Endorsement Exam: Culturally-Sensitive, Relationship-Focused IMH
Study Notes

Exam Components

Part I: Multiple Choice Qs

A. Theoretical Foundations
B. Direct Service Skills
    - Pregnancy
    - Early Parenthood
    - Infant/young child development and behavior
    - Attachment
    - Separation
    - Grief and loss
    - Disorders of Infancy and toddlerhood
C. Reflective Supervision and Consultation

Part II: Vignette responses: <u>Differs from clinical or licensing exam.</u>

Goal: demonstrate your:

- Capacity for Reflection, Thinking, Working with others, and Use of Self
- Understanding of Parallel process
- Relationship-based therapies/treatments
- Knowledge of attachment, separation, trauma, how unresolved loss affects development, behavior, and caregiving; Ghosts and Angels in the nursery
- Generate a reasonable # of hypotheses

<u>Demonstrate these competencies in BOTH written vignette responses (clinical care and RSC)</u>

<u>Each vignette will have 4 questions.</u>

We should include and comment on the following as the portals into our response:

- Concrete assistance;
- Emotional support;
- Developmental Guidance;
- Early Relationship assessment and support;
- Advocacy;
- Infant-parent psychotherapy

AAIMH Code of Ethics:

6 core values:

1. Importance of relationships
    - As instrument of change
    - Promote, support, restore, and sustain nurturing relationships
    - Collaborative relationships with community partners: transdisciplinary
    - Past relationships as influence on development of current relationships (Importance of early relationship to child's lifelong trajectory; Ghosts and Angels in parent's past history)

2. Respect for Ethnicity, Culture, Individuality, and Diversity (D-I-T)

3. Integrity
    - Ethical, trustworthy, honest, reliable, responsible

4. Confidentiality

5. Knowledge and skill-building

6. Reflective practice (Reflective Functioning)

Professional perceptions of Endorsement

Enhances:

1. Service to families
2. Development of Self
3. Development of Team
4. Advancing the field

Reflective Supervision and Consultation:

Support for the emotional well-being of the IMH workforce
Self-Care
Address secondary trauma; compassion fatigue, burn-out, turnover

Community MH Professional Development **Model to expand Reflective Practice and Supervision: Shea, Goldberg, and Weatherston**

Key points:

Reflection:

- Awareness of one's own beliefs, thoughts, feelings
- Examination of our values—personal, familial, ethnic, cultural, professional, organizational (**Zeanah**)
- Integration of these with knowledge of HOW these affect our practice and the effects upon others
- Discusses issues, concerns, and actions to take, with their RS/C
- Understands own emotional response to a family
- Recognizes areas for own growth

Reflective Capacity:

- Therapist having and expressing emotions in response to something said, done, or experienced
- Therapist curious about these feelings
- Therapist exploring meaning and sharing observations
- Therapist open to other perspectives

Parallel Process:

- Parental reflective capacity is associated with positive parenting, capacity for attachment (leading to healthier child outcomes)
- Parental reflective functioning = Parents' ability to have and explore thoughts and feelings about their child, understand the child's behavior, take their child's perspective, wonder about their child's experience, and "hold those experiences in mind" (**Slade**, 2005)
- Safe and trusting relationships in the early years builds child's reflective capacity
- Child develops reflection and self-awareness within the parent-child relationship
- RS/C provides exploration of parallel process: the RS/C, therapist, parent, and child are all unconsciously influencing each other, resulting in "shared affective states"
- Infant development of "efficacy" (and parent's) is related to the therapist's (and her RS/C's) sense of efficacy. What does it mean when it feels to the therapist like it is difficult to engage—with the family? With the RS/C?

IMH services:

- Relationship-centered

- Builds parental reflective capacity by helping parent to express thoughts and feelings about their baby within a trusting relationship
- Needs a RSC relationship for the therapist; a "relationship for learning" (**Shahmoon-Shanok**, 2006).
- Involve work with trauma, DV, mental illness, poverty; all as threats to health of infant and family and increase therapist risk for secondary trauma

Reflective Supervision and Consultation:

- Brings therapist into reflection on own emotions to minimize secondary trauma
- Allows therapist to explore "fragmented feeling states"
- Safely holds the therapist in the mind of a trusted other
- This helps the therapist do the same for families
- RS is a collaboration: both the therapist and the RS/C learn together in dialogue = partnership formed for learning and deeper awareness about all aspects of a case, especially the social, emotional, and developmental domains
- Emphasis is on the therapist's emotional response to the work
- Parallel Process: Focus on the development of the relationship in the supervision; the therapist's emotional responses are information about the parent-child relationship and the therapist-parent relationship
- Individuation process: RS/C relationally assists the therapist to individuate—and independently arrive at their own realizations and decisions
- The IMH therapist receives support of the kind intended for the family from the therapist while problem-solving
- Strengthens the therapist's reflective functioning and helps the therapist create the sense of safety for the family needed to encourage disclosure, curiosity, and self-exploration
- As therapist self-explores and discloses, this deepens self-awareness

Weatherston's elements of RS/C and the Reflective Supervisor:

- Quiet, private space
- Consistency
- Attentive, self-aware, reflective
- Able to observe
- Curious and engaged
- Compassionate
- Tolerant
- Non-judgmental

Weatherston's elements of the reflective supervisee:

- Open,
- Collaborative
- Self-aware
- Non-defensive
- Realistic expectation of the supervisor
- Able to ask for help

Weatherston's suggested mutual behaviors in RS/C:

- Safety
- Trust
- Respect
- Shared attention
- Shared power
- Journey in the relationship

Reflective Supervision Assessment Tools: (I think these will be relevant for our prep for the vignette responses on the exam)

1. Reflective Supervision Rating Scale (Ash): supervisee rates the RS/C
2. Reflective Supervision Rating Scale for Supervisors (Weatherston): RS/C rates the supervisee
3. Use of Self and Reflective Practice Skills (Heffron): self-report by supervisee
4. Provider Reflective Functioning Assessment 5 (Heller): codes discussions of cases
5. Self-Efficacy Scale for Supervisors (Shea & Weatherston)
6. RIOS: Reflective Interaction Observation Scale (Watson): assesses video of RS/C:
    - Understanding the story
    - Parallel process
    - Holding the baby in mind
    - Professional's use of Self
    - Working alliance
    - Mutuality, reciprocity, relationship-based nature of the RS/C

RIOS examples of desired techniques:
"What do you find yourself wondering about your supervisee's participation in RS and her request to postpone (e.g.)? "What do you think is happening for the supervisee with the family and what do you think is happening in the family?" "How might you bring this up?" "Bring up your thoughts and feelings?"

<u>Goldberg and Weatherston: 12 capacities for using RS vs Offering RS</u>
Examples of vignette responses rated as highly representative of the capacities:

Supervisee:
"I would use the supervision to give time and space to sit with feelings that arise when I'm in the home. Why? Where are they coming from? To let myself feel and be in tune with what I need from my RS/C. How can I articulate this? I can feel challenged in expressing all of this. This is all information about what the family feels and what they need to move forwards."

