Early Childhood Mental Health Treatment

Training Reference Guide

Knowledge for Early Years
(K.E.Y) Resources created by
Invest in Kids
with contributions from
Invest in Kids Foundation
Hincks-Dellcrest Centre
The Creche Child and Family Centre

CHILDREN’S MENTAL HEALTH ONTARIO Summer 2002
Contents

Training Reference Guide

Early Childhood Development
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 4
FAQ’s & Guided Reflection ......................................................................................... 6

Attachment
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 8
FAQ’s & Guided Reflection ......................................................................................... 17

Child Psychopathology
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 3
FAQ’s & Guided Reflection ......................................................................................... 5

Risk and Protective Factors
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 5
FAQ’s & Guided Reflection ......................................................................................... 6

Parental Mental Health
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 4
FAQ’s & Guided Reflection ......................................................................................... 6

Systems and Eco Systems
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 3
FAQ’s & Guided Reflection ......................................................................................... 4

Cultural Diversity
Fact Sheet .................................................................................................................. 1
Strategies .................................................................................................................... 4
FAQ’s & Guided Reflection ......................................................................................... 6

cont’d...
## Contents

### Training Reference Guide

#### Engaging Hard To Reach
- Fact Sheet ................................................................. 1
- Strategies ........................................................................ 4
- FAQ’s & Guided Reflection ........................................... 6

#### Screening and Assessment
- Fact Sheet ........................................................................ 1
- Strategies .......................................................................... 3
- FAQ’s & Guided Reflection ................................................ 16

#### Multidisciplinary Practice
- Fact Sheet ......................................................................... 1
- Strategies .......................................................................... 4
- FAQ’s & Guided Reflection ................................................ 6

#### Planning Interventions
- Fact Sheet ......................................................................... 1
- Strategies .......................................................................... 5
- FAQ’s & Guided Reflection ................................................ 11

#### Personal Well-Being
- Fact Sheet ......................................................................... 1
- Strategies .......................................................................... 3
- FAQ’s & Guided Reflection ................................................ 5

#### Effective Consultation
- Fact Sheet ......................................................................... 1
- Strategies .......................................................................... 3
- FAQ’s & Guided Reflection ................................................ ?
Early Childhood Development

There is a growing base of knowledge that has led to advances in understanding how the connection between a child’s early experiences, life-long health and well-being is established through the development of brain structure in the early years. Research literature is demonstrating that:

- There are sensitive periods between birth and age 5 upon which children rapidly develop foundational capabilities upon which subsequent development builds
- These time periods are significantly influenced by biological, environmental and interpersonal sources of resiliency and vulnerability – nature and nurture work together, each influencing one another
- Failure to provide appropriate stimulation, consistent responsive care and opportunities to explore their immediate environment, may fail to develop the neural connections and pathways that facilitate the essential learning and lead to self-regulating skills
- Exposure to trauma, neglect or severe stress has been shown to be damaging to the developing brain and resulting in learning disabilities, emotional and behavioural problems

Nurture - consistent and responsive caregiving is critical to shaping the essential social, emotional, cognitive, language and motor skills of a child’s development.

Nature- normal developmental sequences and patterns are predictable, however, a child’s temperament and the “goodness of fit” between a parent’s and child’s temperament is also critical to the evolving developmental trajectory.

The three tasks of childhood:

1. **Emotional Development – negotiating transition from external to internal self-regulation**
   - From birth the child must learn to regulate a number of physiological and emotional functions
   - Throughout childhood regulation encompasses more emotional elements
   - Emotion, behaviour and attention are highly linked, therefore success in one area can lead to success in another and difficulty in one can lead to difficulty in another
   - Child’s ability to regulate is deeply embedded in his relations with others
   - Emotional demands can be conflicting, confusing and overwhelming when children are raised in environments where there is family dysfunction, interactions are coercive or abusive, or a parent is suffering from depression or other affective disorders

cont’d...
2. Cognitive Development – acquiring capabilities that are the underpinning for communication and learning

- Researchers speak of “babies wired to learn” which places the onus on society to be ready for the competencies with which the child arrives; appropriate response lays the groundwork for later learning and problem-solving
- Thinking, social interactions, relationships and emotions converge in a powerful way during the second year of life
- The quality and quantity of verbal and social stimulation that a child receives will determine the language learning process

3. Social Development – learning to relate well to other children and forming relationships

- A child’s evolving cognitive, language and emotional regulation skills will play a role throughout social skill and relationship building
- Secure attachments to caring adults during infancy and toddler years lays the foundation for relationships
- Having positive relationship skills has been found to be a predictor of popularity with peers during the preschool years (Sroufe, 1983, 1990)
- Infants who exhibit ambivalent attachments may develop into unhappy, easily frustrated and rebuffed toddlers and preschoolers (Erikson, Sroufe & Egeland, 1985; Renken et al., 1989)
- Children who are socially competent at the toddler or preschool age have parents who actively help their children learn to play; those who appear socially inept often have parents who view social competence as a function of the school system and generally devalue the importance of social skills

NB • Safety

- Injury, not sickness, is the leading cause of death of Canadian children. Most childhood injuries can be prevented with proper information and care. Similarly neglect, which can take many different forms, can have serious and life-long implications.

cont’d…
Resources


◆ www.zerotothree.org

◆ www.cich.ca website of Canadian Institute of Child Health which offers numerous publications and resources

◆ www.cfc-efc.ca/cccf - website of Canadian Child Care Federation which offers numerous resources and publications in the field of early childhood development education and care


◆ National Centre of Excellence in Early Childhood Development - www.excellence-earlychildhood.ca

◆ www.investinkids.ca

◆ www.cmho.org

◆ www.hincksdellcrest.org
Strategies to support emotional development will focus on:

- Parents recognizing an infant’s cues and responding appropriately
- Soothing and comforting an unsettled infant
- Providing predictable routines
- Talking about feelings, elaborating on the child’s emotional experiences as well as those around them
- Helping children to understand that how they feel may not be the same as how their friends or others are feeling and why
- Helping children find the strategies to deal with challenging emotions
- Providing children the opportunity to explore different emotions through pretend play, puppetry, drawing or stories

Strategies to promote a child’s language development include:

- Talking to the baby before the child can speak
- Paying close attention when an infant, toddler or preschooler is talking to the parent
- Following the child’s lead and going with the flow of his/her ideas and statements
- Being patient and understanding that finding words and using correct pronunciation takes time
- Being comfortable with silences knowing that the child may be thinking or working on a skill in another area
- Reading to children and talking about what has been read
- Modelling reading variety of texts

Strategies to promote reasoning and problem-solving include:

- Encouraging curiosity during naturally occurring play situations
- Having lots of conversations with children throughout the day
- Being available to interact even when a child is playing independently
- Being aware that a child’s temperament, level of development, interests, preferences and moods all influence his/her ability to learn from the experiences being offered

cont’d...
Thinking out loud so the child can see the reasoning and problem solving processes being modeled

Reading, reading and more reading

Being part of the child’s day and joining in activities the child is enjoying

**Strategies to support a child’s social development include:**

- Providing social experiences with other children
- Providing a structured play experience with other children on a regular basis
- Providing unstructured play experiences
- Talking about the play experiences before and after the activities
- Offering strategies to help overcome challenging situations in play or with others
- Recognizing and respecting the child’s social abilities such as shyness or assertiveness
- Understanding the influence of a child’s temperament and how it influences how the child relates to others
Guided Reflection

Q: What are the key findings emerging from research on the science of early childhood development?

A: The volume *From Neurons to Neighborhoods: The Science of Early Childhood Development* states the following conclusions based on rigorous literature review:

- The traditional “nature versus nurture” debate is simplistic and scientifically obsolete.
- Early experiences clearly influence brain development, but a disproportionate focus on “birth to three” begins too late and ends too soon.
- Early intervention programs can improve the odds for vulnerable young children, but those programs that work are rarely simple, inexpensive or easy to implement.
- How young children feel is as important as how they think, particularly with regard to school readiness.
- Healthy early development depends on nurturing and dependable relationships.
- Culture influences all aspects of early development through child-rearing beliefs and practices.
- Substantial scientific evidence indicates that poor nutrition, specific infections, environmental neurotoxins, drug exposures and chronic stress can harm the developing brain.
- Significant parental mental health problems (particularly maternal depression), substance abuse, and family violence impose heavy developmental burdens on young children (Shonkoff & Phillips, Zero to Three, April/May 2001).

Q: What does biological embedding mean from the perspective of children's mental health?

A: The real implication is that professionals need to intervene with children from the earliest age possible to prevent negative neurological adaptation to take hold.

Guided Reflection

- How will your practice be influenced by the new knowledge available?
- What do you feel is important information to share with parents?
UNDERSTANDING ATTACHMENT

• The concept of attachment focuses on the process through which infants and young children develop a feeling of security in their parents' ability and willingness to protect them from harm.
  > Attachment theory is well supported by empirical research
  > Attachment theory includes social, emotional, and intellectual development.
  > Attachments can last a lifetime
  > Attachments can and likely will change over time
  > Attachment theory is strongly influenced by Bowlby, Ainsworth and Main

• Using the Strange Situation Procedure Ainsworth (1973) identified attachment behaviours. There are two main patterns of attachment:
  > Secure attachment: A child who has a secure attachment feels confident that s/he can rely on the parent to protect him/her when the child experiences distress. This confidence gives the child security to explore the world and establish a trusting relationship with other people
  > Insecure attachment: A child who has an insecure attachment is not confident that the parent will protect and comfort him/her when feeling distressed (although the parent may be available and loving at other times). These children feel that they cannot rely on their parents and therefore, have to develop other strategies for calming themselves when they need comfort

Insecure attachment can present in three distinct forms:

1. Insecure – Avoidant
  > Children exhibiting insecure avoidant attachment behaviours show:
    - very little attachment behaviour during separation from their mother
    - no signs of distress in situations which would be considered stressful.
    - no affect
    - self reliance and use avoidant behaviour to protect themselves from overt rejection as a strategy to staying close to mom
  > Mothers of infants with insecure-avoidant attachment will:
    - frequently ignore or reject the baby

cont’d...
- speak about their baby in negative terms
- often appear to be angry with their infant

➤ Through his research of long term implications of attachment, Sroufe (1990) has found that as they grow these children will:
- continue to show these avoidant behaviours beyond infancy
- show higher levels of hostility and unprovoked aggression
- show a higher level of negative interactions with other children
- behave negatively, be emotionally distant, sulk, and withdraw
- use avoidance and self-reliance strategies to distance themselves from others

2. Insecure – Ambivalent/Resistant

➤ Children who show insecure ambivalent/resistant attachment behaviours will:
- React intensely to separation from mom, but will then resist approaching/interacting upon her return.
- Be difficult to soothe
- feel anger towards mom due to a lack of consistency provided by her
- show both heightened affect and ambivalent behaviour
- not explore and will be focused on attachment as toddlers

➤ The mothers of infants with insecure ambivalent/resistant attachment will:
- be insensitive to a baby’s cues
- often be unable to recognize baby’s cues
- respond inconsistently

➤ The findings of Sroufe (1985,1989) suggest these children will:
- remain focused on attachment issues even into school-age
- lack assertiveness
- be easily inhibited
- have poor peer interactions
- often withdraw from social situations.

cont’d…
3. Insecure – Disorganized/Disoriented

Infants experiencing disorganized/disoriented attachment will:
- show confused and disorganized behaviour when reunited with mom
- not have any strategies for eliciting comfort when stressed
- show both avoidant and ambivalent behaviours of attachment
- possibly show signs of abuse

The mothers of these infants:
- usually are victims of some form of trauma (e.g. victim of abuse, or witness to violence)
- have not resolved the trauma and are anxious and fearful
- will project their fears onto their present circumstances
- often express their emotions in a fearful and intense way
- are unable to recognize their baby’s cues
- provide inconsistent patterns of responses

Little is known at this time about the long term implications of disorganized attachment. These children appear to show high rates of aggressive, hostile and coercive behaviour as school-age children (Lyons-Ruth, 1996).

- **The attachment experiences a child has will influence that child’s behaviour for future relationships.**
  - The parental role modeling is the child’s reference point about how relationships should look
  - This parental model will be subject to change due to experience
  - The effects of early experience are carried forward through new relationships
  - Some aspects of the model provided by parents may be resistant to change

- **Similarly, the model a parent uses to form an attachment with an infant will influence the type of interactions and attachment that are established.**
An individual’s parenting ability will influence the attachment relationship they have with their child. Research (Main et al., 1985) suggests there are three main factors that influence parenting ability:

- The caregiver’s own experience of caregiving that is based on the parenting she received as a child.
- Parental risk factors such as mental illness or substance abuse.
- The availability of external supports.

The parenting each parent received influences the type of attachment parents will share with their infant. Parents who were securely attached as children:

- Value attachment relationships;
- Believe their relationships have influenced their own personality development;
- Describe their own relationships in an objective way;
- Talk comfortably about attachment; and
- Have realistic views about their parents and their own attachment experiences.

In contrast those parents who experience insecure attachment as children will have a poor working model to work from in their role as a parent. These parents tend to be:

- Dismissive adults;
- Preoccupied (still trying to please their own parents and anxious about their current relationships); and
- Suffer from unresolved loss or trauma.

