on the Developing Child. (2007). *The science of early childhood development* (InBrief). Retrieved from <https://developingchild.harvard.edu/resources/inbrief-science-of-eed/>
- Center on the Developing Child. (2011). *Three core concepts in early development*. Retrieved from <https://developingchild.harvard.edu/resources/three-core-concepts-in-early-development/>
- Fowles, T.R., Masse, J.J., McGoron, L., Beveridge, R.M., Williamson, A.A., Smith, M.A., & Parrish, B.P. (2017). Home-based versus clinic-based Parent-Child Interaction Therapy: Comparative effectiveness in context of dissemination and implementation. *Journal of Child and Family Studies, 27*, 1115-1129. doi: 10.1007/s10826-017-0958-3

- Jadwin, G. (2019). The Impact of Social-Emotional Development in Preschool (Thesis, Concordia University, St. Paul). Retrieved from https://digitalcommons.csp.edu/teacher-education_masters/13
- Kim, M., Woodhouse, S.S., & Dai, C. (2018). Learning to provide children with a secure base and a safe haven: The Circle of Security-Parenting (COS-P) group intervention. *Journal of Clinical Psychology, 74*, 1319-1332. doi: 10.1002/jclp.22643
- Oh, E., & Bayer, J.K. (2015). Parents' help-seeking processes for early childhood mental health problems. *Child and Adolescent Mental Health, 20*, 149-154. doi: 10.1111/camh.12081
- Scaramella, L.V., & Leve, L.D. (2004). Clarifying parent-child reciprocities in early childhood: The early childhood coercion model. *Clinical Child and Family Psychology Review, 7*, 89-107.
- Spieker, S.J., Oxford, M.L., Fleming, C.B., & Lohr, M.J. (2018). Parental childhood adversity, depressive symptoms, and parenting quality: Effects on toddler self-regulation in child welfare services involved families. *Infant Mental Health Journal, 39*, 5-16. doi: 10.1002/imhj.21685
- Sroufe, L.A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment and Human Development, 7*, 349 – 367. doi: 10.1080/14616730500365928
- Thomas, R., & Zimmer-Gembeck, M.J. (2012). Parent-Child Interaction Therapy: An evidence based treatment for child maltreatment. *Child Maltreatment, 17*, 253-266. doi: 10.1177/1077559512459555
- Tronick, E., & Beeghly, M. (2011). Infants' meaning-making and the development of mental health problems. *American Psychologist, 66*, 107-119. doi: 10.1037/a0021631

World Health Organization (2016). *Early child development*. Retrieved from

<https://www.who.int/topics/early-child-development/en/>

NCTSN Core Curriculum on Childhood Trauma Task Force (2012). The 12 core concepts:

Concepts for understanding traumatic stress responses in children and families. Core Curriculum on Childhood Trauma. Los Angeles, CA, and Durham, NC: UCLA-Duke University National Center for Child Traumatic Stress

Yadolla Saeednia, M. (2010). Innovation in scheming Maslow's hierarchy of basic needs. *US-China Education Review*, 7, 96-100.

Yarger, H.A., Hoye, J.R., & Dozier, M. (2016). Trajectories of change in Attachment and Biobehavioral Catch-Up among high-risk mothers: A randomized clinical trial. *Infant Mental Health Journal*, 37, 525-536. doi: 10.1002/imhj.21585

Zero to Three (2017, August). *The basics of infant and early childhood mental health: A briefing paper*. Retrieved from <https://www.zerotothree.org/resources/1951-the-basics-of-infant-and-early-childhood-mental-health-a-briefing-paper>