Reflective Supervisor/Consultant:
"I would not start with administrative stuff. I would sit for 2 minutes. Ask my supervisee how she's doing. This is a hard case. I would wonder with her about this and if this case is what she had expected. What is challenging? How are we doing? I would parallel this with how the mom might be feeling and wonder why it was difficult for me to show empathy and just sit with her (my supervisee). It is really hard to balance administrative needs and reflection. I would remind myself how important it is to slow down and follow the other's lead. I would ask, 'What do you find yourself wondering about? What feelings are you aware of following your visit? How might

these feelings inform the work with the family? How might you use RS to better understand what the family needs from you and how best to respond?"

Weatherston: IMH Therapist's Reflective Skills in the RS/C:

- Show that you Follow parent's lead and child's lead
- Show that you asked parent Qs that invited parent to talk and listened carefully & sensitively
- Show that you used observations and listening skills to assess child's skills, strengths, and needs (maybe diagnosis)
- Express feelings and thoughts when discussing family in the RS/C
- Use the RS/C to explore if your own feelings may interfere with ability to identify or meet the infant or family's needs.
- Describe and discuss interactions and the developing relationship between the parent and child
- Demonstrate capacity to think and have feelings about your Self in relation to the work and share this in RS/C.
- Demonstrate the capacity to use the relationship with your RS/C to be reflective
- Demonstrate capacity to be quiet and hold parents' feelings—and with the parent, to "not know" and "not do"
- Demonstrate ability to build relationship with the family
- Show different ways to enter a case discussion (e.g., concerns re parental ability to provide care, concerns re parental history, concerns re home environment)
- Describe observations of infant/child; attending to their health, social, emotional, cognitive capacities
- Describe/discuss observations of parents; attentive to strengths and concerns/risks

Weatherston: IMH Reflective Supervisor's skills:

- Seeks own RS/C
- Forms a trusting relationship
- Consistent schedule
- Questions the supervisee and encourages details about practice
- Shares and explores
- Stays engaged the whole session
- Teaches and guides
- Shows how to integrate emotion and reason into case analysis
- Improves supervisee's ability to be reflective
- Allows time for the supervisee to come to their own solutions
- Explores supervisee's feelings and thoughts about the RS itself
- Collaboratively set the agenda

- Thinks with supervisee about improving observation and listening skills
- Listens carefully for supervisee's emotions
- Encourages expression of emotions
- Keeps families' unique experience in mind in RS
- Wants to know how they feel about the supervisee's practice
- Helps supervisee explore cultural considerations
- Builds trust and safety with supervisee
- Builds safety for supervisee to express emotions and explore thoughts relative to the infant and family
- Supports supervisee's self-worth and sense of competence and examines own thoughts and feelings, strengths and growth areas
- Attends to the emotional state of the supervisee
- Facilitates, teaches, and guides
- Facilitates supervisee's ability to discuss their observations and listening skills to assess the infant
- Help supervisee to explore parallel process and challenging feelings
- Attend to **content and process**
- Facilitate supervisee's ability to describe observations of parent(s)

Fenichel's principles of Reflective regularity:

- Reflection: challenge to explore reactions
- Collaboration: the mentor or supervisor thinks together with the group
- Regularity: consistency of communication and planning with the learning community

Alicia Leiberman: Angels in the Nursery

Repetition of the past in the present: pre-verbal and bodily/sensory memory is the primary building block of the physical sense of Self.

Fraiberg's Ghosts in the Nursery: ways in which parents may re-enact with their small child, scenes from their own unremembered early relational experiences of helplessness and fear, and thereby transmit child maltreatment. Visceral reactions to the child that do not recognize the child's need but attributes badness to the child due to own internalized 'badness' and creates risk for child to internalize 'badness'. Parent represses own affect associated with the original event (terror). Repression and isolation of affect (defenses; coping strategies) create energy later when individual becomes parent to re-enact original affect: "identification with the aggressor/betrayer" (to protect Ego from the external attack). Perpetration = protection against feeling out of control.

Leiberman's Angels in the Nursery: Care-receiving experience of intense shared affect between parent and child in which the child feels nearly perfectly understood, accepted, and loved, lending to a core sense of security and self-worth that the child can draw upon when they become a parent. Angels present can lead to "identification with the protector".

Angels:

- Protective intergenerational influences that foster healthy development
- Messages to the child of their intrinsic goodness and of unconditional love
- Growth-promoting forces critical to revisit in treatment

Ghosts and Angels co-exist in dynamic tension: the past influences the present. Not in awareness, yet felt in the moment. The act of parenting can elicit "effortless re-capitulation"

Treatment:

- Recover and place traumatic triggers (Ghosts) in the context of "beneficial cues" (Harris).
- Critical to integrate Angels into the treatment, not just exploration of pain, conflict, and alienation
- Goal: bring the emotional polarity into consciousness to create object constancy and enhance emotional integration and tolerance for affective experiences
- Angels as powerful instrument of change
- Sense of Self develops from the early bond that comes from emotional availability and empathic responsiveness.
- These experiences of availability and responsiveness leading to sense of self are aka:
  Mirroring
  Attunement (Stern)
  Containment (Brion)

Attachment (Ainsworth)
Felt Security (Sroufe)
Re-fueling (Mahler)
Secure Base (Bowlby)
Mentalization (Fonagy)
Transmuted Internalization (Kohut)

- Treatment assesses the attunement: too high parental responsiveness can yield anxious attachment. Moderate levels of coordination are healthier (Beebe). Mismatch and repair are necessary (Tronick).
- Therapeutic space and relationship fosters resilience by retrieving the memories of positive (Angels) that were repressed because of the associated pain of loss (tension with the Ghosts).
- Child psychotherapy: Reorganization of the Self in relation to attachment figures.
- Depending upon the child's developmental stage, different aspects of a parent's childhood are triggered (Touchpoints).
- Treatment uses the recovery of positive memories (Angels) to counter 1-sided views of attachment figures, leading to improved current parent-child relations through an improved, more positive parent sense of self. Joy, intimacy, pleasure, love need recovering as much as trauma; leading to forgiveness and compassion; for parent's own self for original attachment figure, for child.
- Adult Attachment Interview (George) helps in treatment assessment and goals
- Working Model of the Child Interview (Zeanah)
- Parent Development Interview (Berger and Kaplan)

Attachment and Bio-Behavioral Catch-Up (ABC):
(Mary Dozier; K. Bernard)

Developed for foster care
Used with adoption
Also applied to reunited birth families

Key Concepts n ABC:

- Adversity in infancy leads to decreased secure attachment and reduced self-regulation
- Disorganized attachment predicts to later externalized behavior and dissociative symptoms
- Goal of ABC: enhance nurturing in foster care as reparative
- Hypothalamus-Pituitary-Adrenal (HPA) Axis regulates diurnal patterns and stress response
- Early neglect disrupts HPA functions; disrupts cortisol patterns
- Premise of ABC: parents who follow their child's lead yield children with better self-regulation than parents who are unresponsive to child's cues. Key strategies:
    - Nurture
    - Follow child's lead with delight
    - Reduce overwhelming behavior (parental frightening responses)
    - Parents identify their own "voices from the past"
    - Make "in the moment comments" to parents as feedback to celebrate their behavior
    - In sessions: Describe parent's behavior; Label the behavior as an ABC target goal; Name the future outcome
    - For Toddlers in care/treatment: Add helping parents to support the child to learn to calm down. Parent is a co-regulator: stay with the toddler.
    - For adopted children: Add goal to address child's indiscriminant friendliness (RAD)

- Contrast to DEF (Developmental Education for Families), which does not focus on parental behavior
- Results of ABC: increased security of attachment, regulated cortisol levels, increased emotional regulation and other aspects of executive functioning: inhibitory control and shift sets. Brain activity measures show increased parental responsivity to infant distress after treatment.