Mary Ainsworth (1973) identifies four developmental phases to attachment:

- ‘Preattachment’ – occurs during the first few weeks of life when infants do not signal to a specific caregiver
- ‘Attachment-in-the-making’ – lasts up to 6 or 7 months when the infant begins to signal clear preferences
- ‘Clear-cut attachment’ - develops between 6 months and 1 year
- ‘Goal-corrected attachment’ – occurs during the preschool years when children have the cognitive capacity to understand that their attachment figures have their own needs and they will have to negotiate recognizing these needs.
• Zeanah (2000) expanded the work of Emde (1989) who looked at developing a model for understanding features of the parent-child relationship by identifying the following caregiving qualities as salient behaviours for the attachment relationship:
  > Emotional availability
  > Nurturance and warmth
  > Protection
  > Provision of comfort

• The above behaviours are found by Zeanah (2000) to correspond to a child's:
  > Security and trust
  > Balanced emotion regulation
  > Vigilance
  > Comfort seeking
  > Expression of feelings and communication

• Conversely, Zeanah (2000) notes that the following behaviours are less salient for attachment:
  > Play
  > Teaching
  > Instrumental care and routines
  > Discipline/limit setting

• Nonattachment in North America is rare:
  > Occurs in less than 1% of children (Zeanah, 2000)
  > May be more prevalent in children living in countries with a higher use of orphanages and institutions

• The rate of disorganized attachment is higher ranging between 14% to 82% (Zeanah, 2000) in countries where child maltreatment or parental psychopathology have been identified

cont’d...
ATTACHMENT DISORDERS

- The DSM-IV identifies 5 kinds of attachment disorders (Zeanah, 1993):
  - Nonattached Attachment Disorder
    - This occurs when an infant has not had any chance to form emotional connections with people
    - This may be due to abuse, foster care or institutionalization, drug addicted or alcoholic mothers, or mothers suffering from severe mental illness
  - Indiscriminant Attachment Disorder
    - May be due to a long separation from an attachment figure
    - May also be due to foster care and the lack of opportunity to form a close relationship with another human being
    - Often seen in children who have been institutionalized
  - Inhibited Attachment Disorder
    - Occurs due to a lack of parental availability or unpredictability as a result of frequent separations such as hospitalizations
  - Aggressive Attachment Disorder
    - Occurs when feelings of anger and frustration dominate the relationship
    - Child may also demonstrate excessive aggression toward attachment figure
  - Role-Reversed Attachment Disorder
    - Child assumes the parenting role
    - Child may show extreme behaviours such as bossiness, overnurturing, or controlling

cont’d...
ASSESSING ATTACHMENT DISORDERS

Attachment disorders are the result of parenting difficulties due to issues such as separation from parents, loss of caregivers, abuse or neglect, or unresponsive caregiving. Some of the signs of a possible attachment disorder may include some of the following:

- Unpredictable behaviour
- Bullying behaviour or being a victim of bullying
- Poor social skills
- Aggressive behaviour with other children
- Low frustration tolerance and self control
- Very disorganized and disoriented in approach to problems
- Frightened both when away from and with caregivers
- Contradictory behaviour
- Fear, generalized anxiety and sadness
- Signs of dissociation or staring into space and not paying attention to what is going on
- Lack of resilience and easily upset in response to challenging situations
- Lack of problem solving or ability to ask for assistance; easily giving up or becoming very angry
- Lack of empathy for others and sociopathic tendencies
- Difficulty making friends and trusting other people
- Frequent tantrums and difficulty regulating difficult emotions
- Emotionless with little pleasure or pain shown in reaction to events that happen

(Landy, Toronto East General Hospital, 2002)
According to Landy (2002), the assessment of an attachment disorder generally should involve:

- Obtaining a developmental history of the child
- Observing and assessing the parent-child relationship and attachment
- Observing the child in play and in the daycare
- Carrying out direct testing when necessary
- Assessment of the history, mental status and current function of the parent(s)

The parent-child relationship and attachment can be measured using the following methods:

- The Strange Situation (12 – 20 months) (Ainsworth et al., 1978)
- Cassidy-Marvin System for Assessing Attachment in Children older than 18 months (2 ½ - 4 years)
- Main-Cassidy Attachment Classification for Kindergarten-age children (4 ½ - 7 years)
- Preschool Assessment of Attachment (2 ½ years – 4 ½ years)
- Attachment Q – Sort (AQS) (12 – 60 months)
- Attachment Story Completion Task (3 years)
- Picture Response Set (6 – 7 years)

Additional measures can be used to assess the parent-child interaction:

- Nursing-Child Assessment Satellite Training (NCAST) Teaching and Feeding Scales
- Parent-Child Early Relational Assessment
- Functional Emotional Assessment Scale
- Home Observational Measure (HOME)
- Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBI-ANCE)

(Landy, Toronto East General Hospital, 2002)

Direct observation should be part of any formal assessment. Such observations:

- Should take place in an environment familiar to the child

cont’d...
May use a formal tool such as Transdisciplinary Play-Based Assessment that can assist in assessing the level of pretend play, and will explore the child’s level of socialization with other children.

It is also encouraged to complete a developmental assessment of the child. It is common for children with attachment disorders to also experience developmental delays. This information will inform the treatment plan developed.

It will also be necessary to assess parental history, mental status, and current functioning. The following interviews and questionnaires can be used:

- The Adult Attachment Interview (AAI)
- Adult Attachment Q-Sort
- Working Model of the Child Interview (WMCI)
- Attachment History (AHQ)
- Mother-Father-Peer Scale

TREATMENT OF ATTACHMENT DISORDERS

The treatment of attachment disorders generally focus on:

- The parent-child relationship
- The child

Interventions focused on the parent-child relationship include:

- Interactional Guidance Using Videotape Viewing (Developed by Susan McDonough, 1995)
  - Successful with high risk parents
  - Includes videotaping interactions and reviewing the tape with the parent and discussing both positive and negative interactions
  - The video is approximately 10 to 20 minutes in length
  - Probing questions are used to facilitate discussion
  - This method has been shown in research to enhance the quality of parent-child interaction and the attachment relationship between parent-child

cont’d...
**Watch, Wait, and Wonder**
- Developed by Wesner, Downling and Johnson (1982) and expanded upon and researched by Cohen, Muir, and Lojkasek (1999)
- Includes an infant-led interaction and a discussion between the mother and therapist about what was observed and experienced
- Involves a 20 to 30 minute play session between mom and tot during which mom is instructed to be on the floor with the child and follow the child’s leads (she is also instructed not to initiate the play or take over the activity)
- During the discussion parents may share their own feelings and difficulties that are raised during the play session. These and any past experiences may be explored by the therapist
- This intervention has been shown to enhance the parent child attachment and the child’s functioning in other areas

**Modified Interaction Guidance (Developed by Diane Benoit, 2002)**
- Used with children found to have disorganized attachment as a result of parental history of unresolved loss and trauma
- Aims to reduce specific parent behaviours such as frightened and frightening behaviours, disorientation, intrusiveness or negativity, and withdrawal; focus on increasing maternal sensitivity and empathy
- Intervention takes place over 5 to 7 sessions usually in the home with 5 to 10 minutes of each session videotaped
- The tape is played back to the parent and reviewed
- Positive and negative behaviours are pointed out. When discussing negative interactions the mother is asked what she thinks is in the mind and heart of the baby at that time
- Parents are also given information on normal child development and parenting

**Infant-Parent Psychotherapy**
- Used when more intensive and long-lasting interventions are needed
- Involves 90 minute sessions that occur weekly for one year
- Focus is on the emotional relationship of the mother and infant and any feelings of pain over own past loss or abuse

*cont’d...*
The aim is to develop a therapeutic relationship with the mother that can influence her relationship with the infant.

Other interventions may also be used in combination i.e. developmental guidance, modeling, “speaking through the baby”

Evaluation has found positive outcomes for the parent and child.

Interventions that focus on the child include:

**Non-Directive Play Therapy**

- The therapist follows the child’s lead showing acceptance
- Usually involves a number of sessions
- The relationship developed between the child and the therapist may be internalized by the child and may replace other negative memories
- The child may project emotions onto the therapist giving the therapist a view of the child’s world
- Sessions provide a structure that may be otherwise lacking in the child’s life
- The child’s feelings are reflected back by the therapist and interpreted
- For children suffering from an attachment disorder the relationship with the therapist may be the most important factor
- This method can also be used with traumatized children with attachment disorders. In such instances, therapy should occur immediately following the trauma.

**Family Based Treatment**

- Referred to as the Family Attachment Program (Cohen & Duvall, 1996), was developed to help adopted children with traumatic life histories
- Focus is on building the family after an adoption has occurred by building attachment relationships within the family

NB: All of the interventions above require training. The Hincks-Dellcrest Institute provides training in many of the interventions listed. See Planning Interventions and Parent Mental Health sections for additional strategies.
### Table 6.1. Brain Development, the Development of Self-Regulation, and Effects of the Environment on This Development

<table>
<thead>
<tr>
<th>Area of Development</th>
<th>Brain Development</th>
<th>Effects of the Environment</th>
</tr>
</thead>
</table>
| Motivation for self-regulation | Intrinsic goals of the executive system:  
* to organize information so it is understandable and meaningful  
* to be able to anticipate events  
* to find a better or more interesting way to solve a problem or reach a goal | Lack of coherence and meaning may impede the expression of intrinsic goals  
Lack of opportunities for choice, control, and becoming more effective may impede the expression of intrinsic goals |
| Self-regulation of emotion  | Emotions exert a powerful influence on self-regulatory functions such as decision making and choice of goals  
Self-regulation of arousal begins in the first year  
Some strategies to control the expression of emotions develop in the second to third year | Early interactions with caregivers lead to neurohormonal changes in the brain  
Warm, responsive care protects against the negative effects of stress  
Responsiveness to biological rhythms and signals helps infants regulate biological and emotional systems  
Some evidence that early intervention can remedy some of the effects of inadequate early care |
| Self-regulation of behavior | The ability to inhibit behaviors develops even before speech (can inhibit initial responses to an event)  
The ability to inhibit behavior increases markedly between ages 2 and 3, before age 3 children are not good at following rules (can follow instruction to start an activity better than instruction to stop an activity); at age 3 can both start and stop following instructions  
Between ages 2 and 4 large increase in metabolic rates in executive (prefrontal) area of the cortex, which controls decision making and voluntary action  
Toddlers are able to comply with simple requests; at ages 3 to 5 children can follow rules and comply with increasingly more complex directions and rules  
Child increasingly able to control interference with an ongoing activity and maintain focus (attention) | Negative experiences (trauma, neglect, institutionalization, maternal depression, poverty) have negative effects on brain development and control of behavior and hinder healthy attachment to others  
Negative experiences may predispose an individual to respond with aggression or violence to stress or frustration  
Some evidence that early intervention can remedy some of the effects of negative early experiences |
| Self-regulation of cognitive processes | The brain spontaneously organizes itself (forms categories, notices and begins to anticipate regularities, detects contingencies, and makes cause-effect inferences)  
Increases in frontal lobe functioning take place in the second half of the first year, at about age 6, and at about age 10  
Children have a nonverbal memory before the development of speech  
Increases in working memory capacity (facilitated by speech) parallel increases in intentionality, decision making, reasoning, and consciousness  
The prefrontal cortex is involved in intentionality, anticipation, planning, monitoring, attention control, decision making, and consciousness | Some evidence that young children need warm, responsive care for normal brain development  
Children need appropriate levels of stimulation for normal brain development  
Children need coherent environments for the brain to organize itself effectively  
Some evidence that early intervention can remedy some of the effects of inadequate early environments |

### TABLE 7.2 (continued)

<table>
<thead>
<tr>
<th>Domain of development</th>
<th>Milestones</th>
<th>Role of adults</th>
<th>Role of environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive self-regulation</td>
<td>Wants predictable routines and resists change. Can choose among a limited number of alternatives. Begins to engage in goal-directed mastery tasks. Begins to notice and correct errors in goal-directed activities. Uses an increasing number of strategies to reach goals. Shows cognitive organization by matching, sorting, and classifying.</td>
<td>Providing developmentally appropriate play materials that support children’s efforts to • experiment and discover the properties of materials (such as water and sand). • organize information (sorting, matching, classifying). • experiment and structure materials (with “open-ended” materials like blocks and clay). • understand and follow sequences (with multistep mastery tasks). • monitor and correct errors (in tasks with clear goals, such as puzzles). Mediating effective language skills. Using scaffolding to broaden children’s understanding and provide assistance.</td>
<td>Provides safe and interesting places for the toddler to play and explore. Contains an appropriate range of materials and, in group settings, a sufficient amount of materials so toddlers can play with them as long as they are interested. Contains space and opportunity for action and investigation with protected spaces for uninterrupted play.</td>
</tr>
</tbody>
</table>

### RESEARCH TO PRACTICE

**TABLE 8.1. Developmental Milestones of Self-Regulation in Preschool and Kindergarten Children and Major Environmental Supports**

