



CWTAC UPDATES

**SERIES ON INFANT AND EARLY CHILDHOOD/
FAMILY MENTAL HEALTH**

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DEFINING EARLY CHILDHOOD/FAMILY MENTAL HEALTH

“What do you mean **infant mental health**?Do you mean we need to have babies on couches? How serious can a behavioral problem be at three? ... How do you assess a one-year-old? ... Does the DSM IV appropriately apply to very young children?”... How do you treat an 18 month old? What role does County Mental Health have in treating infants, toddlers and young children anyway?”... Do we **have to** serve babies, toddlers and very young children ... Are we expected to solve all the family’s problems once we identify an infant mental health disorder?... How do you do it ...and why now?”

There has been a surge of interest in the field of infant and early childhood/family mental health in the last decade. This cross-disciplinary field acknowledges that early childhood mental health is an interagency

responsibility, and that all service systems play a role in addressing the mental health needs of very young children. Unmet early childhood mental health needs can result in significant impairment at home, with peers, in school, and in the community.

This is the first article in a four part series on infant and early childhood/family mental health. Future articles will address (1) typical early childhood development and identification of emotional disorders including characteristics of emotional health, indicators of emotional disorders, and co-occurrence with developmental disorders; (2) assessment and diagnosis including screening and assessment tools, differential diagnosis, and treatment implications, and (3) treatment models including parent training, childcare-based approaches, and dyadic interventions.

INFANT AND EARLY CHILDHOOD/FAMILY MENTAL HEALTH

Infant and early childhood/family mental health refers to the development of social and emotional well-being in infants and toddlers, including infant health and brain development, family functioning, and the “goodness of fit” in the infant/child-parent relationship. Typically infant mental health refers to children birth to three. Early childhood mental health is the more generic term referring to children birth to five.

Child-parent relationships provide the emotional foundations of child development, and the biological underpinnings for the development of resilience that enables the child to better cope with the challenges of growing up. Mother*-infant attachment provides the template from which the child learns what to expect from the world. These expectations will guide how the child learns to interpret, experience and respond to loving, challenging and distressing events.

The factors that support mother-child relationships and optimal developmental trajectories are multi-faceted. Either partner can facilitate or hinder the process. When young children are healthy, temperamentally easy and developmentally competent, when parents have a healthy history of being parented and current social supports, and when families can provide emotional attention, appropriate guidance, and low environmental stress, the stage is set for healthy brain development, rich attachments and emotional health.

The field of infant and early childhood/family mental health emphasizes a developmental approach. Infant developmental and neurobehavioral competencies, as well as the ability of the caregiving environment to regulate the development of the child, are addressed in assessment and treatment processes.

* The term *mother* will be used to designate primary caregivers



WHAT ARE THE HALLMARKS OF EARLY CHILDHOOD MENTAL HEALTH?

The hallmarks of a positive developmental trajectory and early childhood mental health are evident in the young child's capacity to:

- Develop enduring relationships with primary caregiver
(Does Anna go to her caregivers to get her needs met when she is feeling scared, lonely, hungry, tired, bored, or wants something, or does she simply whimper?).
- Initiate, discover, play and learn
(Can Anna initiate and focus on playing with her blocks or does she randomly finger her toys?).
- Persist when discouraged and attend when distracted
(Does Anna keep trying to re-build or always throw the blocks in frustration whenever her tower falls?).
- Cope with disappointment and recover from disruption

(Does Anna get upset whenever it is time to stop and put the blocks away or is she able to tolerate change?)

- Develop self-regulation and a range of emotional responses that match the social-cultural-developmental expectations of the situation
(Does Anna eagerly engage or avoid responding to caregivers' overtures? Does she show pleasure or despondence in engagement? Does she refuse or respond when her mother says no? Has she learned that biting is not the way to relate to her peers?).

All behaviors noted can be normal ways of responding. Behaviors are concerns only when they are intensive, extensive and pervasive and/or when parents feel overwhelmed to the extent that they are unable to cope with their child's behavior. Infant mental health addresses infants and young children's emotional and behavior disturbances through the lens of parent-child relationships within the context of social and cultural expectation and the child's level of neurodevelopmental functioning.

WHY THE EMPHASIS ON ATTACHMENT AND MOTHER/INFANT RELATIONSHIPS?