Attachment Therapies:

Target/enhance:

- Caregiver availability and responsiveness
- Not just a child's response to separation
- Caregiver emotional communication
- Reparative processes to re-install confidence in the bond
- Corrective emotional experiences

Models:

- Circle of Security: encourages caregivers to explore how their internal world shapes their perceptions and reactions; encourages self-awareness of filters that affect their perceptions
- Parent-Child Psychotherapy (and CPP): addresses parental internal working models from childhood experiences on current parent-child interactions
- Attachment-based therapies (e.g., Corrective emotional experiences of Bowlby):

Continuum:

- History of severe attachment disruption affects "attachment organization." Treatment addresses rigid defenses that distort expressions of attachment needs and feelings.
- Treatments explore histories of attachment disruptions

Key Concepts:

- Early loss is associated with later sadness and depression
- Attachment history affects later coping with grief (Bowlby's patterns of "disordered mourning")
- Experiences of grief: Disbelief, Anger, Searching, Sensing continued presence
- Grief/bereavement are "complicated" by attachment history: if attachment history included chronic anticipation of loss and rejection, later grief is complicated
- Infantile response to loss/separation:
    - Normative separation ----- protest
    - Prolonged separation ----- despair
    - Continued separation ------ detachment
    - Patterns of reunion: from aloof to clingy

- Loss of parent: anxiety, anger, denial ----- sadness, hopelessness (if under the age of 1 year, baby recuperates in the relationship of another nurturing adult)

Core IMH Concepts; Kristie Brandt

- Most early childhood memories from birth to 3 are not available to conscious recollection
- Still, somatosensory or implicit memories remain and represent how we were handled as infants.
- These influence the rest of our lives: neurobiology and inner emotional lives.
- Mental Health is the capacity to experience a full range of emotions at each developmental phase in a stable manner (**Greenspan**) when each part of the system contributes: what child brings, what parent brings, what environment brings.
- IMH term coined by Selma Fraiberg
- Zeanah: IMH is:
    - Multidisciplinary
    - Developmental
    - Multigenerational
    - preventive
- WAIMH: IMH is the ability of children to "develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environs, IMH involves the psychological balance in the infant-family system."
- Zero to Three: IMH = "healthy social and emotional development of a child birth to 3 and a growing field of research and practice devoted to the promotion of healthy S-E development, prevention of MH problems, and treatment of MH problems in very young children in the context of their families":
    - Promotion (policy, public health campaigns, support of breastfeeding)
    - Prevention (mitigate risk and stress factors)
    - Early Intervention (clarify and address concerns)
    - Treatment (1.Pandisciplinary services [HFA, Help me Grow, D-I-R, Circle of Security ------- 2. Discipline-specific services by a credentialed professional: CPP, PCIT, NFP, Trauma-focused CBT. , Video Intervention therapy)
- Zero to Three: 5 essential ingredients of IMH:
    1. Safe, healthy, less-stress pregnancy
    2. Opportunity and ability to fall in love and be in love with a safe, nurturing adult
    3. Support in learning to self-regulate
    4. Support in learning to mutually regulate
    5. Nurturing, contingent, developmentally appropriate care
- IMH treatment is dyadic
- Dyadic exchange = foundation for what makes people human
- Micropatterns of interaction assemble over time to construct whole relationships

- Infants negotiate a series of dyadic relationships (parent, sibs, teachers, peers, etc.), which leads to a pattern of interactions, which creates the child's repertoire for development
- Treatment addresses moment by moment interactions.
- Video Intervention Therapy for parents with psychiatric disturbance
- Treatment helps to navigate together the range of affect, strengthens the dyad and each individual, helps each individual learn from the (-) and the (+) interactions about self-regulation, mutual regulation, asynchrony, dissonance, and then re-achieve regulatory stability through reciprocal coordinated states.
- Treatment repairs interactive errors, with a movement from (-) to (+) over time as key to positive development (**Tronick**): moment by moment mismatch and repair is the "homeostatic pulse" and foundation of lifelong interaction patterns.
- = Schemata (Piaget)
- Inability to restore matched states overtime leads to withdrawal and defensiveness.
- Sander: the dyadic relationship is the "patient"; the core of the system is the health of the parent, child, environment, and relationship
- IMH is a truly collaborative, transdisciplinary model

<u>Newborn period as contribution to relationship building:</u>

- Capacities: move in rhythm to caregiver voice, facial imitation, eye contact, reflexes that signal parent (e.g., palmar grasp), release of oxytocin in parent and child
- Newborn arrival and period activate systems that are open to intervention:
    - Attachment system
    - Meaning-making system
    - Regulatory system
    - Relational system
    - Somato-sensory system
    - Neurodevelopmental system
    - Memory system
    - Mentalizing system
    - Intersubjective system

<u>Brazelton Touchpoints:</u>

- Points of change in the system related to neurodevelopmental process
- Natural progress towards autonomy and independence; self-agency
- Tension between independence and dependence
- Grief, loss, and separation themes (as well as joy and pride, etc.) are common themes for parents at Touchpoints.

- At each Touchpoint, intrapersonal (inner life of each person in the system) and Interpersonal interchanges destabilize; leading to risk for derailment or opportunity for optimal trajectories
- This process at each Touchpoint is embedded in the history of patterns in the present relationships and within the internal representations embedded in the family system.

Contributing theorists:

- Bronfenbrenner: ping-pong
- Shonkoff: serve and return
- Brazelton: reciprocity
- Greenspan: 2-way interchanges
- All: shape brain architecture

Treatment Models:

- Brazelton: Touchpoints
- Bruce Perry: Neurosequential Model of Therapeutics
- Brandt: Mobius Care with a Tile and Grout (Touchpoints and Perry)
- Barnard: NCAST Parent-child interaction feeding and teaching scales
- Nugent: Newborn Behavioral Observations
- Gilkerson: Fussy Baby Network
- Video intervention treatment
- Reflective Practice

Each requires/relies upon a Theory of Change (why change happens) and a Process of Change (how change happens).

Brandt:

- Treatment is entered through the Implicit gateway (thoughts, feelings, feelings, memories, neurochemistry) or the Explicit gateway (actions and behavior initiate the work).