<table>
<thead>
<tr>
<th>Domain of development</th>
<th>Milestones</th>
<th>Role of adults</th>
<th>Role of environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/ emotional behavior</td>
<td>More capable of controlling emotions, abiding by rules, and refraining from forbidden behaviors</td>
<td>Function as models, resources, and guides for:</td>
<td>Contains a trusted adult to support independence, self-control, and appropriate interactions with peers</td>
</tr>
<tr>
<td></td>
<td>More capable of using language to regulate own behavior and influence others</td>
<td>• social interaction styles and strategies</td>
<td>Contains clear guidelines (appropriate for age and developmental level of the child or children) for responsibilities, opportunities (choices), expectations, and consequences that are consistently and appropriately implemented</td>
</tr>
<tr>
<td></td>
<td>More interest in peers and peer acceptance, so more apt to regulate self in relation to peers</td>
<td>• self-control strategies</td>
<td>Provides opportunities for supervised interactions with peers</td>
</tr>
<tr>
<td></td>
<td>More capable of cooperative interaction with peers</td>
<td>• values and attitudes</td>
<td>Contains materials that support constructive peer interaction and dramatic play</td>
</tr>
<tr>
<td></td>
<td>Can learn more effective interaction strategies</td>
<td>Use responsive guidance techniques that:</td>
<td>Minimizes exposure to negative behaviors and attitudes</td>
</tr>
<tr>
<td></td>
<td>Can engage in dramatic play with roles and rules</td>
<td>• use language to assist self-control</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• emphasize individual control over behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• support developing inner controls</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• give reasons for desired behaviors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• suggest appropriate strategies in context</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supervise play with peers and help to resolve or negotiate conflicts when necessary (using a problem-solving approach)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide opportunities for dramatic play and for choice among appropriate alternatives</td>
<td></td>
</tr>
<tr>
<td>Prosocial behavior</td>
<td>Begins to talk about mental states of self and others</td>
<td>Model prosocial attitudes and behaviors</td>
<td>Provides opportunities for positive and cooperative interactions with others</td>
</tr>
<tr>
<td></td>
<td>Better understanding of how others may feel</td>
<td>Minimize exposure to violent or antisocial models (live or media)</td>
<td>Includes materials and activities that encourage and support cooperative and prosocial behaviors and attitudes</td>
</tr>
<tr>
<td></td>
<td>Can engage in deliberate helping, sharing, and comforting behaviors</td>
<td>Attribute prosocial motives to children</td>
<td>Provides guidelines that require, encourage, and support responsibility, respect, and care for others, and positive interaction styles</td>
</tr>
<tr>
<td></td>
<td>Internalizing standards of behavior</td>
<td>Assign appropriate responsibilities to children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developing more stable prosocial (or antisocial) attitudes and behaviors</td>
<td>Expect and encourage responsible behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide guidelines for behavior that connect behavior with its effects and include the consequences of behaviors for others</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 8.1 (continued)

<table>
<thead>
<tr>
<th>Domain of development</th>
<th>Milestones</th>
<th>Role of adults</th>
<th>Role of environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive self-regulation</td>
<td>Can engage in a wider range of cognitive activities</td>
<td>Provide developmentally appropriate play materials and activities that support:</td>
<td>Coherent and predictable enough for the child to comprehend the order and predictability</td>
</tr>
<tr>
<td></td>
<td>More able to carry out multistep activities</td>
<td>• appropriate choice</td>
<td>Flexible enough for the child to appropriately influence or affect aspects of the environment</td>
</tr>
<tr>
<td></td>
<td>More able to control attention and resist distraction</td>
<td>• developing learning and problem-solving strategies</td>
<td>Contains an appropriate range of materials for child’s interests and abilities</td>
</tr>
<tr>
<td></td>
<td>Can learn to use more advanced task attack and problem-solving strategies</td>
<td>• engaging in multistep activities</td>
<td>Provides for choice within interest and ability range</td>
</tr>
<tr>
<td></td>
<td>More able to choose tasks appropriate for own level of skill (from among familiar alternatives)</td>
<td>• attention focus and control</td>
<td>Provides time for choice and carrying out chosen activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• construction of cognitive categories that mediate understanding of order, structure, predictability in the environment</td>
<td>Contains space and opportunity for action and investigation, with protected spaces for uninterrupted, focused activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Model and communicate effective language</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use “scaffolding” to broaden children’s understanding and provide assistance (including suggesting appropriate task attack and problem-solving strategies in context)</td>
<td></td>
</tr>
<tr>
<td>Motivation for self-regulation</td>
<td>Moving from a primary focus on exploration in tasks to a focus on mastery and reaching chosen goals</td>
<td>Demonstrate reinforcing attitudes toward independence, persistence, and mastery efforts</td>
<td>Contains enough coherence, predictability, and flexibility that the child can both understand what is expected and engage in independent self-regulated action</td>
</tr>
<tr>
<td></td>
<td>Moving from primary interest in process of doing tasks to products produced</td>
<td>Design the environment for independence</td>
<td>Provides appropriate level of challenges to match the child’s interests and abilities</td>
</tr>
<tr>
<td></td>
<td>Beginning to evaluate own competence in relation to:</td>
<td>Design materials and activities so that a child or small group can carry them out without constant direction from others</td>
<td>Provides materials that the child can structure independently</td>
</tr>
<tr>
<td></td>
<td>• reaching chosen goals</td>
<td>Protect the child’s focused involvement and independent action</td>
<td>Contains opportunities to practice self-regulation and choice</td>
</tr>
<tr>
<td></td>
<td>• evaluations of other</td>
<td>Use assistance strategies that protect the child’s independent focus and agency (including providing strategies the child can later use independently)</td>
<td>Provides materials that the child can access and use independently</td>
</tr>
<tr>
<td></td>
<td>• success of others</td>
<td></td>
<td>In group settings, provides rules that support and protect independent action (such as provision for independent or small-group focused activities and guidelines on how many can occupy an interest area)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Includes techniques for independent organization of activities (such as planning or choice boards)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain of development</th>
<th>Milestones</th>
<th>Role of adults</th>
<th>Role of environment</th>
</tr>
</thead>
</table>
| Social/ emotional behavior | Capable of conscious self-control  
Can reliably abide by rules but may be rigid and punitive in applying them  
Capable of using language to regulate own behavior and influence others  
High peer interest and involvement—desire for acceptance makes peer norms more influential  
Capable of cooperative interaction with others: can engage in independent negotiation and social problem solving with peers and needs less direct adult supervision  
Can use problem-focused rather than emotion-focused strategies in interactions with others  
Can learn from discussions as well as direct experience  
Can play games with rules | Continue to function as models, resources, and guides, but emphasis now is on open and frequent communication with children about attitudes and values and issues that concern the adult(s) and/or the child  
Can use guidance techniques that:  
- use problem-solving techniques  
- involve discussions about issues and problems (can now go beyond specific instances to general problems)  
- emphasize individual control/responsibility  
- involve general principles and standards  
- suggest appropriate strategies in context  
- bring decisions to conscious awareness | Provides climate of respect, acceptance, and positive expectations for self-regulated behavior  
Contains opportunities for positive interactions with peers, both at home and at school  
Contains clear guidelines (appropriate for age and developmental level of the child or children) for responsibilities, opportunities (choices), expectations, and consequences, which are consistently and appropriately implemented  
Contains materials and activities that support constructive peer interaction  
Structured (classroom) experiences minimize exposure to negative behaviors and attitudes (that exist in the environment or culture), give attention to children’s developmental level and ability to assimilate negative information, and include discussions with adults as well as peers when these exposures occur |
| Prosocial behavior | Can reflect on own and others’ behaviors and their consequences  
Consciously aware that self and others have mental states and feelings  
Begins to understand the perspectives of others  
Interested in reciprocity and “fairness”  
Has some internalized standards of behavior and still developing others  
Shows somewhat stable prosocial (or antisocial) attitudes, values, and behaviors  
Can engage in conscious prosocial behaviors  
Has developed some degree of moral responsibility or “conscience” and is considered accountable for an increasing number of own actions | Model prosocial attitudes and behaviors  
Attribute prosocial motives to children  
Assign appropriate responsibilities to children  
Expect and encourage responsible behavior  
Monitor exposure to violent or antisocial models (live or media) and discuss behaviors or events that violate prosocial values with the child  
Guide the child away (when possible) from experiences that the adult believes would be harmful  
Provide guidelines for behavior that connect behavior with its effects and that include reference to general principles and values as well as the consequences of behaviors for others | Social climate and guidelines for behavior require, encourage, and support responsibility, respect, and care for others, and positive interaction styles and sanctions negative or antisocial behavior  
Provides opportunities for positive and cooperative interactions with others  
Includes materials and activities that encourage and support cooperative and prosocial behaviors and attitudes (board games, cooperative learning activities) |

Q: Researchers are now trying to understand the short and long term implications of attachment. Can attachment patterns change over time?

A: Yes. Interventions during the early years are based on the assumption that if early attachments can be altered the trajectory of long term attachments and new attachments will also be altered.

Q: What should the focus of therapy be – the parent, the child, or the parent and the child?

A: We now know that the most effective therapy focuses on the parent-child (Lieberman, 2001). This does not mean that additional therapy focused on the child cannot be part of the intervention plan, but generally in order to maintain positive changes within the child, the parent will need to be involved.

Q: I see many parents who seem unable to recognize the cues their child is giving them. Can this be changed?

A: Yes. Research shows through infant-parent psychotherapy and interactional guidance, parents can begin to better recognize their child’s cues and respond to these cues in a consistent manner.

Q: Can I use the interventions described in this chapter?

A: No. Each of the interventions described requires training by certified trainers. If you do not have the training necessary, you may wish to consider the inclusion of a certified therapist in your team.

Q: When working with a child who has an insecure attachment, should I also be concerned about other areas of development?

A: Yes. It is always advised to use an holistic approach to working with children and families. An attachment disorder may have an impact on other areas of development that should be considered in a treatment plan. Developmental measures are listed in the Screening and Assessment section.
Guided Reflection

- For many parents admitting that their relationship with their child may not be what they had hoped is a very big step. How might you help parents prepare for this realization?

- How might your own relationships influence how you see the relationships of others?

- How will you stay engaged with a family that is having difficulty moving forward after many months of intervention?

- For the professional working with children who may suffer from an attachment disorder the work can be draining and daunting at times. What support systems will you build in for yourself?

Resources

- Dancing with My Baby An attachment-based parenting program for at-risk parents. For more information contact samen@mail.cspp.edu or check out the site www.cspp.edu

- Michigan Association for Infant Mental Health - www.mi-aimh.msu.edu

- IMPrint - magazine developed by the Infant Mental Health Promotion Project www.sickkids.ca/imp

- www.icfy.msu.edu - this site hosts Dr. Marguerite Barratt’s work at the Institute for Children, Youth and Families
Websites


- Parenthood in America
- Proceedings of the conference held in Madison, Wisconsin April 19-21, 1998, paper written by Kelly Bost, Brian E. Vaughn and Carrol Heller – 17 pages
Website: http://parenthood.library.wisc.edu/Bost/Bost.html

Controversial Aspects of Bowlby’s Attachment Theory.

- From home page of Buenos Aires Attachment Research Center: an institution devoted to Research, Promote and Restore Mental Health
- A critical approach to Attachment Theory, paper by Juan Carlos Garelli – 9 pages
Website: http://garelli.freeyellow.com/controversy.html

Chapter II: Literature Review.

Website: http://www.visi.com/~jlb/thesis.html

Attachment Literature.

- List of Resource material from the Irving B. Harris Training Center for Infant and Toddler Development, the College of Education & Human Development at the University of Minnesota – 4 pages
Website: http://education.umn.edu/ICD/harriscenter/AttachmentReferenceList.htm

Bonding and Attachment in Maltreated Children: Consequences of Emotional Neglect in Childhood.

- From Scholastic website, Teacher Resource Center, paper by Bruce D. Perry – 6 pages
Website: http://teacher.scholastic.com/professional.bruceperry/bonding.htm

Early Childhood: Attachment.

- Lecture notes from Psychology 350: Developmental Psychology, at the University of Chicago – 2 pages
Website: www-personal.umich.edu/~suekane/psych/350/Notes/lecture8.html


- Article from Western Criminology Review (Vol. 1, Num. 2 – 1999), by Rebecca S. Katz – 19 pages
Website: http://wcr.sonoma.edu/v1n2/katz.html
Culturally competent professionals recognize that differing attitudes, values and beliefs are enriching rather than threatening. They understand that a vast commonality exists among all human beings (i.e. need for love, security, friendship and sense of belonging, to be competent and achieve one’s potential, etc.,) and that it is how these similar needs come to be expressed that differ greatly from one culture to another, as well as among family members of the same culture.

Principles of Culturally Competent Service Providers (Lynch & Hanson, 1998)

• A professional must have an understanding of his/her own cultural, ethnic, and language background and the values and beliefs that are held about individuals who are different from him/herself.

• All families are unique and although they are influenced by their ethnic, cultural, racial and language backgrounds, they are not fully defined by them. Differences in these areas should not be used to stereotype or serve as the sole determination of an intervention approach.

• Culture is not static. Learning about one’s own or another’s culture cannot happen as a single experience but rather as a lifelong journey.

• The professional’s role has two foci: to work with families to develop interventions that are culturally competent; and to interpret mainstream culture to families so that they can find ways to negotiate it effectively.

• All interactions and interventions take place in a larger sociopolitical context. The ultimate goal of cultural competence is to recognize and rectify political and societal barriers that separate us artificially.

• Culture is co-constructed by parent and child according to a system of shared meanings. The following represent issues and challenges on the path toward cultural competency:

  Language and communication style difficulties
  - understanding the what and how of early childhood mental health services
  - even with interpreters, nuances and subtleties of meaning may be lost so that discussions remain at a superficial level or distorted by inaccuracies or incompleteness of interpreters
  - differences in non-verbal communication styles may limit and constrain the parent-professional relationship i.e., nodding of the head to indicate “yes I understand” is not to be confused with “yes I will comply”
  - previous experience with “authority figures” may have drastic consequences on participation in assessment and intervention.

cont’d...
Difficulties in sharing meaning at a deeper level
- gaps in mutual understanding of relationships, parenting and child development can cause barriers and conflict

Differences in perceptions of “appropriate” dress and behaviour
- families may have specific cultural or religious beliefs about style of dress, forms of greeting, body language, topics of discussion and behaviour in interaction

Lack of awareness of family dynamics and roles
- understanding the values that dictate inclusion and roles of different family members in the assessment and intervention process

History of oppression of a cultural group
- understanding the effect of direct or vicariously experienced trauma (e.g., separations from families and communities; abuse, foster care, etc.,) on parenting and child development
- mistrust, resentment and anger if the professional represents the ethnic group of the oppressor
- history of oppression and disparity in power have influenced how families will deal with professional relationships as well as their perceptions about what is necessary for their children to adapt and survive.