Today it is generally recognized that the quality of mother-infant relationships provides the emotional foundation for all development, and that the roots of child emotional well-being lie in their shared emotional experiences. Through predictable, nurturing emotional experiences over time, the robust-enough child in a healthy-enough family develops an internal working model of emotional connectedness and sense of self. This internal working model guides how the child feels about self, relates to others, and how the child responds to and recovers from distress.

Quality attachment is the basis for the infant to learn that the world can be trusted and that needs will be met. Through quality attachments, the older infant and toddler acquire a secure base and the 'emotional fuel' that enables them to engage with life with an eagerness to explore, to discover and to learn. Thus the

child learns to be in touch with the joy that comes with self-accomplishment and learns that life is richer when there is someone with whom to share that joy. And most importantly, quality attachment helps the child learn that one can turn to others for nurturance, for help, for play, for comfort, for protection, for acknowledgement, and for guidance. The resulting internal working model sets the stage for all later social relationships.

Developmental and infant brain researchers are finding that the 'goodness of fit' between infant needs and caregiver's capacity to note and respond to emotional needs is critical to infant brain development and the development of secure attachment. The quality of the child's primary relationships is predicated on the emotional availability of both mother and child. The foundation for emotional availability is based on:

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- The robust infant's inborn capacity to initiate and respond to relationships
- The mother's learned capacity to read and respond to her infant's cues, her internal working model based on her own relationship history, her current life circumstances and social and economic supports.

An important developmental task for infants and toddlers is the development of self-regulation. Parents play a critical role in helping their infants self-regulate physiologically, emotionally and behaviorally to match the socio-cultural and developmental expectations of their community, including:

- The establishment of sleeping and eating patterns
- Arousal and focused alertness

- Sustained attention, concentration and persistence
- Balance among emotions in everyday activities
- Inhibition of outbursts to developmentally appropriate expectations
- Expression of autonomy in a socially acceptable manner
- Recovery from disappointment and distress

Emotional regulation is central to the capacity of the child to self-monitor behavioral responses to experience. Bruce Perry (1998) notes that parents play a critical role in setting up the neural circuitry that helps children regulate in response to the stressors in their young lives. A key notion of infant/family mental health is that it takes parental involvement (dyadic regulation) in order for a child to develop self-regulation.

WHAT ARE THE RISK AND RESILIENCE FACTORS THAT INFLUENCE THE QUALITY OF MOTHER-CHILD RELATIONSHIPS AND EMOTIONAL DEVELOPMENT?

Quality mother-infant relationships are contingent upon the emotional availability of each partner. When there are child health, neurobehavioral, temperament or developmental vulnerabilities, or when parents are isolated, overwhelmed or dealing with debilitating life circumstance, child emotional well-being may be in jeopardy. When infant and parent are both struggling with significant biological or psychosocial circumstance, the parent-child relationships and quality of attachment may be in peril. Maternal characteristics and circumstances, infant characteristics and the transaction between them both are critical elements in understanding the attachment process.

Child Emotional Availability

Charles Zeanah (1997) emphasizes that in infancy and toddler periods, psychiatric disorders are less clearly differentiated and less well validated, and that "...much is to be gained by focusing instead on risk and protective factors for infant development." Babies are born with certain temperamental/neurobehavioral characteristics

that can influence how they initiate and respond to nurturing care. A child's capacity to manage stress and regulate emotions stems from interactions among temperamental/neurobehavioral status, early experiences and the quality of attachments.

There is considerable new understanding relating to brain-behavior relationships. Behavior, such as impulsiveness, distractibility, aggression and a lack of responsiveness to ordinary disciplinary and socialization guidance, is thought to stem from insufficient inhibitory or over-reactive mechanisms in the brain and/or insufficient ability to process and organize information. This research has underscored the notion of neurobiological vulnerability that holds that biological factors can make one susceptible to developing emotional disturbance, but does not itself cause such an outcome.

When an infant's neurobehavioral functioning is compromised, infant emotional availability and the attachment process can be in jeopardy. Abnormal sensory threshold, intensity of reaction, and poor self-regulation

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are neurobehavioral characteristics that can interfere with the development of a healthy stress management system, leading to increased tantruming, aggression and oppositional responses to behavioral expectations.

A highly sensitive over-reactive nervous system sets the young child up for non-adaptive ways of dealing with the world if caregivers are not aware that protective caregiving strategies are needed to calm down an over-reactive nervous system. A neurobiological vulnerability may be mild enough to require severe environmental influences in order for dysfunction to arise. Conversely, an actual neurobiological deficit may be serious enough for behavioral disorders to occur, even in the presence of nurturing caregiving. In fact, children with neurological damage evidence a 2 to 3 times higher incidence of behavioral disorders than other children. The question remains how much of the behavioral disturbance is due to biological deficit and how much is due to biological vulnerability that has been compounded by negative environmental and/or ineffective caregiving influences. The task of the mental health professional is to sort out and address the differences.