- Zone of reflection and Plane of transformation enhance movement from implicit to explicit; from explicit to implicit

- "Telling" parents what to do has limited influence on deeply held beliefs, thoughts, and feelings

- Speculation and interpretation may be more related to the clinician's projections than to parents'

- Parents' implicit thoughts, feelings, beliefs may not be in their awareness but are evoked and manifested in their reactions to the child (automatic or reflexive).

- Treatment provides reflective process to discover the implicit "procedural caregiving memories"; Treatment is hour by hour

- Treatment goals: Secure safe passage for mother and baby through pregnancy; scaffold, support, and foster process of parent and child falling in love; treatment starts by identifying, securing, and reinforcing this primary love relationship and evaluating the baby's attachment status; Treatment reinforces safety and predictable patterns of caregiving form nurturing adults, mutually recoverable stress mediated by attunement to create healthy satisfying relationship

ACES (Adverse Childhood Events) (Felitti, et al)

Man concepts:

- As # ACES increases, lifespan estimates decreases; and MH and health disorder diagnoses increase
- Early adversity = in utero stress, neglect, maltreatment, impoverished environment
- Brain growth/development most susceptible to effects of environmental stressors: corpus collosum, hippocampus, hypothalamus, amygdala
- (+) early attachment is directly related to adult attachment status, adult relational competency, adult communication style, psychopathology, PTSD, and ability to rely upon others when stressed

Creating a Nest of Emotional Safety: RS in a CPP Case
Many, Kronenberg, and Dickson

Key Notes:

- CPP leverages the caregiver-child relationship as the mechanism for change in young children impacted by trauma and stressors
- Primary CPP objective is assisting caregivers in their understanding the meaning of their child's distress and improving the relationship to a safe and supportive space for healing.
- Clinician being emotionally "triggered" by family (-) patterns needs RS for a parallel process to feel understood and contained by the supervisor, so as to then be able to support the family's efforts.
- Shahmoon-Shanok: Any practitioner working with children birth to 3 needs a "safe, stable, supportive relationship with a supervisor capable of deeply listening and reflecting with the provider about their experiences" because of the emotions that come up associated with working closely with children and their caregivers.
- "It is not possible to work on behalf of human beings to try and help them without having powerful feelings aroused in yourself" (**Pawl**).
- RS Goal: improved insight and skillful use of Self; Providers to feel more competent and supported. How: the provider "being held" in mind by the RS helps the provider hold the family in mind; creating a parallel process = nest of relationships.
- RS: 3 key elements: reflection, collaboration, regularity within a relationship of "respect, mutuality, and safety" that can provide knowledge and skills and a place for states of mind for all involved can be considered
- Use of video recording of therapy session to use in RS
- Fraiberg's IPP: supporting caregivers as they become able to remember what it felt like to be a frightened, hurt child. Caregiver can then better identify with their own child's feelings. Therapists too might have unacknowledged memories and feelings that can influence how they interact with the child and family. RS brings suppressed or rejected feelings into conscious awareness so as to lose their power over behavior.
- Mentalization (**Fonagy**): ability to understand the other's mental state
- Child attachment security is associated with parental reflective functioning: child feels secure when they know their caregiver can accurately identify and sensitively respond to their internal states, thoughts, feelings, needs, and desires.
- Goal of CPP: increase parental reflective capacity. Necessary to speak of the trauma and not collude with avoidance
- Goal of RS: increase therapist mentalization; as strong emotions might be evoked in the therapist. These emotions can become useful rather than disruptive.
- CPP therapist's fidelity to CPP:

  - Awareness of own emotional reactions and personal and cultural biases
  - Ability to consider multiple perspectives
  - Use of reflective supervision to process emotions and consider alternative perspectives, and seek new knowledge and skills.
  - These are challenged by: difficult to engage families; significant cultural differences in perspective or beliefs; severe and specific trauma

- CPP: (1) Family History and assessment; (2) Treatment begins, (3) Impasse: when the client is mirroring the therapist; (4) Therapist's growth creates space for client's growth; (5) Expanding the circle of empathy; (6) Clinician joins with both parent and child; (7) Connecting the past with the present—directly link the stress/trauma with current behavior and emotions (e.g., anger and grief manifesting in aggression); (8) Ending: working through complicated feelings

Ghosts in the Nursery: Selma Fraiberg

- "Visitors" from unremembered past
- Arise with historical or topical agenda: feeding, sleep, discipline, toileting
- Parents might feel helpless and seek assistance; able to find renewal and healing of childhood pain in the experience of bringing a child into the world (whether through therapy nor not): History is not destiny as parent actively "banish the ghosts"
- But, other parents appear to be fully burdened by their pasts; repeating the patterns, but not seeking assistance
- Treatment: "Emergency phase": direct observation of I-P interaction; with dialogue between therapist and mother moving back and forth between past and present interactions and exploration of relationship: e.g., depressed mother who cannot "hear" her baby's cries was a mother whose cries were not heard. Treatment listens and puts into words the mother's feelings as a child. Mother comes to more readily feel and remember. As grief is expressed, baby becomes more real and responded to. Therapist speaks for the baby: "It feels so good when mother knows what you want." Join the parent in baby-watching with joy. Treatment directly helps mother see the connection between past and present, how without realizing it, mother had brought her sufferings of the past into her relationship with her baby. Bond emerged. Over time: treatment revisits the affective links between loss and denial of loss, assists the mother to re-experience the grief, loss, rejection.
- Treatment starts with an essential question: e.g., "Why does mother avoid touching, etc". Goal: uncover the pain so as to enable mother to behave protectively towards the child. Parental avoidance associated with fear of hurting the child due to own anger and destructive feelings. Parent unaware of past painful events more likely to act out. Parent might attach their feelings of anxiety etc onto the therapist (negative transference; transference resistance). Name and anticipate the anger towards the therapist with the patient. Fear of perpetrators leads to identification with them. Parent who remembers clear events, but not the associated affects appear most at risk for repetition of the past. In remembering, they are "saved from the blind repetition of the past." The parent becomes the protector.

Implementation and Sustainability of CPP: the role of RC

Carmen Rosa Norona and Michelle Acker
Early Trauma Treatment Network

Functions of the Reflective Consultant:

I. Teaching/training and mentoring in the application of foundational CPP core knowledge, core competencies, fidelity framework
- Ongoing didactic training
- Case-based application
- Constructive feedback
- Opportunities for self-reflection on provider's own professional development
- Extended contact following in-person training
- Further resources

II. Providing a holding environment: Setting the tone, offering a safe dependable, empathic environment for participants to be able to reflect and ask Qs
- Maintain an open and mindful stance
- Listen carefully and without judgment
- Pay attention to content and process
- Incorporate key principles of reflective practice (reflection, collaboration, regularity)

III. Facilitating open communication and successful team functioning
- Acknowledge breaks in communication
- Encourage dialogue
- Establish social contracts regarding confidentiality and interactions
- Manage differences of opinion and strong emotions

IV. Facilitate adherence to treatment model and avoid conceptual drift: Overseeing processes that occur within the learning community to establish a stance of emotional safety, respect, curiosity, and open communication
- Transmit the core principles in a systematic and structured way
- Encourage use of the fidelity framework to monitor adherence to the model
- Hold providers, organizations, and selves accountable