Conflict in values between the professional and the family
- certain beliefs, practices and circumstances may be an affront to the value systems of both professional and parent, i.e., while the practitioner believes in a family-centred approach, the family may have a cultural expectation that the professional should be authoritative and take the lead; failure to do this may result in lack of trust and confidence in the service provider.
- reluctance of the family to adopt mainstream values and child rearing practices
- the Western clinical view is individual-centred, while other views are more family-focused. The practitioner may fall into the trap of pathologizing a cultural value, i.e., needing to discuss decisions with extended family members is seen as overdependence on others
Impact of immigration – the following factors may contribute to a resistance or distrust of a professional:

- loss of professional and economic status
- new stresses in the family
- lack of informal support
- lack of awareness of and comfort with seeking formal support system
- racism and discrimination

• Signs that “culture” possibly may be an issue:

➢ resistance to participate

➢ disagreement about the main components of the therapeutic interventions

➢ clinician is working too hard

➢ avoidance, “You don’t understand”

➢ the therapist observes problem behaviour but can identify no explanation for it
The child exists within a context of family, physical and social environments, culturally regulated customs and childrearing practices and dominant beliefs about childhood.

To be culturally competent requires the professional to explore the social-contextual framework to child development and family life. Ask questions related to key family perceptions and beliefs in the following areas:

**Child Characteristics:**
- temperament
- health
- milestone achievement
- importance of gender and birth order

**Parent practices:**
- modes of child rearing – feeding, sleeping and socialization practices (includes both affection and aggression)
- role of religion and beliefs about childhood
- traditions that are important to preserve
- belief about health and healing (includes family view of a disability or special need)

**Parent-child interactions:**
- attachment practices
- role of the primary caregiver and importance of other family members in the child’s life
- communication and interaction styles
- perception about independence and dependence for differing stages in a child’s life
- approach to discipline

**Family Context:**
- priorities and concerns
- values related to help and intervention

*cont’d*
Community Context:

- how is the community system of services and networks viewed?
- what forms of interactions with the community are preferred?
- what is the accessibility to and availability of informal and formal supports and resources?
- what are the barriers to supports and resources?

Strategies to support culturally sensitive relationship building with families:

1. Be open to learning about a family’s cultural beliefs and practices
2. Recognize one’s own values, beliefs and behaviours as culture-based
3. Establish sensitive, responsive rapport with families by:
   - being sensitive to challenges and concerns facing new families in Canada
   - finding a commonality with the family as a starting point
   - appreciating the dramatic change in economic and social status of new Canadians
   - being understanding of feelings of grief, loss and homesickness
   - being alert to indicators of trauma
4. Problem solve and negotiate around cultural/racial differences
5. When there is no progress in a case consider that there may be an issue in cultural differences not having been addressed as a possible issue and review.

Resources

FAQ’s
& Guided Reflection

Cultural Diversity

Q: How do I make a family understand the importance of treatment for their child?

A: If you believe James Garbarino’s point that “each culture has something to teach and something to learn” (1995) then you will be able to listen to the issues that a family might be having with treatment. It may mean that once you have a stronger appreciation for the family’s values and beliefs you will be able to find a way to explain why a strategy would be helpful or find common ground from which to problem solve an intervention that meshes with the family’s outlook. If the professional can only listen to what a family is telling him/her within his/her own theoretical and clinical categories of understanding, then impasses will occur.

Q: What do I do if there are no interpreters for a specific language in my community?

A: Try the informal support system and explore whether the family has friends, colleagues, religious leaders, or anyone in the community that can help with interpretation.

Q: What if the family wants to have a service provider from their own cultural background?

A: Ultimately it is all about making the services fit to meet the family’s needs. If the family believes that someone from their culture will understand traditional practices and values, then the integration of clinical and cultural needs may be better served with respecting the family’s request.

Q: There are so many permutations in relation to culture, religion, race, etc. How do I keep this in mind and do what I need to do?

A: It can be overwhelming if not paralyzing, if we think that a parent’s every behaviour, every statement or every action has some cultural, ethnoracial or religious implication. Cultural competence is more about recognizing that families operate within a larger sociopolitical context and that although this context is influenced by one’s race, culture, language and economic status, families are highly distinctive. Therefore making assumptions and using stereotypical knowledge defeats the process of learning about individual families from themselves through our interactions with them. When there is a sense of engagement and a sense of moving forward from the family it is unlikely that you need to worry about having a cultural gap in your intervention. If this is missing you need to consider cultural needs as a possible issue that has not been adequately addressed.
Guided Reflection

► How does your own cultural and family context influence the values that form your perceptions of family relationships, the role of parents and key child rearing practices?

► Are there cultural values that feel more natural or comfortable to you, or conversely feel more foreign or threatening? How do you handle the emotions that are evoked?

► How do you increase your personal cultural awareness and sensitivity?
• **Overview**

A systems perspective requires a specific way of looking at children, caregivers and families:

➤ Avoiding a focus on individual units

➤ Avoiding a focus on attributes - “this child is aggressive”

Focussing rather on:

➤ Context - parents, extended family, community

➤ Patterns and sequences of behaviour

➤ The contextual factors which either support growth and adaptive behaviour or help maintain maladaptive behaviour

• **Family systems can be understood in terms of the following:**

➤ Structure -
  - Boundaries - permeable, defuse, or rigid
  - Hierarchy
  - Open vs. conflicted communications
  - Affiliations and alliances

➤ Cybernetics - i.e., positive and negative feedback loops (note this concept is different from positive and negative reinforcement. It is not about rewards and punishments). Rather this relates to information or signals which either increase particular behaviour - i.e., signal “do more” (positive feedback) or decrease the behaviour - signal “do less” (negative feedback). Problems arise when either the calibration of these loops or the regulations of them becomes dysfunctional or unadaptive.

➤ Family scripts - These result in the main from the meshing of:
  - Each parents attachments patterns from his/her family of origin
  - Each parents memory and feelings about how he/she was parented

Parenting scripts may be: Replicative
Corrective
Improvised

cont’d...
Healthy scripts are flexible and adaptive
Unhealthy scripts are rigid, repetitive and maladaptive.

**Implication**

A child’s apparently unhealthy behaviour may therefore be less indicative of psycho-pathology, e.g., aggression, oppositionality, fearfulness, insomnia, than it is indicative of the child’s need to adapt to specific family structures, communication patterns, feedback loops, and scripts.

This has clear implications for the nature and focus of interventions.

Similarly a family’s functioning may also be highly influenced by their context, e.g., isolation from extended family and friends, presence of intrusive family, unsupportive community and social structures and scripts. Examples of the latter are particular scripts about: (a) single parent families; (b) particular ethnic/racial origins; (c) parental behaviour - past and present, e.g., drug use, criminal convictions, lack of employment etc. Communities may have clear, rigid scripts about such factors.

Families and communities (like parents) can be understood as providing a secure or insecure base for their members.
**Strategies**

**Systems & Eco Systems**

- Gather information from a variety of perspectives - i.e. informants on family and wider contextual factors before coming to a conclusion (diagnosis) about the implications of specific behaviours.

- Formulate a systemic diagnosis which includes individual, familial and wider social factors

- Decide where to intervene keeping the following factors in mind:
  - Factors in the system which seem most influential both in 1) creating and maintaining symptoms or dysfunction and 2) in supporting healthy adaptability.
  - Where and with whom in the system you as an intervener can make a positive alliance

- Decide how to intervene keeping the following factors in mind:
  - The urgency - if the system is moving towards breakdown or serious lack of control, urgent decisive interventions including the removal of a child may be indicated.
  - The overall desirability of using interventions which:
    - Strengthen parents competence and self esteem
    - Encourage parents or (parents substitutes) to work together towards solutions
    - Facilitate parents (caregivers) creating their own unique solutions to problems
    - Encourage parents to reflect on factors influencing their behaviour, e.g., their own experiences as children
    - Move the family toward more healthy, flexible structures and patterns

- Monitor your own subjective experience and behaviour keeping in mind that systems exert considerable power and pressure over all who come in contact with them. This may include powerful pressures to:
  - Collude with denying what is happening - e.g. abuse or neglect
  - Side with one part of the system
  - Create within you negative feelings of incompetence, feeling traumatised or hostility, just when you are succeeding and pushing the system to change. The system will often resist such a push.

- If possible, always have a team or consultant to support you and regard it as a sign of professional competence to consult freely.
Q: How can a systems perspective be used in a way that takes into account the reality and seriousness of certain behaviours and situations, especially those involving abuse and neglect of infant and preschoolers?

A: A systems perspective can be very helpful in this area if the following are taken into account:

1. The child’s physical and emotional vulnerability

2. Factors in the parental, extended family and wider social systems which can be used to support the child and the parent-child dyad, and thus mitigate against abuse. Also factors which may act to increase or perpetuate it, for example in assessing the potential harmful effects of behaviour of a mother bear in mind, can another member of the family reliably help or on the contrary, is she about to be subjected to further stress, such as the immediate release from prison of an abusive partner.

Q: What is the difference between a systemic perspective and a family or community perspective?

A: A systemic perspective looks at all the relevant systems, e.g., our physiological systems, individual psychological systems as well as family and community systems. It also looks at the complex interactions among them. A family perspective alone, has the danger that it focus solely on the family as a unit, e.g., may privilege the “family” its autonomy etc., over a particular member of the family, such as a vulnerable child.

Q: How does a systemic perspective include the influence of genetic endowment and temperament?

A: Most infant researchers now agree that genetic and environmental factors form a complex system of interaction from the moment of conception. Genes interact with other genes as well as with the intrauterine and postnatal environments. An understanding of the contribution of genetic endowment is therefore essential to a true systemic perspective.

Q: How do some of the recently developed “schools of thought,” e.g., solution focus, narrative, constructivist, etc., relate to a systemic perspective?

A: It is useful to note that while these “schools” have arisen in the context of family and wider systems theory and practice, to the extent that each privileges a particular perspective it is no longer truly systemic, e.g., solution focussed therapy privileges a particular style of intervention; narrative therapy, a particular set of patterns and interactions (the individual's constructed story) and constructivism, emphasizes the subjective nature of our perception of reality.
Guided Reflection

▶ How do you take into account and therefore maximize the positive potential of both the dominant culture in a society and your own personal perspectives in joining and intervening in a range of family systems and contexts.

▶ How do you privilege the specific individual and ethnic perspectives of each family?

▶ Think about how you and others you know, will feel and behave differently in different contexts.

Resources


cont'd...

Screening & Assessment

Fact Sheet

For children 0-6 years of age, it is important to rule out health and developmental issues before determining that there is a mental health problem. The paradigm shift in early childhood treatment also includes assessment. The following principles reflect the significant changes to early childhood assessment in recent years.

PRINCIPLES OF SCREENING AND ASSESSMENT

• Screening and assessment should be viewed as part of the continuum of intervention and not only a means of identification and measurement.  

  The screening and assessment process must examine those aspects of a child’s experience that are central to development in a way that is natural, familiar, and non-threatening. The family drives the process and is involved in evaluations of strengths, resources, and needs. Family involvement is an integral part of the screening and assessment process.

• As children’s mental health does not work in isolation, current best practices are multilayered and need to be examined in multidimensional profiles of the child's strengths and capacities.

  Assessments by persons representing multiple perspectives, of contexts for a multidimensional profile of the child's strengths and capacities, and instruments administered in a formal environment are traditionally used highly specialized procedures and norm-referenced. Meanwhile, assessments focused on the child alone, today assessments view the child in relation to the family and caregivers, and the larger ecosystem. The family drives the process and is involved in evaluations of strengths, resources, and needs. Family involvement is an integral part of the screening and assessment process.

• The screening and assessment process must examine those aspects of a child’s experience that are central to development in a way that is natural, familiar and non-threatening. Traditionally, the approach to assessments of young children took place in structured environments under controlled circumstances. The more recent trend is to assess in environments under controlled circumstances. The more recent trend is to assess in familiar and inclusive settings that are comfortable, non-threatening and of interest to the child. e.g., at home, at child care or at school.

  Traditional assessments used highly specialized procedures and norm-referenced, non-threatening and of interest to the child. The paradigm shift is to assess in familiar and inclusive settings that are comfortable, non-threatening and of interest to the child. e.g., at home, at child care or at school.
• Screening and assessment must be culturally sensitive
• Extensive training is required in two areas – a) test administration, scoring and interpretation and b) information related to family systems theory, interactional processes and cultural diversity
• Assessors must be effective communicators with families to identify and support family strengths and discuss family needs
• Debriefing with families is essential. Results must be given in clear concrete terms and must relate back to the family’s concerns/needs
• Translating and interpreting other clinical assessments for the family

Resources

List of Screening and Assessment Measures

Understanding Young Children’s Mental Health: A Framework for Assessment and Support


Fact Sheet

Screening & Assessment

Translating and interpreting other clinical assessments for the family

Debriefing with families is essential. Results must be given in clear, concrete terms and must relate back to the family’s concerns/needs.

Assessors must be effective communicators with families to identify and support family strengths and discuss family needs.

Extensive training is required in two areas – a) test administration, scoring and interpretation and cultural diversity.

Screening and assessment must be culturally sensitive.
Strategies

Screening & Assessment

Family assessment within early childhood mental health has been strongly influenced by ecological systems and empowerment models. The result has been an emphasis on family-focused assessment strategies that enable families to drive the process and participate as equals.

CONDUCTING AN EFFECTIVE AND SENSITIVE INTERVIEW

- Facilitate communication by:
  - letting the parent set the pace
  - using language that is concrete (not professional jargon)
  - allowing the parent to share information about his/her observations of the child

- Show interest
  - actively listen
  - paraphrase statements made by the family
  - reflect content and feelings
  - use statements that show appreciation of issues and feelings

- Time questions appropriately
  - refrain from focusing on anxiety-producing issues initially
  - time questions and comments with the parent's flow of thought

- Formulate appropriate questions
  - allow for spontaneous discussion of life histories or topics of importance to the family
  - avoid leading questions
  - avoid use of "why" as it sounds interrogatory or judgmental
  - use open-ended questions to discover values, perceptions and perspectives

cont'd...