Several biological and environmental circumstances can adversely impact neurobehavioral functioning making the child more susceptible to emotional disturbances. The emotional disturbance can be worsened if not addressed or can become compounded by multiple risk factors.

- **Low Birth Weight** - Tiffany Field's (2002) research indicates that low birth weight babies (1600 grams) are at increased risk for a variety of behavioral difficulties at two and five years as measured by parental response to the Behavior Problem Checklist. Increased risk is due to neurobehavioral immaturities that may not be appropriately addressed. There are over 40,000 low birth weight babies born each year in California who are susceptible to regulatory vulnerabilities or disorders.
- **Developmental Delays, Disabilities and Chronic Illness** - Infants, toddlers and young children with delays, disabilities and chronic illness may be at increased risk for social, emotional and behavioral disorders due to vulnerabilities related to reactivity, intensity of response and other neurobehavioral sensitivities that require special caregiving strategies.

The mental health disorders are not due to the disability or illness directly. When the need for special caregiving strategies go unaddressed, the child can be set on a negative developmental trajectory that later requires mental health treatment in addition to developmental services. Regional Center and Mental Health programs need to work in partnership to triage Department of Developmental Services preventive intervention and mental health treatment needs. It is important to note that there are neurodevelopmental disabilities of such severity that dyadic/environmental regulation supports play only a small part of the total intervention plan.

- **Nutrition** - Inadequate nutrition and iron deficiency anemia can seriously interfere with brain development leading to neurological and behavioral vulnerabilities. Malnourished children and iron deficient children may evidence more irritability, emotional unresponsiveness, fearfulness, lethargy, and mental apathy resulting in decreased sustained attention and a lack of persistence in task completion and interpersonal engagement. Nutrition/iron deficiency screening must be considered in the assessment process.
- **Drug and Lead Exposure** - Prenatal drug, cigarettes and alcohol exposure and pre and postnatal lead exposure can lead to low birth weight and central nervous system compromise that effect neurobehavioral functioning and child resilience. Hundreds of thousands of babies are born annually prenatally exposed to toxic substances. The impact on infant outcome will depend on the extent of maternal use, resiliency of the fetus, general health, nutrition and lifestyle of the mother, and, most importantly, postnatal care and special caregiving supports.
- **Exposure to Violence** - Exposure to community violence is taking its toll. A study by Taylor and Zuckerman (1994) reported that 47% of the mothers using a community hospital recounted that their children heard gunshots in their neighborhoods and one in ten of these young children had witnessed a knifing or shooting before the age of six, half in the streets and half at home. With repeated exposures to violence, children are in danger of becoming ac-

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customed to and emotionally dead to its impact, leaving them to feel hopeless or to identify with the aggressor.

- **Maltreatment** - Maltreatment including neglect, abuse, separation and loss can result in central nervous system dysfunction. Annually, 140,000 children are seriously physically injured by caregivers, with the vast majority being under four years of age and 1,500 of that group being victims of “Shaken Baby” syndrome. One of three physical abuse reports is about a baby less than one year. Many times the inconsolable crying of a distressed infant unleashed the torrent of rage of the caregiver – described as distressed fathers, stepfathers and boy-friends. When any baby is described as an inconsolable crier, there needs to be assurance that the family is able to tolerate it and that the baby will be protected from harm via family support, caregiving strategies, respite care, and so forth.
- **Stress** - Evidence suggests that high levels of stress can actually undermine brain development. Extremes of experience from trauma or neglect can result in prolonged elevated stress hormone (e.g., high cortisol levels) which increases activity in the brain structures involved in vigilance and arousal. Patterns of hyperarousal develop, including affective lability, behavioral impulsivity, increased anxiety and sleep abnormalities. As a result, the brain becomes wired to be on ‘hair-trigger’ alert. Everyday events that do not initiate a stress response from a robust child may elicit an exaggerated one in the vulnerable child. Regions of the brain that were activated by trauma are immediately reactivated when a potential threat is perceived. This unleashes a new surge of the stress hormone, leading to behavioral difficulties in intensity of reaction and self-regulation. This can set up the child to repeatedly experience events as catastrophic, leading to surges of stress hormones, patterns of arousal and lingering distress behaviors. And thus potentially begins a negative chain reaction. The rationale for early intervention for reactivity and self-regulation difficulties is to break the cycle before it becomes ‘hard wired’ and perpetuates the risk effects. Infants and young children at biological risk are more vulner-

able to adverse environmental influences than are non-risk children. Thus, these young children are in double jeopardy.