V. Problem-solving implementation challenges
- Share own experience with the model
- Share strategies that were effective in other settings
- Facilitate communication among members
- Create space for peer support

VI. Provide training and implementation oversight and coordination
- Develop training plan and budget
- Develop application package and organizational self-assessment
- Schedule meetings with interested agencies to establish readiness for a learning community

- Coordinate data collection
- Coordinate or oversee training logistics

VII. Planning for sustainability

- Ongoing collaboration with the LC and organization
- Programmatic and financial sustainability

Parental reflective functioning: An Introduction
Arietta Slade

- Essential human capacity to understand behavior in light of underlying mental states and intentions
- Parental reflective functioning = parent's capacity to hold the child's mental states in mind and anticipate the child's actions and needs
- Construct at intersection of attachment and psychoanalytic theories, and cognitive neuroscience = advance in the understanding of development of self-regulation and social relatedness in early childhood
- Mentalization of internal experiences, feelings, and intentions leads to the development of self- and affect- regulation
- Reflective capacities underlie the development of social relationships
- The more someone can envision mental states in self and another, the more likely are productive, intimate, and sustained relationships (Fonagy)
- Cognitive and affective: capacity to think about feeling and feel about thinking (M. Target)
- Capacity to hold, regulate, and fully experience emotion
- Non-defensive willingness to engage emotionally
- The parent's capacity to hold in their own mind a representation of her child as having feelings, desires, and intentions based upon observations of moment by moment changes in the child's mental state allows the child to discover his own internal experience via the parent's representation of those.
- **Winnicott**: parent's ability to enter into the "transitional playspace" between playing and reality; the "True Self" does not become a living reality except as a result of the mother's repeated success in meeting the child's spontaneous cues.
- Derailments in developmental processes are at the root of pathological adaptations and personality disorders in adults.
- Parental reflective capacity of the child's state—rather than own subjective experience of the child's state—is crucial for development of healthy boundary between self and other = parent's ability to contain their own experience which helps the infant learn to manage theirs.
- Chronically insensitive or mis-attuned caregiving disturbs the construction of the Self, since the child is forced to internalize the parent's distorted representation based upon their own state of mind- not the child's.
- Health = parent's capacity to hold the child in mind and the child's experience of the parent's mind as knowable and safe. This contemplation of their parent's mind is key to intimacy and connection.
- Parent as mediator, reflector, interpreter, and moderator of the child's mind.

- Adult Attachment Interview including RF: High RF associated with Secure/autonomous on the AAI, and child secure attachment at 1 year.
- A reflective individual has an internal working model of emotion and intentions.
- Higher RF on the AAI even in the context of h/o trauma yielded less adult personality dysfunction
- Parent Development Interview: rates current P-C relationship
- Zeanah's Working Model of the Child Interview: parents rated as balanced, detached, or entangled
- High parental RF grasps the complex interplay between her own and her child's mental states, between her inner emotions and own behavior, and between her child's inner emotional experience and behavior. The RF parent uses this to guide her parenting choices, and thus, is associated with sensitivity.

Fonagy:

- Reflective Functioning, or mentalization, = essential human capacity to make meaning of one's own and other's behavior trough understanding the "beliefs, feelings, attitudes, desires, hopes, knowledge, imagination, pretense, deceit, intentions, and plans" that inform and give meaning to that behavior,
- Reflective Functioning Manual
- Parents who cannot reflect with such understanding on their child's inner experiences and respond accordingly deprive their child of a core psychological structure which they need to build a viable sense of Self (ala Theory of Mind).
- **Processes enhanced through pro's individual or group reflective supervision**
- Enhances regulation in all parties in the system
- Heffron: Awareness and use of Self by professional = ability to identify one's own responses to clinical material; promotes presence in the here and now and capacity to empathize. Group supervision can enhance reflective functioning in each.

Tomlin Hines and Strum: HomeVisting:

- EI and HV across all 50 states. HV's themselves need support to manage their own responses and provide quality support by helping pros understand the connections among their own, the parents' and the children's experiences.

Sparrow:

- Relational, cultural, and systems core of Touchpoints approach integrate infant behavior (Brazelton), parent-infant interactions (Main, Lewis, etc), child and parent developmental processes, parent-provider interactions (Barnard, etc), therapeutic relationships (Stewart,

etc), culture as context for child-rearing (LeVine; Rogoff, etc), dynamic developmental systems theory (Bronfenbrenner; Sameroff), organizational learning (Duglass; Glisson, etc), role of community-level processes in human development (Sampson; etc).

- Core Touchpoints elements can be used to support individual and group reflective supervision, as well as organizational change and learning, and community self-strengthening; ranging from individual supervision to staff and community convening, all the way to policies and procedures, performance evaluations, hiring criteria, data used for org learning activities.
- Cultural humility = search for and recognition of one's own contributions to miscommunications and misunderstanding, of one's assumptions about the universality of one's own cultural values and beliefs. Leads to valuing of errors as opportunities for reparation and fresh insights and valuing systems change.

Attachment Theory

Bowlby: "ethological –control systems theory of attachment" (attachment ensures biological protection): 3 stages in the first year

- Stage one: birth to 2-3 months: infant is open to many potential attachments; open system [birth to 12 weeks: parents use goal-directed behavior; baby cues proximity ala Piaget's sensorimotor period; 4 weeks: preferences for familiar people but no internal model yet]
- Stage two: 2-3 months to 7 months: discrimination among people and social responses = preferences and attachment behaviors are directed to specific people [2 months: reaching, grasping, clinging and pre-language reciprocity as attachment behaviors in response to patterns of caregiver responses; more complex behavioral chains; infant develops control; recognizes cues and anticipates caregiver response; infant seeks contact; directs cues to familiar "other"]
- Stage three: 7months+ : child seeks social relationships through proximity maintenance with the secure base; cognitive leap; proximity seeking through locomotion and signaling. Infant has an internal image of parent; uses verbalizations to regulate others; Internal working model is constructed of behavioral sequences
- Stage four: Goal-directed partnership with the attachment figure
- Failure to process distress of early loss "walls off feelings" (dissociated) yields later eruption of intense emotions/caught off guard as adult.
- "Absolute" absence of initial grieving yields more symptoms later in life
- Attachment security yields healthier future personality organization
- Insecure attachment yields compulsive self-reliance/ "immunity" to loss at a price
- Recovery = rearranging perceptions of the world and defenses
- Inconsistent attunement in early relationship yields anxious attachment yields prolonged grief later
- Consistent unavailability in early relationship yields few outer signs of grief

Later: DSM5 adds the "bereavement exclusion" from the Major Depressive Disorder diagnosis. Attachment and grief researchers question this decision. Advocate for complicated grief diagnosis in next DSM..

Inventory of Complicated Grief:

- Complicated grief >6 months of severe yearning; life feels meaningless, mistrust of others, bitter, identity confusion, avoidance of reality of the loss, difficulty moving on.