Conducting an effective and sensitive interview

Strategies

Screening & Assessment
Strategies

Screening & Assessment

Inquiring about and reflecting emotions

- Search for agreement
- Ask for help from family
- Label the issue(s)
- Enlist solutions from parent to solve the problems
- Adapt and find common ground
- Meet resistance with reflection

Handling resistance

- Observe changes in facial expressions and appropriate tone of voice
- Observe motor behavior and activity level and changes in posture
- Tune into both verbal and non-verbal indicators that reveal emotional tone

Recognize a parent’s anxiety

- Repeat the parent’s reply, then pause
- Repeat or modify the question
- How do you feel about that?
- Could you give me some examples to help me understand?
- Would you please tell me more about that?
- To delve deeper into an issue or to prompt the parent to elaborate, e.g.,

Use probes
Silence is not necessarily a “bad” thing. However, you need to be aware and under:

- How parents respond to behaviour displayed by children
- Whether support is appropriate or pertinent
- How family members respond to each other
- Non-verbal behaviour

Observe:

- The parent is hoping someone else will answer
- The parent has finished giving the information
- The parent needs time to recall information or consolidate thoughts
- The parent is feeling guilty or depressed
- Fear of examining an issue or him/herself too closely
- Fear of parents own emotions
- Fear of the interviewer

Standing that silence may indicate:

Strategies
<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITFI - Infant-Toddler and Family Instrument</td>
<td>Caregivers &amp; children 6-36 months</td>
<td>Tool consists of interview and observation components that allows assessment of family functioning, child development and home environment</td>
<td>No evaluation to date</td>
</tr>
<tr>
<td>NCAST - Nursing-Child Assessment Satellite Training Teaching</td>
<td>0-36 months</td>
<td>76 items in both scales assess caregiver sensitivity and responsivity as well as clarity of infants’ cues</td>
<td>Reliability: Test-retest better for parent item (.75) than for infant subscales (.53) on Feeding Scale; Test-retest good for parent while child score not stable for Teaching Scale</td>
</tr>
<tr>
<td>Family Needs Scale</td>
<td>Caregivers</td>
<td>Focus is on assessment of current needs and family support</td>
<td>Not available</td>
</tr>
<tr>
<td>MSRI – Maternal Self-Report Inventory</td>
<td>Mothers</td>
<td>Assesses parenting self-confidence including mother’s perceptions about pregnancy, labor and delivery, body image, caregiving ability, acceptance and relationship with infant</td>
<td>Not available</td>
</tr>
<tr>
<td>PSI - Parenting Stress Index*</td>
<td>Caregivers of children 1 month - 12 years</td>
<td>This measure identifies parent stress and predicts the potential for dysfunctional parenting, parent behavior problems and child adjustment difficulties within the system. There are 7 parent &amp; 5 child subscales</td>
<td>Not available</td>
</tr>
<tr>
<td>Beck Depression Inventory - II (BDI-II)</td>
<td>Caregivers</td>
<td>This self-report questionnaire is designed to screen current symptoms of depression. This can be particularly useful in identifying/evaluating possible post-natal depression in new mothers. Specific training in the use and interpretation of the measure is required.</td>
<td>New edition shows improved clinical sensitivity with reliability .92</td>
</tr>
</tbody>
</table>


*Indicates French version available
<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
</table>
| General Screening Tools Child                                        | 0-60 months | Is used to monitor the, cognitive, motor and social/emotional development of children from birth through the preschool years. Parents answer questions in seven key areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Professionals evaluate scores and compare them within empirically derived cut-off points. | Validity: concurrent validity ranged .74 for 4 months to .91 for 36 months with overall agreement .84  
Reliability: N/A  
Specificity high; sensitivity .72                                                                                                          |
<p>| Ages and Stages Questionnaire and New ASQ: Social-Emotional         | 0-60 months | 13 Questionnaires monitor Child Development (No training required)                                                                                                                                                  | Face validity claims; no reliability research conducted                                                                                                                                           |
| Paul H. Brookes Publishing Co. Inc. Online: <a href="http://www.pbrooks.com">www.pbrooks.com</a> or <a href="http://www.wpspublish.com">www.wpspublish.com</a> | 1-4 months | Parent responses assess infant’s reactions to the environment across 9 temperament categories                                                                                                                                 | Not available                                                                                                                                                                                   |
| Nipissing District Developmental Screen* Online: <a href="http://www.ndds.ca">www.ndds.ca</a>          | Birth – 1 year | Same as above                                                                                                                                                                                                     | Not available                                                                                                                                                                                   |
| Temperament Questionnaires: EITQ -Early Infancy Temperament         | 1-3 years   | Same as above for older children                                                                                                                                                                                  | Not available                                                                                                                                                                                   |
| Pediatrics, 14, 230-235                                             |             |                                                                                                                                                                                                                  |                                                                                                                                           |
| ITQ-R - Infant Temperament Questionnaire - revised                   | Birth – 1 year | Same as above                                                                                                                                                                                                     | Not available                                                                                                                                                                                   |
| (1978) Pediatrics, 61, 735-739                                       |             |                                                                                                                                                                                                                  |                                                                                                                                           |
| TTS - Toddler Temperament Scale Questionnaire (1984)                | 1-3 years   | Same as above for older children                                                                                                                                                                                  | Not available                                                                                                                                                                                   |
| Journal of Pediatric Psychology, 9, 205-216                         |             |                                                                                                                                                                                                                  |                                                                                                                                           |
| BSQ - Behavioural Style Questionnaire (1978) Journal of Child        | 3-7 years   | Parent responses assess child’s behaviour across 9 temperament categories. As with all the above, child’s behaviour can be rated in 5 temperament categories ranging from easy to difficult. | Not available                                                                                                                                                                                   |
| Psychology and Psychiatry and Allied Disciplines, 19, 245-253       |             |                                                                                                                                                                                                                  |                                                                                                                                           |</p>
<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Screening Tools Child (cont’d)</td>
<td></td>
<td>Parent Report and Other Questionnaires Minimal Training Required Unless Otherwise Specified</td>
<td>Concurrent validity and reliability assessed on a single sample size of 30 children. Interrater reliability high as is internal consistency of 5 subscales. More research is underway.</td>
</tr>
<tr>
<td>PECFAS – Preschool and Early Childhood Functional Assessment Scale Dr. Kay Hodges 2140 Old Earhart Road Ann Arbor, MI 48105 734-769-9725</td>
<td>3-7 years</td>
<td>Questionnaire completed by MH service provider based on interview with caregivers (childcare providers and/or teachers) to measure level of functioning in 8 areas: school/daycare, home, community, behaviour toward others, moods/emotions, self-harm, thinking/communication and caregiver resources and formulate service plan.</td>
<td></td>
</tr>
<tr>
<td>CBCL – Child Behaviour Checklist (Achenbach/Edelbrock) Child Behaviour Checklist, University Medical Education Associates, 1 South Prospect Street, Room 6434 Burlington, VT 05401-3456</td>
<td>4-18 Currently</td>
<td>Questionnaire completed by caregivers, childcare workers/teachers to provide information in order to distinguish typical behaviours from those indicating significant behavioural disturbances.</td>
<td>Reliability: test-retest and inter-rater reliability is high .87-.89 Validity: distinguishes extreme behavioural and emotional problems better than moderate or mild problems.</td>
</tr>
<tr>
<td>Eyberg Child Behaviour Inventory Psychological Assessment Resources Online: <a href="http://www.parinc.com">www.parinc.com</a></td>
<td>2-16 years</td>
<td>Parents rate frequency of common behavioural problems to obtain an intensity and problem score. Scale is used to get ratings of conduct problems and acting out behaviours and identifies problems indicative of aggression, impulsivity and hyperactivity.</td>
<td>Reliability: test-retest .86 and .88 Validity: Good validity established with conduct disorders Sensitivity: .80 and specificity .86</td>
</tr>
<tr>
<td>Temperament and Atypical Behaviour Scale (TABS) Paul H. Brookes Publishing Co. Inc. Online: <a href="http://www.pbrooks.com">www.pbrooks.com</a> or <a href="http://www.wpspublish.com">www.wpspublish.com</a></td>
<td>11 months - 71 months</td>
<td>This norm-referenced assessment tool is specifically designed to identify critical temperament and self-regulation problems. Parents complete either a 15 item screener or 55 item assessment check-list. 4 categories can result: detached, hypersensitive-active, underreactive and dysregulated.</td>
<td>Normed on 1000 children. Both content and construct validity confirmed.</td>
</tr>
</tbody>
</table>

### Screening and Assessment Measures Frequently Used with Families and Children 0-6 Years

<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tools Measuring Social-Emotional Development</strong></td>
<td></td>
<td>Specific Training is Required Unless Specified</td>
<td></td>
</tr>
<tr>
<td>TOESD – Test of Early Socio-emotional Development</td>
<td>3-7 years</td>
<td>Examines behavioral perceptions at home, school and in interpersonal relationships. Children complete a set of three behavior reading scales. Low scores are seen as evidence of problematic behavior. Because positive behaviors are not included, the test is better at identifying problematic behavior than measuring social emotional competence.</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Tools to Measure Overall Development, Cognitive, Visual, Motor and Verbal Abilities</strong></td>
<td></td>
<td>Specific Training in Psychological Assessment is Required Unless Otherwise Indicated</td>
<td></td>
</tr>
<tr>
<td>BNBAS - Brazelton Neonatal Behavioural Assessment Scale</td>
<td>Birth – 4 weeks</td>
<td>Assesses infants neurological condition and the infant’s responses to the postnatal environment. Interesting and informative for new parents. Can be administered by specially trained nurses/ ECE.</td>
<td>Reliability: interrater reliability is quite high, but test-retest reliability suggests poor temporal stability; Validity: demonstrates ability to correctly identify neonates who are underweight, who have experienced in utero drug and alcohol exposure, maternal malnutrition, and gestational diabetes; shown to predict infant-parent attachment, however, research has not consistently shown it to be a good predictor of infant development beyond the first year.</td>
</tr>
<tr>
<td>BSID-II Bayley Scales of Infant Development</td>
<td>Birth - 4 years</td>
<td>The Mental &amp; Motor Scales assess child’s current level of cognitive, language, personal, social, and fine and gross motor development and identifies delays. Behavioural rating scale evaluates qualitative aspects of child’s behaviour during assessment, e.g., attention and arousal.</td>
<td>Reliability: moderate to high internal consistency for Mental scale, average .88; Motor scale, average .84 and Behaviour rating scale average .88; Test-retest reliability coefficients more variable, given the natural variability for children’s behaviour and functioning. Validity: extensive data regarding construct and criterion validity</td>
</tr>
</tbody>
</table>

### Screening and Assessment Measures Frequently Used with Families and Children 0-6 Years

<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tools to Measure Overall Development, Cognitive, Visual, Motor and Verbal Abilities (cont’d)</strong></td>
<td></td>
<td>Specific Training in Psychological Assessment is Required Unless Indicated</td>
<td></td>
</tr>
</tbody>
</table>
| DISC – Diagnostic inventory for Screening Children  
Mainland Consulting, Inc.  
St. Clemens, ON  
519-699-5429 | Birth to 6 years | This scale provides a standardized direct screen for overall ability including fine/ gross motor development, receptive and expressive language and self help skills. It may be administered by specially trained ECE/teachers – interpretations and reports supervised. | Reliability: test-retest .98 Validity: correlates with the Denver, Stanford-Binet scores. Concurrent validity shows scale can distinguish those children requiring further attention. Specificity: 0.17 to 0.69 |
| Brigance Diagnostic Inventory of Early Development  
Curriculum Associates  
Online: www.curricassoc.com | 21-26 months | Assesses skills in 11 domains, including areas of reading, math and handwriting. Strong criterion reference measure of developmental functioning which also incorporates family observations. | Reliability: internal consistency .81-.99; test-retest under 3 months .86; over 3 months .82; inter-rater .97  
Validity: strong content; substantive predictive validity and identifies majority of children who have school difficulty. Good sensitivity and specificity to giftedness and to developmental and academic problems. |
| WPPSI – Wechsler Preschool and Primary Scale of Intelligence - Revised  
The Psychological Corporation  
Online: www.psychcorp.com | 3-7 years | A standardized measure of overall ability with the advantage of separate verbal and performance sub-scales that may be used as indicators of possible learning disabilities. | Reliability: test-retest is high with Verbal IQ .90, Performance IQ .88 and full scale IQ .91 Inter-rater reliability range .88 -.96.  
Validity: wealth of data attest to the comparability with, if not superior quality to other current preschool intelligence tests. |
| TONI-3 Test of Nonverbal Intelligence  
Online: www.proedinc.com | 6 years – Adult | Designed as a norm-referenced, language-free measure of intelligence, aptitude, abstract reasoning, and problem solving. It is nonverbal and largely motor-free, requiring only a symbolic gesture to indicate response choices. Specific Graduate Training Required in Assessment | Exhaustive validity data reported in manual. Meets highest psychometric standards for norms, reliability and validity. |