- **Out of Home Placements** - Out of home placement is always a traumatizing event and has escalated in the last decade. Multiple placements within the foster care system is leaving thousands of young children without rich attachments, and without a history of self, memory of family rituals, and persons to whom they really belong. In California, there are approximately 26,000 children under 5 who are living in out of home placement as a result of maltreatment. A University of California study indicated that 62% of toddlers in foster care lived in at least three different homes within six years of entering the system. A census at one California child protective services shelter listed 42 children under the age of four. Twenty-two had histories of multiple placements within the system. The 22 infants and toddlers had a mean age of 13 months and had been in 64 placements and still were in a temporary setting.

Maternal Emotional Availability

Central nervous system (CNS) vulnerability of an infant can be offset if the mother is emotionally available to read and respond to her baby’s emotional and social needs. However, parenting is not an inborn capacity. It is an apprenticeship process needing support in understanding, interpreting and responding to infant/toddler cues. Societal changes have left many young parents without the traditional supports needed to help them in the process of becoming parents. Many are isolated from their extended family, and concomitant guidance and support. Research has documented that the lack of social supports is deleterious to positive parenting and family well-being.

There are several circumstances that can interfere with a mother's capacity to be emotionally available for her child. If preventive intervention community supports are not accessible for these mothers, her child may later require mental health treatment.

- **Depression** - Maternal depression has become a

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major focus in identifying mother/child dyads in need of preventive intervention or treatment programs. Mothers struggling with depression have more difficulty in establishing and maintaining nurturing relationships with their young children. According to research, depressed mothers tend to:

- Be sad, slow, understimulating and withdrawn
- Show tenseness that can feel intrusive or rough to the infant
- Demonstrate a lack contingent responding to the infant despite generally positive affect

The latest infant-brain research reveals that brain activity in children of depressed mothers mimics the changes seen in their clinically depressed mothers. Consequently, infants of depressed mothers show less positive affect, more fussiness, more withdrawal, less focused attention, and lower activity levels. The positive side is that, in many cases, when mothers' depression goes into remission with treatment, their infants' brain activity and interactions return to normal.

- **Parenting Skills** - Serious impact to rich mother-child relationships can come from women who were poorly parented themselves and who are naïve about how a child grows and develops. Poor parenting history may lead to an inappropriate internal working model of relationships with a deleterious effect on parental expectations and attributions of infant behavior. Without effective understanding of child development and child rearing strategies, a parent can be over or under concerned with a behavior or have unrealistic expectations. Inappropriate expectations and inappropriate interpretation of infant, toddler and child behavior can have severe repercussions. Seventy percent of all cases of child abuse begin with inappropriate or overly severe discipline. Oftentimes the discipline escalates because the toddler is seen as defiant and oppositional by saying "no," the 24 month old will not stay his 15 minutes in time-out, or the three year old is evil because she "steals." When appropriate caregiving needs goes unaddressed, social, emotional and behavioral disorders may develop.

Maternal naivete can also be benign and touching. One mother spent her welfare check on five pairs of tennis shoes (including Nikes, Reebok) for a five month old so he could have "good self-esteem;" another bundles her baby up in 98° weather because that is her understanding of what "good mothers do." Parenting is an apprenticeship process and when there are no neighbors, no grandmothers, no community of moms, no relatives, basic child development and caregiving needs to be addressed.

- **Social Support** - Unsupported single parenthood places the child at risk when the lack of emotional, financial, and social resources is so overwhelming that the mother is not able to attend to her infant's emotional needs. One-third of babies born are to single women, many without benefit of a supportive mate, an extended family, a neighborhood or a community of moms to help them learn how to be mothers, let alone how to care for a child if there are biological vulnerabilities to begin with. When extreme social isolation, and/or a history of broken relationships accompany unsupported single parenthood, maternal emotional unavailability for her baby may be a significant consequence.
- **Poverty** - Child biological vulnerability becomes compounded when circumstances such as poverty compromise the parent's ability to provide nurturing, protective and enriching care. In our state, one in four of our children live in poverty. Jane Knitzer (2001) in her study of parents dealing with poverty reported that 47% of parents self-identified "poverty-related sadness, demoralization and other indices of despair." Among this group are the homeless. And of the homeless, one in four is a young child. One study showed that 50% of the homeless women are clinically depressed which is an additional risk in an already high-risk situation.
- **Domestic Violence** - Domestic discord and abuse has serious repercussions for children, even if they are not the targets of abuse. Many mothers think if they are the recipients of abuse, they are protecting their children from harm. It is estimated that 15 million women are abused by their spouses annually and that 3.3 million children are witnesses –