Ainsworth:

- Strange Situation: 3 types: secure, resistant, avoidant (disorganized added later)

- Babies who develop avoidant attachment style are those who experienced fewer "termination of cries" by parental response in the first 3 months of life = Internal Working Model

Main: secure, avoidant, anxious/ambivalent

Bonanno:

- Continuum: Common grief, Chronic grief, Delayed grief, Resilient grief:
- Resilience = adaptive coping with loss is associated with secure attachment

Bartholomew:

- Fearful/avoidant versus Dismissive/avoidant styles
- Continuum: attachment related anxiety is conscious; attachment related avoidance is unconscious
- Avoidance yields long term difficulties adjusting to loss

Maccallum and Bryant:

- CAM—Cognitive Attachment Model: Incorporation of reality of loss entails revision of self-identity:
- Merged Identity versus Independent Identity : merged is when sense of self is strongly connected to the lost individual; Independent is when sense of self is autonomous from the primary attachment figure.

Simpson and Belsky: Attachment Theory as Evolutionary Biology (ensuring survival until reproductive independence)

- Infant protest upon separation ensured survival
- Despair as response to lack of attunement was evolutionarily adaptive (i.e., lack of movement attracted fewer predators)
- Detachment as final phase of separation response in context of lack of parental attunement
- EEA = environment of evolutionary adaptation
- Synchronization of infant-parent responses in 1st months of life (e.g., Fernald's "motherese") and proximity-seeking behavior thereafter (signal behavior, aversive behavior, active behavior) ensure survival and establish safe haven/secure base
- Age 3 years : "goal –corrected partnership" with attachment figures leads to and depends upon 'theory of mind' (reflective capacity!)
- Belsky: Children differ in their susceptibility to parental influences
- Manuck, Craig, Flory, Flader, and Ferrell: Gene X environmental interactions
- Epigenetics: intergenerational parenting patterns

Sroufe:

- "psychological proximity"
- Early adolescents transfer their safe haven/secure base from parents to peers
- Later, to romantic partners (Furman and Simm)
-

Trivers:

- Parent-offspring conflict (negotiation of weaning, etc) mediates energy for parental investment and child's eventual investment in relationships

Charnov:

- Somatic efforts; Reproductive efforts; Mating efforts; Parenting efforts

Life History Theory (LHT): How and why energy is given to certain traits, behavior, and tasks is all associated with eventual reproductive fitness

The Belsky-Steinberg-Draper Model:

- Early context affects child-rearing experiences and responsiveness to each other; which affects psychological and behavioral development, and even somatic development
- Social-emotional stress can yield insensitive, harsh, rejecting, inconsistent parenting
- Parents with social supports can enact warmer, sensitive parenting
- Adults with secure attachment have more satisfying later relationships
- Sensitive periods
- Children can form attachments after the age of 1 year even if there was lacking caregiving in the first year; but after the first year, it is more difficult for the child to adapt
-

Chisolm Model:

- Immediate versus delayed reproductive behaviors are related to population mortality rates
- Parental Indifference/insensitivity (inability or unwillingness to invest) yields child's avoidant working model as adaptive
- Parental warmth and sensitivity (most likely with lower population mortality rates) yields secure working model

Del Giudice Model:

- By middle childhood: Sex differences in attachment styles: boys with insecure attachment show avoidant style; girls with insecure attachment show anxious style

Hazan-Zeifman Model:

- Early childhood attachment style yields romantic partner styles in later relationships (e.g., proximity-seeking; value traits in partner that are like traits in original caregiver
- Evolution of Secure adult to adult attachment ensures mating bond
- Father absence and marital strife during childhood predicts to earlier puberty and less stability in later marriage

Kirkpatrick:

- Adult attachment evolves to enhance reproductive fitness based on child hood experience, but Kirkpatrick questions if security and protection are the primary reasons for the bond
- Not always evolutionarily advantageous to use monogamous mating
- Adult attachment style = best strategy given one's early life experience
- Sensitive, responsive parenting yields long term mating
- Avoidant attachment yield pursuit of short-term mating strategies
- Slow versus fast reproductive strategies are correlated with population mortality rates and SES

Ontongeny of Attachment: Preston, Britner, and Russell:

- Attachment bonds facilitate child's ability to explore and become autonomous
- Systems: (1) Attachment (see Bowlby's stages), (2) Fear/wariness; (3) Exploration; (4) Sociability
- Rutter: developmental disorders are derailments of these systems
- Ontongeny: reflexes yield fixed action patterns yield goal-directed behavior yield seeking of predictable responses
- This process yields an internal working model/representation of the expected behavioral sequences
- Kogan: Moments of repair of mismatch are the most crucial information : the discrepancy between set-goals and satisfaction of goals
- By toddlerhood and preschool: Internal Working Models yield behavioral patterns towards autonomy, self-control, independence, and socialization
- Attachment-seeking behaviors are sometimes misunderstood as "attention-seeking", regressive, or controlling
- Ages 3 and 4 years: child is more able to tolerate separation because their secure base is internalized and the primary relationship is maintained without the physical contact
- Goal-directed partnership is the last stage of ontongeny

Precursors of Attachment Security
Fearon and Belsky

Consider stressors *and* supports; Risks *and* protective factors

- Infant makes an equal contribution to the pattern
- Consider temperament (Chess and Thomas), but there is a low correlation between temperament and attachment style
- Greater correlation of attachment style among MZ twins than DZ, but most variance is still related to environment
- Molecular gene studies: some association of polymorphic DRD4 dopa receptor gene among Disorganized attachment infants (Lakotos) but correlation not definite
- Greater incidence of disorganized attachment among infants with of polymorphic DRD4 dopa receptor gene whose mothers had unresolved loss (Attachment Q Sort)
- Greater incidence of disorganized attachment among infants with 5-HTT LPR (serotonin receptor gene) disturbance whose mothers provided less responsive care
- Across cultures: Maternal sensitivity is associated with secure attachment
- Maternal intrusiveness is associated with insecure attachment
- Maternal autonomy is associated with secure attachment
- Disorganized attachment is associated with parental frightening behavior and with maltreatment and affective communication errors
- Maternal Behavior Q Sort: maternal mind-mindedness" = readiness to treat infant as an individual with his/her own mind is associated with infant secure attachment
- Parental "reflective functioning" (insight into the infant's feelings and thoughts) is associated with infant secure attachment (Fonagy; Slade)
- Depressed mothers (detached and intrusive types) are associated with infant insecure attachment
- Marital discord associated with infant insecure attachment
- **Bronfenbrenner:** ecological model: *distal* processes (e.g., marriage) exert effect on *proximal* processes of parenting
- **Cicchetti:** Consider *mediating* variables within both mother-infant and father-infant dyads: parental psychological health, marital relationship, negative and sensitive temperament, social supports, work-family stress

Infant Mental Health RS as Best Practice Guidelines
Zero to Three
Weatherston

- View, wonder, consider, understand pregnant women, infants, young children, and families
- Support professionals working with young families
- Shift perspective, address personal biases, set boundaries, slow down, observe and listen
- Professional to be heard, validated, and affirmed in RS
- Examine own thoughts, feelings, reactions evoked by IMH work in a safe, reliable, consistent learning environment (**Fenichel:** a relationship for learning)
- Pro's strengths are supported; vulnerabilities partnered
- RS = shared exploration of parallel processes
- All relationships in the system are attended to; including the RS/C to Reflective practitioner relationship
- The intention is to affect the relationship with the parent and child
- Provide the parent with holding, responding, nurturing that we are asking them to give baby
- RS = holding environment for the pro; a secure relationship
- D-I-T promote self-awareness: reflect on our own culture, values, beliefs, biases, society's "isms" and oppression of families; D-I-Ts honor non-dominant ways of knowing
- **RS: Listen and wait**
- Allows the pro to self-discover, expose our insecurities & mistakes, and ask Qs
- At Policy level: policy pros can benefit from RS/C. Faculty level as well: understand the impact of teaching about attachment and loss, trauma
- Fitzgibbons, Smith, McCormick: RS/C is a "Safe Harbor": it is trauma-informed and mitigates against secondary trauma.