<table>
<thead>
<tr>
<th>Tools to Measure Overall Development, Cognitive, Visual, Motor and Verbal Abilities (cont’d)</th>
<th>Specific Training in Psychological Assessment is Required Unless Indicated</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leiter International Performance Stoelting Co. 620 Wheat Lane Wood Dale, IL 60191</td>
<td>Designed as a norm-referenced, language-free measure of intelligence, (visualization &amp; reasoning; attention &amp; memory) like the TONI for adults, it is non-verbal and largely motor-free, requiring only a symbolic gesture to indicate response choices.</td>
<td>Standardized on over 2,000 children. Both reliability analyses and validity evidence are comprehensive.</td>
</tr>
<tr>
<td>PLS-3 - Preschool Language Scale - 3 The Psychological Corporation Online: <a href="http://www.psychcorp.com">www.psychcorp.com</a></td>
<td>A standardized measure with two scales: Auditory Comprehension &amp; Expressive Communication</td>
<td>Reliability: was assessed for internal consistency, ranging from .47-.94 across age intervals and subscales; interrater reliability is reported at .89, however, use of only one pair of raters is not adequate evidence. Validity: concurrent validity showed correlations between the PLS-3 and two other standardized tools ranging .68-.88. Problems with construct validity suggest the test may not adequately discriminate between children with and without language disorders thereby limiting its use.</td>
</tr>
<tr>
<td>PPVT III - Peabody Picture Vocabulary Test American Guidance Service Inc. Online: <a href="http://www.agsnet.com">www.agsnet.com</a></td>
<td>Measures the child’s receptive vocabulary and estimates verbal ability. Easy / frequently used.</td>
<td>Reliability: internal consistency .92-.98 Test-retest .91-.94 Validity: .69 correlation with OWLS listening comprehension scale; .74 with OWLS oral expression scale; .91 correlation with WISC-III</td>
</tr>
<tr>
<td>PDMS-2 - Peabody Developmental Motor Scales The Psychological Corporation Online: <a href="http://www.psychcorp.com">www.psychcorp.com</a></td>
<td>Standardized measure that provides both in-depth assessment, training or remediation of gross and fine motor skills. The assessment is composed of six sub-tests that measure the inter-related motor abilities of reflexes, balance locomotor receipt and propulsion of objects that develop over this time.</td>
<td>Not available</td>
</tr>
</tbody>
</table>

### Screening and Assessment Measures Frequently Used with Families and Children 0-6 Years

<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools to Measure Overall Development, Cognitive, Visual, Motor and Verbal Abilities (cont’d)</td>
<td>3-5 years</td>
<td>Designed to identify children with delays in sensory, motor and perceptual skills. Familiarity with pediatric and motor assessments is necessary for administration.</td>
<td>Some questions relating to theoretical assumptions are still outstanding. Significant problems with inappropriate statistical derivation of items, unrepresentative samples and lack of acceptable reliability of some scales sound a caution against clinical use in its present form.</td>
</tr>
<tr>
<td>TSI – Di-Gangi-Berk Test of Sensory Integration</td>
<td>3-5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Psychological Services Online: <a href="http://www.wpspublish.com">www.wpspublish.com</a></td>
<td>4-12 years</td>
<td>Standardized measure that assesses visual perception in children. Especially useful with those who may have learning, cognitive, motor or physical disabilities.</td>
<td>Reliability and validity data is based on the original 1972 sample and none established for the revised version due to the high correlation (r=.85) between the two versions. Correlation data between the MVPT and other tests of visual perception did not describe children in the comparison.</td>
</tr>
<tr>
<td>MVPT-R – Motor-free Visual Perception Test</td>
<td>3-8 years</td>
<td>Short form used with children 3-8 years</td>
<td>Reliability: a well-defined sample of 2,614 children yielded high level of internal consistency (.88); high interrater reliabilities of .94 for the VMI, .98 for Visual subtest and .95 for Motor subtest. Validity: sufficient levels of validity found in studies on construct, concurrent and content. Usefulness as a predictive tool requires more information, while using it with the intention to prevent or remediate academic failure is highly questionable.</td>
</tr>
<tr>
<td>VMI – Beery Developmental Test of Visual Motor Integration</td>
<td>3-18 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Strategies: Screening & Assessment

#### Tools to Measure Overall Development, Cognitive, Visual, Motor and Verbal Abilities (cont’d)

<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRAVMA - Wide Range Assessment of Visual Motor Ability</td>
<td>3 - 17 years</td>
<td>Assesses visual motor integration as a composite score derived from separate subtest assessments of fine motor, visual spatial and visual motor abilities. Assessments of fine motor (Drawing Test), visual spatial (Matching Test), and visual motor abilities (Pegboard Test)</td>
<td>The 3 tests have good reliability and reasonable validity (composite score correlated .62 with full scale WISC-III), but users should be aware that individuals score rather differently upon retest.</td>
</tr>
<tr>
<td>DAP - Draw - a - Person Test</td>
<td>Infancy to Adult</td>
<td>Assesses drawings of young children; one point is allotted for each characteristic and then compared to norms.</td>
<td>Normed on sample size of 2,260. Yields standard T score that determines if further assessment is/ is not indicated or strongly indicated.</td>
</tr>
<tr>
<td>CMS – Children’s Memory Scale</td>
<td>5-16 years</td>
<td>Assesses deficits in learning and memory, recall strategies and underlying processing disorders. It can be used as a screening instrument for children with learning disabilities or memory and attentional deficits.</td>
<td>Standardized scale links learning and memory directly to ability as measured by WISC-III and WPPSI-R. Extensive clinical validation studies performed to demonstrate validity and clinical utility.</td>
</tr>
<tr>
<td>Transdisciplinary Play-Based Assessment</td>
<td>6 months - 6 years</td>
<td>Multidisciplinary team of early childhood professionals assess a child’s development in cognitive, social-emotional, communication and language and sensor-motor domains during play session.</td>
<td>This is not a formal psychometric instrument; little research has been conducted on reliability and validity although it appears rich in content and construct validity.</td>
</tr>
</tbody>
</table>

#### Specialized Tests

<table>
<thead>
<tr>
<th>Title</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADOS – Autism Diagnostic Observation Schedule</td>
<td>Evaluates individuals at risk for autism by testing social, communication, and imaginative play behavior relevant to diagnosis. Consists of four modules, each requiring 35-40 minutes to administer. One module is administered depending on the individual’s expressive language level and chronological age. Uses standardized materials, questions, and scoring system.</td>
<td>Not available</td>
</tr>
</tbody>
</table>

### Screening and Assessment Measures Frequently Used with Families and Children 0-6 Years

<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialized Tests</strong>&lt;br&gt;(cont’d)</td>
<td></td>
<td>Specific Training in Psychological Assessment is Required</td>
<td></td>
</tr>
<tr>
<td>CHAT – Checklist for Autism in Toddlers&lt;br&gt;Online: <a href="http://www.nas.org.uk">www.nas.org.uk</a></td>
<td>18 - ? months</td>
<td>Used by primary health professionals during the 18-month developmental to identify children at risk for social-communication disorders. This test is not a diagnostic instrument. It consists of nine questions asked to parents, and five observations that score pretend play, protodeclarative pointing, following a point, pretending, producing a point.</td>
<td>Not available</td>
</tr>
<tr>
<td>CARS – Childhood Autism Rating Scale&lt;br&gt;Western Psychological Services&lt;br&gt;Online: <a href="http://www.wpspublish.com">www.wpspublish.com</a> or <a href="http://www.psychcorp.com">www.psychcorp.com</a></td>
<td>2 years +</td>
<td>15-Item Behavioural Rating Scale - based on direct observation that distinguish children with mild to moderate or moderate to severe autism from developmentally handicapped children with out the autism syndrome.</td>
<td>Extensive data from 1980 provided Reliability: Internal consistency is high, .94; test-retest one year apart correlation .88; inter-rater reliability was .71 Validity: Criterion-related validity high, .80 correlating CARS scores with independent clinical ratings of child psychologists and psychiatrists. Additional validity found across use in variety of settings</td>
</tr>
<tr>
<td>TSFI – Test of Sensory Functioning in Infants&lt;br&gt;Western Psychological Services&lt;br&gt;Online: <a href="http://www.wpspublish.com">www.wpspublish.com</a></td>
<td>4-18 months</td>
<td>Measures sensory processing and reactivity. The test has five subdomains: Reactivity to Tactile Deep Pressure, Adaptive Motor Functions, Visual-Tactile Integration, Ocular-Motor Control, and Reactivity to Vestibular Stimulation. The domains are significant in identifying children with sensory integrative dys-function, particularly children at risk for learning disabilities.</td>
<td>Reliability: inter-rater reliabilities range from .88-.99 for 5 subscores and .95 for the total test; test-retest reliabilities for a 1-5 day lag period ranged from .64-.96 Validity: Content validity positively assessed. Major weakness is the narrow population of infants and the need to address the complications of assessing infants who have been abused</td>
</tr>
</tbody>
</table>

## Screening and Assessment Measures Frequently Used with Families and Children 0-6 Years

<table>
<thead>
<tr>
<th>Title</th>
<th>Age Range</th>
<th>General Description</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>EACADDES – Early Childhood Attention Deficit Disorder Evaluation Scale</td>
<td>2-7 years</td>
<td>Evaluates Attention Deficit/Hyperactivity Disorder using 2 primary observers of behavior, the parent (Home Version) and a teacher (School Version). Both scales contain two subscales, Inattentive and Hyperactive-Impulsive. The Home Version includes 50 items and can be completed in approximately 12 minutes, while the School Version for educators includes 56 items and can be completed in approximately 15 minutes.</td>
<td>No clear consensus about the tool’s psychometric soundness. Concerns reside in lack of appropriate standardization sample and weak evidence of validity.</td>
</tr>
<tr>
<td>CPTRS - Conners Rating Scales</td>
<td>3-17 years</td>
<td>Assesses psychopathology and problem behaviour including hyperactivity and conduct disorder – can be used to assess effects of medication; Parent, teacher ratings Self report for ages 12-17</td>
<td>Reliability: test-retest .72-.91 Validity: Discriminant, construct and concurrent validity well established; predictive validity is weak.</td>
</tr>
<tr>
<td>CAT- Children’s Apperception Test</td>
<td>4 years - adult</td>
<td>10 Animal pictures in a social context that present children with common family situations [prolonged illness, physical disability, mothers pregnancy, separation of parents] that may be a special concern to children.</td>
<td>No psychometric data reported. Research largely nonempirical and case-study in orientation therefore leaving psychometric integrity in question</td>
</tr>
</tbody>
</table>

Q: What are the benefits and deficits to an in-home assessment?

A: When an assessment is conducted in a family’s home it is implicit that they are viewed as a key participant in the process as well as retaining some control over it. This sense of family-centredness is not conveyed when a family comes into a clinical setting and is forced to concentrate their attention on the professional’s turf.

Observations of children and their families in a familiar and natural setting yield invaluable information including how family members behave, how they interact and treat one another, and what strengths they use to enhance their functioning in their environment. Information regarding how family members behave, how they interact and treat one another, Observations of children and their families in a familiar and natural setting yield invaluable information.

Q: What criteria should we use in selecting assessments for children and families?

A: Fundamentally the test should be geared to the individual child’s needs. General assessments of family functioning and well-being are an important part of the profile. Standardized measures of family functioning and well-being provide a view of the child as she compares to others of the same age, while other tools will not always provide this level of validity. General assessments of family functioning and well-being are an important part of the profile. Standardized measures of family functioning and well-being provide a view of the child as she compares to others of the same age, while other tools will not always provide this level of validity.

Q: What part of the assessment process presents emotional challenges for you as a professional and for the family and the child?

A: What part of the assessment process presents emotional challenges for you as a professional and for the family and the child?

Q: How do your feelings about a child/family affect your observations and analysis of findings?

A: How do your feelings about a child/family affect your observations and analysis of findings?

Q: How do you handle differences of opinion in observations and information?

A: How do you handle differences of opinion in observations and information?
Risk & Protective Factors

- The notion of risk is present before conception and can be:
  - biological (i.e., a gene variant)
  - environmental (i.e., substance abuse)

- Rutter (2000, 2001) and Werner (1995) describe protective factors as those that modify risk conditions in order to create resilience in children.
  - Protective factors include personal strengths of the individual child (intelligence, resourcefulness, temperament, personal efficacy), family strengths (supportive home environment, socioeconomic advantages), and school and community strengths (safe and effective schools, participation in social groups) (Garmezy, 1991)

- The number of risk factors is critical in determining child outcomes
  - a single risk factor is seldom responsible for compromised development, but may induce other risk factors
  - the trajectory of a child’s development is generally the result of the additive contributions of risk factors rather than a single variable (Sameroff, 2002)

- An accumulation of environmental risk factors seems to have powerful negative effects on cognitive and mental health outcomes (Furstenberg et al., 1999)

- A number of child, family, parent interactional and environmental/contextual factors are consistently found to be related to poor outcomes in children:
  - infant-parent relationships are the conduit through which young children experience environmental risk factors, i.e., poverty, domestic violence or maternal mental health are filtered to the infant through the caregiving relationship (Zeanah & Zeanah, 2001)
  - in contrast, premature infants with developmental issues have better outcomes when their caregiving environments are supportive and moderate the risks (McCarton, et al., 1997; Ramey et al., 1992)

- Certain types of risk and protective factors may have different effects at different ages:
  - proximal factors have more influence during infancy and early childhood, e.g., parent functioning and parent-child interactions
  - distal factors have increasing importance during later childhood, e.g., psychosocial such as poverty, poor mental health, substance abuse, etc. (Sameroff & Seifer, 1990; Seifer et al., 1992)

cont’d...
• Parenting behaviours and interactions that influence the child’s developmental path, in particular attachment, emotional regulation and self-esteem are (Landy, 2000):
  ➤ sensitivity
  ➤ emotional availability
  ➤ responsivity
  ➤ acceptance of the child
  ➤ positive emotionality
  ➤ caring responses when the child is upset