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most are preschoolers and younger because they have no means of avoidance or escape. There are also repercussions when pregnant women are recipients of spousal abuse. Battered women are four times more likely to have low birth weight babies with accompanying vulnerabilities than their non-abused counterparts.

- **Teen Parents** - Several maternal circumstances can seriously interfere with a mother's capacity to be emotionally available. This is exemplified by maternal adolescence and the concomitant social-emotional and economic needs of both mother and child that must be addressed.
- **Substance Abuse** - Women struggling with drug recovery will need added support to be able to recognize and respond to their children's emotional needs. Many professionals are aware of the 375,000 babies born each year to drug using women. What many may not be aware of is the 12-15,000,000 children being raised in alcoholic homes that may appear stable from the outside, but may be wrought with discord and instability within. In one study of 12,000 households where the mothers were categorized as drinkers, the children sustained two times the risk of serious injury as children of abstainers, a marker of maternal neglect.

Risk and Resilience

Risk is not destiny. For the most part, single risk factors usually do not impact child outcome. However when a risk circumstance is compounded by family adversity (e.g., poverty, domestic violence) or maternal vulnerability (e.g., drug use, unsupported single parenthood, maternal depression, adolescent parenthood), the risk to positive outcome grows exponentially. The number, rather than the nature of the risk factors, appears to be most important for determining outcome.

It is easy to see how quickly maternal, family and infant risks can accumulate for certain populations. The Kauai Longitudinal Study (Werner & Smith, 1982) followed at-risk children in at-risk families for thirty years. Significant risk factors included: infant perinatal stress, poverty, lack of maternal education, family discord, di-

vorce, abandonment by parent, parental substance abuse and parental mental illness. Any four of these risk factors at the age of two placed the child at high risk. The presence of three critical variables almost assured child disturbance. Those were: low birth weight, poverty, and an unstable discordant family life.

Other studies also yielded data to support the notion that multiple-risk status correlates with behavior problems in children. Risk factors that have been strongly implicated as potential markers of risk for psychological problems in children include: low income, lack of housing, parent without high school degree or equivalent, single parent household, permanent separation of parents, parent/sibling death, foster placement, abuse and violence exposure.

Rutter identified marital discord, low socio-economic status, large family size, parental criminality, maternal psychiatric disorder and child welfare involvement as the most significant risk factors. A child experiencing any two of these circumstances is four times more likely to have a psychiatric impairment, and those with four risk factors are ten times as likely to have a mental health disorder.

Rutter has also written extensively on the significance of protective factors in helping a child overcome adversity. The core components include emotional health and social competency, which he reports comes from a process of "adaptive transactions between mother and child." Supportive environments improve the social, emotional and behavioral outcomes of young children through responsive emotional engagement, protection from overstimulation, alleviation of distress, encouragement of persistence, and development of self-efficacy. Gabriano's work cites parental self-esteem, parent-child attachment and physical necessities of shelter, food and health care as being the protective factors for children raised in communities that experience poverty and violence.

From an infant mental health perspective it is important to address developmental pathways to competence and family resilience, as well as developmental pathways to disorders. Treatment needs to address both positive and negative influences on child and family social, emotional and behavioral health.



WHY NOW? WHAT ARE THE INFLUENCES ON THE RESURGENCE OF INTEREST IN INFANT MENTAL HEALTH?

There has been a surge of national attention on the impact of experience on brain development and on child outcome. This in part stems from the 1996 University of Chicago Conference on Brain Development in Young Children. Neuroscientists, having used research tools such as brain imaging technologies, provided insights on the influences of early experience on brain development and neurobehavioral competence. Not only was there validation that early experience influences developmental trajectories, but also they provided evidence that early experience actually affects how the intricate circuitry of the brain is wired. Infant brain research data have reinforced the role of early interactive nurturing experience between mother and child as a significant cornerstone to the development of self-regulation in early childhood.