Book of IMH Case Studies: 17 core practices:
Designed to understand our personal view; create a safe place; observe, listen and guide
Focus on Present relationships, Past relationships, Reflective Functioning, Commitment to emotional health

- Relationship is the instrument of change
- See the child and parent together
- Observe child growth and development
- Anticipatory guidance
- Alert parent to child's accomplishments and needs

- Help parent to find pleasure in the child
- Create opportunities for p-c interaction and exchange
- Allow parent to take the lead
- Identify and enhance capacity that each parent brings to the care
- **Wonder about parents' thoughts and feelings related to the presence and care of the child (responsibilities)**
- **Wonder about child's feelings and interactions**
- **Listen for the past**
- **Allow core relational conflicts and emotions to be expressed by the parent (Holding environment)**
- **Attend to parents' history of abandonment, separation, and loss as this affects infant care**
- **Attend to the infant's needs within the relationship**
- **Identify and treat or collaborate with others in the system (e.g., MH, EI)**
- Be curious and reflective

RIOS: Reflective Interaction Observation Scale:

- Observes the "space between the two"
- Builds a 'Reflective Alliance'

Essential Elements and Collaborative Process Tasks:

Essential Elements:

- **Understanding the family story:** observe to understand the interactions and relationships among all parties in the family system; the family history and culture
- **Holding the baby in mind:** the baby in relationship(s) is the focal point of treatment and of RS/C
- **Professional Use of SELF:** attention to our own subjective thoughts, beliefs, emotional responses, and reactions as important information
- **Parallel Process:** how one relationship affects another. RS connects the immediate experience of one relationship with another (**Heffron**)
- **Reflective Alliance:** quality of the RS relationship

Collaborative Tasks:

- **Describing:** What do we know?
- **Responding:** How do we and others feel?
- **Exploring:** What might this mean?
- **Linking:** Why does this matter?
- **Integrating:** What have we learned?

Best Practice Guidelines for RS/C as <u>separate and different</u> from administrative or clinical supervision. Focus is on the relationship with each other.

- Regular time and place; punctual
- Protect against disruption
- Set agenda together
- Be open, curious, emotionally available
- Address trainee's level of pro development: respect trainee's pace, encourage expression of emotions and thoughts, share/apply specialized knowledge
- Ally with supervisee's strengths
- Observe and listen
- Use of silence
- Strengthen supervisee's observation and listening skills
- Suspend judgment and criticism
- Invite details about the family

- Listen for emotional expression
- Invite the supervisee to talk about feelings.
- Wonder about, name, and respond to feelings with empathy
- Explore parallel process of those feelings
- Encourage exploration of supervisee's feelings about the RS/C and the supervisor and how these might affect work with the family
- Attend to content (what is happening) and process (how the relationship is unfolding and the feelings attached)
- Maintain shared balance of attention on the infant/parent relationship and on the supervisee
- Reflect on RS/C before the next session
- Remain available in between
- RS/C to engage in his or her own RS/C (category 4 Mentors: 12 hours yearly for continued Endorsement; from a RS/C with knowledge of infant and young child behavior and development, attachment, trauma, separation, loss, grief, cultural competence – knowledge of racial oppression and racial trauma--; mental and behavioral health diagnoses and treatment, and RP

Peer Supervision is not RS/C
Collaborative Consultation is not RS/C
RS/C can be facilitated in groups: 6-8 participants is ideal; up to 10 pp
Virtual technology: attend to cues for relationship: ponder together about impact of the technology connection; ponder together about silence; pause to wait for input; gather feedback from the group.
Relationship with each member and among the members is still front and center

Best Practices for the Reflective Supervisee:

- Agree to the regularity of time and place
- Remain open and curious
- Come prepared to share details of the family encounter content
- Ask Qs to allow more depth of thinking
- Be aware of own feelings as able
- Explore relation among these feelings and the work with the family
- Allow your RS/C to support you
- Suspend critical judgment of yourself and others
- Reflect on the RS/C session before and after to enhance professional and personal growth
- RS/C is not clinical diagnostic and treatment planning—it is a place to explore emotions

Release, Reframe, Refocus, and Respond
Harrison

RS/C conducted with EI HVs; themes of change emerged:

- **Reframe:** strengths-based: pros felt their own emotions and bodily reactions responded to with empathy. Became data for their own application of empathy to families.
- **Refocus:** Where *can* I make a difference? Not stuck in helplessness. Explore new avenues. = renewed sense of self-efficacy
- **Respond:** Slow down, observe, listening= being truly present. More able to consciously provide a parallel experience for the child and family.

DTR Case Vignette Outline

From Introduction to the IMH Program (Deb Weatherston)

I. Infant Mental Health Services

A. Concrete assistance
B. Emotional Support
C. Developmental Guidance
D. Early Relationship Assessment and Support
E. Advocacy
F. Infant-Parent Psychotherapy

II. Infant Mental Health Practitioner Skills

A. Skills for MULTIPLE disciplines:

1. Building relationships and using them as instruments of change
2. Meeting with the infant and parent together throughout the period of intervention
3. Sharing in observation of the infant's growth and development
4. Offering anticipatory guidance to the parent that is specific to the infant.
5. Alerting the parent to the infant's individual accomplishments
6. Helping the parent to find pleasure in the relationship with the infant
7. Creating opportunities for interaction and exchange between parent(s) and infant or parent(s) and practitioner
8. Allowing the parent to take the lead in interacting with the infant or determining the "agenda" or "topic for discussion"
9. Identifying and enhancing the capacities that each parent brings to the care of the infant.

B. Strategies for Infant Mental Health Specialist (what distinguishes their work across service levels – prevention, promotion, early intervention; intensive assessment and treatment); Attending to the health and development of both parent and child, through…

10. Wondering about the parent's thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood
11. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent
12. Listening for the past as it is expressed in the present – inquiring and talking
13. Allowing core relational conflicts and emotions to be expressed by the parent – holding, containing, and talking about them as parent is able
14. Attending and responding to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant , the infant's development, the parent's emotional health, and the early developing relationship

15. Attending and responding to the infant's history of early care within the developing parent-infant relationship.
16. Identifying, treating, and/or collaborating with others, if needed, in the treatment of disorders of infancy, delays and disabilities, parental mental illness, and family dysfunction
17. Remaining open, curious, and reflective.