• Psychological functioning of a parent affects the child’s development. Areas to consider are (Landy, 2000):
  ➤ emotion regulation and capacity for empathy
  ➤ capacity for self-reflectivity
  ➤ locus of control/sense of self-efficacy
  ➤ parental confidence
  ➤ unresolved loss and trauma
  ➤ cognitive capacity including problem solving, adaptation and competence
  ➤ working models or attributions of the child
  ➤ defensive functioning
  ➤ family functioning and family violence
  ➤ cultural beliefs and parenting practices

• Competence in children is the result of a complex interplay among variables, therefore changing one thing in the young child or family or the community is generally too simplistic and will not be effective. Rather the intervention will be more likely to be successful if several factors can be targeted.
## Risk And Protective Factors

### The Child
- Exposure to toxins in utero
- Full term/prematurity
- Birth weight
- Congenital abnormalities/genetic condition
- Temperament
- Level of muscle tone
- Sensitivity to touch
- Responsiveness
- Degree of health
- Establishment of feeding and sleeping routines
- Establishment of attachment
- Signaler of cues
- Degree and intensity of crying
- Developmental trajectory
- Disruptive or inhibited behaviour
- Anxiety
- Ability to concentrate
- Ability to self-soothe

### Parent History & Current Functioning
- Issues of abuse or loss from childhood
- Experience with foster care system
- Self-esteem
- History of competence and success
- Feelings of control over one’s life
- Problem-solving abilities
- Social and interpersonal skills
- Parental physical health
- Parental mental health
- Outlook on the future
- Coping strategies and resilience
- Support network (family and beyond)
- Criminality
- Substance abuse
- Sense of responsibility
- Family violence
- Participation in community activities

### Parental Attitudes, Behaviours & Interactions
- Preparation during pregnancy
- Parental knowledge of child development
- Meeting of infant’s basic and medical needs
- Eye-to-eye contact with the child
- Sensitivity/attunement to infant’s signals or cries
- Consistency and predictability with child
- Vocalization to child
- Affect toward child
- Attributions toward the child
- Encouragement of child’s development
- Structure and rules within household

### Sociodemographic & Societal Factors
- Adolescent parenting
- Employment
- Level of income
- Stability of housing
- Access to telephone
- Level of education
- Single parenthood
- Life stresses
- Degree of isolation or connectedness
Resources


◆ Toronto Public Health (2000). Tool for Determining Type and Frequency of Family Home Visitor Intervention. Developed by Dr. Sarah Landy, this tool provides the opportunity to assess and monitor risk and protective factors in a family’s life as well as assist in intervention planning and periodic review.

Develop a clear understanding of the ecological-systems perspective of families and how it will affect your work with the child and family:

- **Ecological model**: Bronfenbrenner (1986) provided the framework for understanding the child’s development within the context of social circles of influence, i.e. a the child in context of the family, and the family in the context of the community.

- **Transactional model of child development** developed by Sameroff (1993) believes that the interactions between the child and her environment are continuously dynamic and bidirectional. This means the child influences her environment and the environment influences the child all the time, over a long period of time.

- **Family systems theorists** have provided the base for identifying the contributions of stresses, coping strategies, and social supports on the behaviours of children and families.

- **Family empowerment models** have shown the importance of harnessing the inherent strengths of families and communities to improve the mental health of children and their families.

Be able to distinguish how risk and protective factors (child and parent) affect parenting and child developmental outcomes. For example:

- Prematurity and low birth weight infants are less responsive to parental interaction, less able to regulate distress, and are at higher risk for behavioural and emotional difficulties (Achenbach and others, 1990); however, risks are moderated when their caregiving environment is supportive and emotionally responsive.

- Adolescent parents frequently engage in poorly regulated patterns of interaction (e.g., child cries, the mother yells at the child for crying), generally are less responsive and initiate verbal interactions less often. These negative patterns of interactions and parenting styles contribute to the child’s risk of developing insecure and disorganized attachment relationships, and poorer social and emotional outcomes; however, adolescents who have a good social support network are competent caregivers.

Assess the quality of the parent-child relationship. Observe the parent for their:

- sensitivity to child’s cues
- developmental understanding of child’s emotions and appropriate responses
- responsivity to child’s efforts to communicate, initiate tasks, etc.
- reciprocity between parent and child
- incidence of positive emotions and acceptance of the child

See strategies in the Parental Mental Health and Planning Interventions Sections.
Q: Is there a clear and specific relationship between risk and protective factors?

A: No. Some researchers have described risk and protective factors as opposites, i.e., isolation is a risk factor while a strong family network or social support system acts as a protective factor. However, risk factors do not occur randomly nor are they unrelated to one another, therefore it is difficult to draw a linear relationship between risks, outcomes and moderating mechanisms.

Q: Is it possible to create a risk and protective factor formula that can be used to predict a child's developmental trajectory?

A: No. It has not been possible to create a risk and protective factor formula that can be used to predict child outcomes because the interactions among variables are complex and change over time. Protective processes may operate simultaneously or successively within the same individual in the face of different challenges and at different points of development (Werner, 2000). Assessment of risk and intervention are most informative to the therapeutic process when tied to a specific point in time.

Q: Are there certain risk factors that are more detrimental than others?

A: The research literature is clear that factors closest to the child, i.e. parental functioning, parent-child interactions and parenting styles have more influence during the sensitive periods of infancy and early childhood, whereas variables external to the family, i.e., psychosocial and sociodemographic stressors, have increasing importance during later childhood and adolescence.

Q: Is there a magic number of risk factors that make a difference?

A: No. Although rare, a single risk factor may compromise development. In general, however, the more risk factors the greater the risk. A number of studies have shown risk factors to be multiplicative, not just additive.

Q: Which protective factors are associated with increased positive outcomes?

A: Protective factors that reside within (1) the individual, include e.g., “easy” engaging temperament, above average intelligence, internal locus of control, strong achievement motivation, positive self-concept, special talents, etc; (2) the family, include e.g., small family size < 4, high maternal education, high maternal competence, close bond with a primary caregiver (not necessarily the biological parent), supportive grandparents, etc.; and (3) the community, include e.g., supportive teachers/caregivers, close and competent peers who are confidants, good schools, etc.
Q: How do I assess for risk?

A: It is essential to assess whether the balance between stressful life events and protective factors is favourable. There are risk assessment measures that are used by child welfare and public health nurses (Risk Assessment Model for Child Protection and the Healthy Babies, Healthy Children Family Assessment Instrument) which permit practitioners to analyze the interplay of risk and protection in a family’s life. Dr. Landy’s Tool for Determining Type and Frequency of Family Home Visitor Intervention assists the service provider to identify both strengths and risks in key areas of child development, parenting and the psychosocial environment.

Guided Reflection

- What have you found to be the four most important protective factors for a young child?

- In what ways have these factors buffered the effects of risk?

- What community factors have you observed to have an effect on the development of young children?

- Have these had a more or less significant influence than the family environment (e.g., the parent-child relationship or the level of social support for the parent)

- How can the degree of social support a mother has affect the developmental trajectory of her child?
Planning Interventions

• A framework for intervention with young children and families has been proposed by Michael Gurlanick (2001) It should:
  ➢ Engage the family in the process
  ➢ Involve a comprehensive assessment of the ebb and flow of stressors
  ➢ Match strategies thoughtfully to all the issues related to information and resource needs; family characteristics that are relevant to patterns of interaction; and child characteristics associated with risk and disability
  ➢ Implement highly individualized, culturally competent interventions in the most natural and typical environments for children and families
  ➢ Organize the service system to coordinate support for the family
  ➢ Document, monitor and evaluate the quality of the intervention’s implementation and outcomes

Promising practices in early childhood mental health treatment and intervention for specific disorders:

• Anxiety disorders
  ➢ Non-medical interventions are the treatment of choice as there is no definitive evidence of effectiveness and some put children at risk for serious side effects
  ➢ CBT with behavioural techniques such as modelling, role playing, shaping and social reinforcement used to build child’s basic coping skills
  ➢ Family anxiety management component that teaches parents anxiety management, contingency management for reinforcing positive behaviours, extinguishing anxiety-related behaviours and skills for emotional containment, coaching and communicating effectively with their child.

• Enuresis (Bed-wetting)
  ➢ The bell-and-pad or urine alarm system along with contingency management is a well-established efficacious treatment and preferred to any drug treatments.
  ➢ Providing information to parents on ways to support night toilet training

• Attention Deficit Hyperactivity Disorder (See specialized Fact Sheets)
  ➢ Although stimulant medication is the treatment of choice, prescription of psychotropic medication for young children must be done cautiously and with side-effects monitored regularly

cont’d...
Planning Interventions

➤ Parent training in behavioural modification has increased compliance with parental requests and parent-child interactions also has shown significant improvement.

➤ Direct intervention with the child to enhance learning capacities and to improve emotional and social functioning

• **Autism** (See specialized Fact Sheets)

> Depending on severity and age of onset one or more the following approaches may be used:

➤ Applied Behaviour Analysis (ABA)

➤ Sensory integration therapy

➤ Auditory integration therapy

➤ Interactive approaches

➤ Supportive work with parents

• **Fetal Alcohol Syndrome/Alcohol Related Birth Defects (ARBD)**

> Selection of treatment options will depend on the child’s level of ability, and behavioural, social and emotional difficulties. (See specialized Fact Sheets)

➤ Providing structure and routine in all of the child’s environments, i.e. home, child care, school

➤ Teaching life and social skills and appropriate behaviours

➤ Support parents in controlling hyperactivity and impulsive behaviours

➤ Strategies that assist the child with memory and information processing

• **Regulatory Disorders**

Regulatory disorders have been defined as “distinct patterns of atypical behaviour coupled with specific difficulties in sensory, sensory/motor, or organizational processing” (*Zero to Three*, 1994). These include very young children who are hyper/hyposensitive and have difficulty with modulating emotions and/or organizing motor activity. At a later stage these difficulties may result in either aggressive behaviour or a precursor to childhood-onset conduct disorder and/or depression.

cont’d...
1. Aggressive Behaviour/Childhood-onset Conduct Disorder

- The primary evidence-based therapy is CBT, especially problem solving skills training (PSST) targeting both the antisocial behaviours and prosocial functioning (improving communication, problem solving, impulse control and anger management).

- Sensory integrative therapy has been used successfully for children with hypersensitivities or attentional problems.

- Parent management training (PMT) to manage child behaviour without physical punishment. Webster-Stratton found the combination of group PMT with videotape modelling of methods for positive discipline and strengthening children’s social skills and group child therapy to be superior to either PMT or child therapy alone.

- Individual child-centred therapy approaches such as Floor Time.

- Home visiting programs to increase social support for families and reduce behavioural problems in children has been shown to be effective in some instances.

2. Childhood Depression

- Given the strong developmental (attachment and neglect) and environment factors associated with early childhood depression, treatment with medication alone is not sufficient and to be used with extreme caution.

- Verify whether the parent is also depressed and requires treatment. Referral should be a priority because it may affect the development of normal parent-child attachment, social, emotional, cognitive and interpersonal skills.

- Cognitive-behavioural and play therapies have been shown to be effective for treating mild or moderate depression in children.

* Attachment Disorder and Infant-Parent Relationship Problems* (See Specialized Fact Sheets)

- Infant-parent psychotherapy which includes unstructured assessment and treatment sessions with themes guided by interactions between the parent and child or child-led play.

- Parents’ rigid and distorted perceptions of the child are modified using a variety of methods (joint play, developmental guidance, emotional support and insight-oriented interpretations) as well as offering a more flexible and developmentally appropriate set of perceptions and behaviours that will allow the child to become more securely reliant on the parent.

- A key component to all these infant-parent intervention programs is the working relationship established between parent and therapist as an alternative working model to rely on.

*cont’d...*
 Resources

◆ Landy, S. (2002). Developmental Services Toronto East General Hospital, Fact Sheets (Autism, Regulatory Disorders, Attention Deficit/Hyperactivity Disorder, Attachment Disorders and Fetal Alcohol Syndrome.


Strategies

Sameroff proposes that the transactional model of intervention be used to determine the natural focus of interventions and strategies:

- Remediation – focus on changing child behaviour, i.e. extreme emotional dysregulation, aggression, withdrawal, etc.
- Redefinition – focus on changing the parent’s perception and expectation of the child, i.e. breaking the maladaptive patterns of negative attributions and parenting practices
- Re-education – focus on changing the parent’s ability, i.e. increased knowledge about child development, specific skills to deal with behaviour, etc.

When choosing the intervention strategy the professional needs to consider whose and what behaviours are creating and maintaining the problem.

Early childhood mental health intervention requires a flexible approach that allows the intervention to “move back and forth between the experiences of the child, the parent and what happens between them to enhance empathic mutuality and developmentally appropriate responsiveness” (Lieberman et al., 2000). Approaches that focus on listening and the primacy of the relationship between parent and child work better than didactic approaches with high-risk families. There are a number of interventions that specifically target sensitivity and responsiveness to signals, parental empathy and perspective taking.

Increasing the parents’ sensitivity to infant’s cues and understanding of their child’s unique characteristics and individuality is the focus of:

- Watch, Wait and Wonder
- Guided Videotaping viewing of mother-child interaction
- NCAST Feeding and Teaching Scales; Keys to Caregiving Model
- Interactional coaching/Floor Time

Further detailed information is provided in the specialized Facts Sheets by Dr. Landy.