Attention to scientific advances never occurs in a vacuum. The growing interest in sponsoring conferences on infant brain research has been stimulated in part by the growing concern about children in America. Countless policy making bodies addressing the needs of very young children and the pediatric clinical literature are reporting that consideration must be given to the thousands of children who are experiencing circumstances that affect the development of the brain, their capacity to cope with the challenges of growing up and their eventual mental health outcome.

Research has indicated that as many as 30% of our children receive emotionally inadequate care that puts them at risk for later social, emotional and behavioral disturbances. The pediatric literature has labeled the behavior and developmental problems of children as the “new morbidity.” Pediatricians are reporting that they are seeing more social, emotional and behavior problems among their patients than instances of infectious diseases.

The Child Development Division of the California Department of Education reports that children as young as the age of two are being excluded from child care due to

persistent and pervasive challenging behaviors.

Young children are telling us by their behavior that the world they are experiencing is overwhelming to them. Their “SOS” signals are demonstrated through tantrums, non-compliance to adult requests, frequent anger, fear of being alone, poor attention, sleeping problems, over-activity and “too easily falls apart” that are beyond the typical expected behaviors of children.

Few clinicians are trained to recognize emotional/behavioral disturbances in children under five years of age and how they differ from normal childhood behavior. The Little Hoover Commission Report on Children’s Mental Health (October 2001) indicated that 313,517 California children birth to four years old experience mental health needs. The Little Hoover Commission also sounded the alarm about the number of children and adolescents with mental health disorders that may have been ameliorated through earlier identification and treatment, including the:

- 72% of children in child welfare programs who have serious emotional disorders
- 68% of children in dependency courts who evidence signs of mental disorder
- 50-80% of children in the juvenile justice system who have mental health needs

A dynamic change occurred in addressing early childhood mental health as funding for needed services has been increasingly available. Increased funding has resulted from expansions in mental health Early Periodic Screening, Diagnosis and Treatment (EPSDT) for Medi-Cal beneficiaries, Proposition 10 grants, and Head Start/Early Head Start programs.



WHO DOES COUNTY MENTAL HEALTH SERVE IN INFANT AND EARLY CHILDHOOD/FAMILY MENTAL HEALTH PROGRAMS?

- 5-month-old Sarah consistently looks away when her mother tries to engage. Both her cries and smiles are rare and muted. Sarah's mother is isolated from family and friends and is struggling with depression.
- 9-month-old Jose "refuses" to be consoled. He stiffens when his mother tries to cuddle him. Jose was born weighing 3 lbs. His mother is now 16. She sees his behavior as "leave me alone" vs. "I need extra help cues." His primary affect is one of somberness.
- 17-month-old Ephram is an overly clingy child. He won't leave his mother's side. He needs his mother to join him in order to go to bed and he awakens and cries at least four times during the night. His mother is worried because his father has been deployed to Afghanistan.
- 3-year-old Annie eats very little and is losing weight. She is a foster child in her third placement. She indiscriminately attaches to available adults.
- 4-year-old Joey has the constant "fall aparts".... hitting, throwing toys, and shrieking whenever he doesn't get his way. Three childcare centers have excluded him. Several times, he has observed his mother being hit.

There is a shortage of community-based mental health practitioners who feel comfortable working with this age group that requires attention to primary caregiver "internal working models," infant neurobehavioral/developmental vulnerabilities and competencies and all relate to rich dyadic relationships.

Infant/family mental health work is qualitatively different and requires practitioners who have had training and supervised experience. Some of the qualitative differences include a paradigm shift in how treatment services are delivered including: viewing the dyad as the client, providing emotional and instrumental supports

and developmental guidance, the need for interdisciplinary perspectives, and a new emphasis on program collaboration and home visiting. Future articles will address (1) typical early childhood development and identification of emotional disorders, (2) assessment and diagnosis, and (3) treatment models.

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Research and Proven Practices Resources

Consistent with the growing interest in using research in child and family service planning and practice, CWTAC Updates will feature resources that highlight information that is based upon solid research and/or describes evidence-based practices.

We encourage you to review, and add to your resource library Taking Stock of Risk Factors for Child/Youth Externalizing Behavior Problems. The report, published by NIMH November 2001 describes what is known about existing risk factors and the processes that contribute to externalizing behavior problems. The report can be downloaded at <http://www.nimh.nih.gov/childhp/takst698sum.html> or by contacting NIMH at :

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