JMS 2019

Case Studies in IMH book

These skills and strategies below form a critical conceptual base for the IMH specialist to consider and use in order to understand and work with families effectively.

1. building relationships and using them as instruments of change;

2. meeting with the infant and parent together throughout the

period of intervention;

3. sharing in the observation of the infant's growth and development;

4. offering anticipatory guidance to the parent that is specific to the infant;

5. alerting the parent to the infant's individual accomplishments and needs;

6. helping the parent to find pleasure in the relationship with the infant;

7. creating opportunities for interaction and exchange between parent(s) and infant or parent(s) and practitioner;

8. allowing the parent to take the lead in interacting with the infant or determining the "agenda" or "topic for discussion";

9. identifying and enhancing the capacities that each parent brings to the care of the infant;

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

11. wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent;

12. listening for the past as it is expressed in the present—inquiring and talking;

13. allowing core relational conflicts and emotions to be expressed by the parent—holding, containing, and talking about them as the parent is able;

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

15. attending and responding to the infant's history of early care within the developing parent-infant relationship;

16. identifying, treating, and/or collaborating with others, if needed, in the treatment of disorders of infancy, delays and disabilities, parental mental illness, and family dysfunction; and

17. remaining open, curious, and reflective.

Core and basic beliefs that support and sustain IMH specialists as they work with infants and families:

• Optimal growth and development occur within nurturing relationships.

• The birth and care of a baby offer a family the possibility of new relationships, growth, and change.

• What happens in the early years affects the course of development across the life span.

• Early developing attachment relationships may be distorted or disturbed by parental histories of unresolved losses and traumatic life events ("ghosts in the nursery") (Fraiberg, Adelson, &Shapiro, 1975).

• The therapeutic presence of an IMH specialist may reduce the risk of relationship failure and offer the hopefulness of warm and nurturing parental responses.

Other things to keep in mind-

- Allying with the mother to make the baby's developmental progress be an organizing focus of reality
- How do you hold the empathy for parent and child in balance so that neither is sacrificed to the other—so that our concern for one does not lead to lack of sufficient awareness and understanding of the other, or that both are not endangered by our strong wish to help them be together? This balance is like walking an emotional tightrope with the need for constant awareness of exactly where you are.
- How do you keep appropriate advocacy for a family with an outside entity delicate enough not to be (or seem) defensive or belligerent?
- Can you do for a parent and with a parent simultaneously?
- How do you avoid a sense of being exploited? When does it happen?
- How do you factor in your own moods and your life's vicissitudes?

DC 0-5: Axis I – V

Cultural Context for diagnostics: cultural identity, cultural explanation of the presentation, cultural factors related to psychosocial and caregiving environment, cultural elements of relationship between the family caregivers and the clinician, Overall cultural consideration

Axis I: Clinical Disorders

- Neurodevelopmental Disorders (e.g., Overactivity Disorder of Toddlerhood)
- Sensory Processing Disorders (e.g., Over- Under- responsivity)
- Anxiety Disorders (e.g., Inhibition to Novelty Disorder)
- Mood Disorders (e.g., Dysregulated Anger and Aggression Dx)
- Sleep, Eating and Crying Disorders (Crying disorders do not crosswalk to DSM5; only to R codes in ICD-10)
- Trauma, Stress, and Deprivation Disorders (Complicated Grief Disorder crosswalks to DSM5 Other specified Trauma- and Stressor Related Disorder and ICD-10 Other Reactions to Severe Stress F code) (e.g., Disinhibited Social Engagement Disorder)
- Relationship Disorders (crosswalk to DSM5 Parent-Child Relational Problems and ICD-10 Other Specified Problems related to Upbringing—Z codes not billable codes)

Axis II: Relational Context

Part A: Relationship Adaptation:

1. Well-adapted to Good Enough
2. Strained in the concerning relationship
3. Compromised to Disturbed relationship
4. Disordered to Dangerous relationship

Part B: Caregiving Environments

1. Well-adapted to Good Enough caregiving environment
2. Strained in the concerning relationship caregiving environment
3. Compromised to Disturbed relationship caregiving environment
4. Disordered to Dangerous relationship caregiving environment

Axis III: Physical Health Conditions and Considerations:

- Prenatal Exposures, prematurity, congenital abnormalities
- Chronic medical conditions (e.g., cancer, neurologic, endocrine)
- Acute medical conditions
- History of medical procedures
- Injuries
- Medication effects

Axis IV: Stressors:

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

Axis V: Developmental Competence

- Competency Domain Rating Summary Table: Exceeds, Functions at age-appropriate, Competencies are inconsistently presenting or emerging, Not meeting expectations (delay or deviance) ACROSS: Emotional, Social-Relational, Language-Social Communication, Cognitive, Movement and Physical

EC/CT Evaluation Measures:

CHILD:

DECA: The screening and assessment tool that focuses on identifying key social and emotional strengths and the planning resources provide caregivers and parents with research-based strategies to promote children's resilience.

TESI-PRR: assesses a child's experience of a variety of potential traumatic events including current and previous injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical abuse, and sexual abuse.

SWYC-MA: is a free, parent-report screening instrument for children under five years of age. The SWYC was developed to provide first-level screening for a wide range of developmental-behavioral domains in a single instrument: cognitive, language, motor milestones, social-emotional/behavioral functioning, as well as autism and family risk factors. The SWYC/MA is a modified version of the SWYC tool that incorporates the Edinburgh Post Natal Depression Scale (EPDS), a validated 10-item questionnaire to identify postpartum depression.

Screening:

ASQ3 and ASQ3-Social Emotional (parent administers tasks and then reports)

Parent questionnaires:

Bayley Scales of Infant and Toddler Development III Social Emotional Questionnaire

ITSEA

BITSEA

Toddlers (2 years): Behavior Assessment Scales for Children 3rd Ed (BASC3); Adaptive Behavior Assessment Scales 3rd Ed (ABAS3)

Evaluation:

Bayley Scales of Infant and Toddler Development III

IDA: Infant-Toddler Developmental Assessment

Mullen Scales

Battelle

Brigance

PARENT:

PRFQ: The Parental Reflective Functioning Questionnaire (PRFQ) developed to provide a brief, multidimensional assessment of parental reflective functioning that is easy to administer to parents with a wide range of socioeconomic and educational backgrounds

PSI: The PSI is a parent self-report, **101-item questionnaire**, designed to identify potentially dysfunctional parent-child systems.

BSI- adult psychological distress (includes 9 subscales)

- BSI GSI: total score/global assessment of psychological stress

- Non-clinical sample average 0.3 on the BSI GSI

LSC-R: adult trauma inventory

MGLQ: The Migratory Grief and Loss Questionnaire (MGLQ) was designed to measure the grief experience associated with immigration

PCL-5: The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. The PCL-5 has a variety of purposes, including: 1. Monitoring symptom change during and after treatment 2. Screening individuals for PTSD

PFS: Protective factors scale

Adult Attachment Interview