Increasing the parents’ ability to see the child’s perspective and empathic understanding of how a child is feeling can be achieved by:

- Fraiberg’s model of “Talking for the Baby”
- Reframing a parent’s negative perspective of a child’s behaviour as a positive developmental achievement

cont’d...
Increasing a parent’s ability to manage behaviour and work on a child’s problem solving capacity has been promoted in the Webster-Stratton programs. Key strategies are:

- increase the parents’ positive communication skills such as the use of praise and positive feedback to children while reducing the use of criticism and unnecessary commands
- improve the parents’ ability to play with their children
- improve parents’ limit-setting skills by replacing spanking and other negative physical behaviours with use of logical consequences, redirection, problem solving and empathy skills and ignoring negative behaviours
- improve parents’ problem solving skills and anger management with noncompliance and other difficult behaviours
- increase family support networks and school involvement

**Intervention Approaches**

- **Play Therapy (Child/Sibling/Group/Family)**
  - Non-directive
  - Theraplay
  - Cognitive Behavioural Therapy
  - Structured
  - Behavioural
  - Psychoanalytic
  - Brief Solution-Focused

- **Group Therapy (Child/Parent/Child and Parent)**
  - Behavioural
  - Cognitive Behavioural Therapy
  - Non-directive
  - Psychoanalytic
  - Solution-Focused

- **Family Therapy**
  - Structural
  - Strategic
  - Narrative
  - McMaster Model
  - Psychoanalytic
  - Brief Solution-Focused
  - Wrap Around
  - Multisystemic Therapy
<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Theoretical Orientation</th>
<th>Nature of Intervention</th>
<th>Target of Intervention</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving Skills Training (PSST)</td>
<td>Cognitive-behavioural</td>
<td>Cognitive-behavioural child and parenting program</td>
<td>• Parents of anti-social children and adolescents • Anti-social children and adolescents</td>
<td>Individual child and parents</td>
</tr>
<tr>
<td>Applied Behavioural Analysis*</td>
<td>Behavioural</td>
<td>• Use of operant conditioning to increase adaptive behaviour and decrease stereotypic behaviour and aggression • Behaviours broken down into small steps; each step taught with a consistent cue that is faded out as soon as possible</td>
<td>• Children with autism</td>
<td>Individual child and parents</td>
</tr>
<tr>
<td>Teaching Children to Mind-Read</td>
<td>Behavioural and Social learning</td>
<td>• Deals with deficits in socialization by teaching specific mental concepts • Learning in 3 areas: - recognition of emotions and how one would feel from facial expressions - perspective taking; how others see and know things differently - pretend play at increasingly complex levels</td>
<td>• Children with autism</td>
<td>Individual child</td>
</tr>
<tr>
<td>Infant Massage</td>
<td>Physical and social</td>
<td>• Individualized touching and massage of infants</td>
<td>• High-risk infants, e.g., preterm, low birth weight, cocaine exposed • Mothers who are depressed • Fathers needing more involvement and responsiveness to infants</td>
<td>Individual child and parents</td>
</tr>
<tr>
<td>Watch, Wait &amp; Wonder*</td>
<td>Psychodynamic and systems</td>
<td>• Child-led play while parent observes and how parent experienced the play</td>
<td>• Parents who are somewhat avoidant with their infants • Parents with a relationship issue in the area of sleeping, feeding, separation, etc.</td>
<td>Individual child and parents</td>
</tr>
</tbody>
</table>

Adapted from Ramona Alaggia (2001), IMPrint, Vol. 31.
<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Theoretical Orientation</th>
<th>Nature of Intervention</th>
<th>Target of Intervention</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Interaction Guidance*</td>
<td>Psychodynamic and behavioural</td>
<td>Videotape viewing of parent-child interaction • Focus on maternal empathy toward child's behaviour • Elimination of “frightening” behaviours</td>
<td>Parents with histories of unresolved trauma and loss • Parents exhibiting frightened, frightening, dissociated or disorganized behaviours</td>
<td>Individual parent and child</td>
</tr>
<tr>
<td>Floor Time/ Interactional Coaching</td>
<td>Psychodynamic and behavioural</td>
<td>Parents learn to adjust their behaviour in response to the child's cues • Forming a partnership with the child • Tuning into mood, individual style of relating • Fostering communication that is purposeful • Following child's lead and expanding play themes</td>
<td>Children who have difficult temperaments or regulatory difficulties • Children who are unresponsive or hard to engage • Parents unable to interact with their children in a sensitive manner</td>
<td>Individual parent and child</td>
</tr>
<tr>
<td>Guided Videotaped viewing</td>
<td>Psychodynamic and Behavioural</td>
<td>Fosters perspective taking and sensitivity • Encourages reciprocity and forming a partnership • Promotes behavioural adjustments through reframing</td>
<td>Parents who have difficulty empathizing with child and/or understanding child's cues • Primary approach to child is intrusive, negative</td>
<td>Individual parent and child</td>
</tr>
<tr>
<td>Right From the Start*</td>
<td>Psychodynamic and Behavioural</td>
<td>Interpretation of and response to infant cues via video vignettes • Identification of parent-child interaction challenges, consequences and alternative behaviours</td>
<td>Parents with infants at developmental risk • Concern with attachment</td>
<td>Parent groups</td>
</tr>
</tbody>
</table>

Adapted from Ramona Alaggia (2001), IMPrint, Vol. 31.
### Strategies

#### Planning Interventions

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Theoretical Orientation</th>
<th>Nature of Intervention</th>
<th>Target of Intervention</th>
<th>Format</th>
</tr>
</thead>
</table>
| Keys to Caregiving Program* (NCAST) | Psychodynamic and Behavioural | • Promotes understanding of infant cues, state modulation and behaviours  
• Fosters more responsive and sensitive interactions  
• positive aspects of parent-child relationship pointed out | • Parents who have difficulty empathizing with child and/or understanding child’s cues  
• Primary approach to child is intrusive, negative | Individual parent and child |
| Incredible Years Series* (Webster-Stratton) | Social learning and cognitive-behavioural | • Managing child’s behaviour and increase child’s problem solving capacity  
• Increase praise and positive feedback while reducing criticism, spanking and other negative behaviours  
• Increase ability to play with child  
• Improve limit-setting skills  
• Increase use of redirection, logical consequences, problem solving and empathy | • Parents with anger management and problem solving difficulties  
• Parents with negative attributions of their child | Parent groups |
| It Takes Two to Talk: A Parents Guide to Helping Children Communicate* | Behavioural | • Parents trained in interaction promoting strategies  
• Child-oriented strategies (following lead and responding) | • Children with speech and language delays; problems in communication  
• Parents with poor skills in interaction techniques | Parenting groups and individual parent and child sessions |
| Parent-Child Mother Goose | Social Learning and Behavioural | • affect regulation  
• strengthening 1:1 interaction through rhythm, rhyme, music and touch | • parents not connecting with their young children  
• parents with poor understanding of linguistic and social-emotional needs of infants/toddlers | Parent and child groups |

Adapted from Ramona Alaggia (2001), IMPrint, Vol. 31.
## Strategies

### Planning Interventions

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Theoretical Orientation</th>
<th>Nature of Intervention</th>
<th>Target of Intervention</th>
<th>Format</th>
</tr>
</thead>
</table>
| Family Support Programs for Improving Maternal Psychosocial Being | Behavioural and cognitive-behavioural; Humanistic and rational-emotive | • Group therapy that focuses on parent's sense of social and parenting competence; deficits in problem solving, self-reflection and perspective-taking  
• Group interchange and support system                | • Mothers who are socially isolated and/or experiencing mental illness  
• Fathers, when they can be included                   | Mothers’ groups                                              |

Adapted from Ramona Alaggia (2001), IMPrint, Vol. 31.  
* Denotes specialized training is required

## Resources


- [www.incredibleyears.com](http://www.incredibleyears.com) for Webster-Stratton's Basic Parent Training (1) Early Childhood - ages 2 through 7 and (2) School Age - ages 5 through 12


- Chedoke Child and Family Centre offers training on 3 parenting programs: (1) Right From the Start Program (2) COPEing with Toddler Behaviour (for parents of 3-4 year olds) and (3) the COPE Program for parents of 4-12 year olds. [www.communityed.ca](http://www.communityed.ca)

- [www.hanen.org](http://www.hanen.org) - offers information on their “You Make The Difference” Parent-Child Interaction Program

- Merrymount Children’s Centre (519) 434-6848 offers a Group Program Manual (No Violence = Good Health) to be used with preschool-aged children who have witnessed Family Violence

- NCAST-Nursing-Child Assessment Satellite Training. [www.ncast@u.washington.edu](http://www.ncast@u.washington.edu)

FAQ’s & Guided Reflection

Planning Interventions

Q: What are the promising practices for early childhood mental health interventions?

A: We know that distinctive interventions are more beneficial when targeted to specific developmental issues and different populations. Promising practices indicate that an integrative knowledge-based approach may be more effective in making a better fit between who needs what.

Q: Who should the focus be: child or parent?

A: Research is indicating that both the child and the parent must be central in early intervention. (Lieberman, Silverman & Pawl, 2000) There are 4 options from which to make combinations when planning interventions for this dyad:

- child-focused
- parenting programs (group)
- parent-focused (individual)
- dual generational parent-child focused (either group or individual)

Guided Reflection

➢ In situations in which the needs of the parent and the child seem to be at odds, how do you reconcile them in your interventions

➢ What strategies have you found to be effective in your work?

cont’d...
Factors that cause stress:

- unmanageable caseloads
- excessive paperwork/completing work in non-scheduled work hours
- prolonged exposure to complex cases
- juggling too many roles and demands at once
- unrealistic expectations of self
- work in unsafe family environments
- highly dependent/needy clients
- exposure to violence, threats or other traumatic events
- inadequate supervision and support

The “cost of caring” is high (Figley, 1995, 1999) for service providers who use themselves as a therapeutic tool (Johns, 2000). Emotions evoked in the work with families and young children have to be recognized to enable the work of the professional to be effective. Key issues in early childhood mental health treatment are:

- Transference - The client becoming unconsciously engaged in a relationship with the clinician which duplicates a primarily relationship in their lives (parent, abuser, spouse, etc.) They act and react to the professional as if they were that person.

- Counter-Transference - The professional becomes unconsciously engaged in the client relationship in a way which duplicates a primary relationship in the professional's life (ie. Parent, child, sibling, boss, spouse, etc). They act and react to the client as if they were that person.

Signs of Counter-Transference include:

- overidentification with either the parent or child.
- strong affect towards the client, (anger, compassion, guilt, rejection etc) This is usually the key sign which prompts the professional to explore counter-transference as an issue.
- feeling “stuck” and unable to move forward
- feeling overwhelmed
- having a difficulty being clear about the case when discussing it

cont’d...
Fact Sheet

Personal Well-Being

- Personalizing - interpreting the client’s actions/behaviours as directed at yourself. For example feeling rejected when a parent does not show up for a session.

- Vicarious Trauma - dealing with your personal reactions/affect to tragic events which may occur in the lives of the children and parents you work with, (death, suicide, physical abuse, murder).

- Flooding - being provided huge amounts of tragic, stressful, and/or intense feelings, issues through the exploration of past and present experiences which are intruding on the client’s world. Common signs of this is feeling overwhelmed and paralysed.

- over-identification - with either the parent or the child. Strong feelings of anger or blame toward one or the other partner jeopardizes the capacity to maintain an empathic connection with both of their experiences.

- feeling rejected by the parent – when a professional’s gesture to reach out to a parent is met by lack of response or rejection the temptation is to retaliate or label a parent as resistant.

- containing negative and painful emotions - may be required of the professional as the parent relives memories and intense feeling of sorrow, rage, fear through the exploration of past experiences that are intruding on the present parenting experience.

- clarity of clinical judgement - may be impaired when parents having experienced extreme deprivation in their own upbringing carry these unmet needs into a therapeutic relationship.

- Feeling “stuck” as no positive change seems to be happening

- Tragic result, e.g., suicide, physical abuse

Resources


The self-care literature is clear on the need for awareness, emotional support and organizational change to create an environment that facilitates prevention, reduction and management of stressors. The following represent an holistic and multidimensional approach:

**CounterTransference**

- The most important step is to move from an unconscious/automatic state to a conscious one. This means finding the “cause” or root of your own responses. The most helpful way is to discuss this with colleagues with whom you feel comfortable and who can help you process your feelings and connect them to the primary relationship or issue you have within yourself. One identified a plan can be made of how to deal with this. By just making the counter-transference transparent will remove much of its negative impact.

**Personal Level**

- Spending more time with friends and family members in a more planful way to experience warmth and the fuller spectrum of happy emotions
- Allowing oneself to indulge in the same kind of self-nurturing that you advocate for families
- Engaging in creative outlets such as music, art, writing, gardening, photography, cooking, etc.
- Engaging in physical activities such as hard exercise, dance or physical work
- Reconnecting with one’s body through yoga, dance or massage
- Reviewing and revising eating patterns
- Taking time for vacation and leisure pursuits
- Understanding the power of humour to release tension and stress
- Becoming involved in community volunteer work to revive feelings of hope
- Joining political or social movements that are working toward change
- Searching for alternative spiritual outlets if one’s beliefs have been tested

**Professional Level**

- Knowing one’s limitations
- Identifying areas that are out of balance and then implementing changes

*cont’d...*
Setting limits by strict adherence to boundaries that support self-care, i.e. overtime, depersonalization of any abusive behaviour, etc.

Advocating for upgrading of skills

Arranging for regular supervision and mentoring

Sharing issues with colleagues/supervisor

Participating in other work-related activities such as research, training and education

Organizational Level

Careful attention to orientation, supervision and workload issues

Formal and informal debriefing and counseling opportunities

Honing of staff problem-solving and case management skills

Opportunities for regular professional and personal development

Provision of a safe environment where staff can speak openly
Q. **What are the key indicators of burnout?**

A. Kahill (1988) has outlined 5 categories of symptoms that indicate burnout:

   a) physical symptoms – fatigue, sleep difficulties, specific somatic complaints such as headaches, gastrointestinal irritations, colds, etc.

   b) emotional symptoms – irritability, anxiety, depression, sense of helplessness

   c) behavioural symptoms – aggression, callousness, pessimism, cynicism, substance abuse

   d) work-related symptoms – poor performance, absenteeism, lateness, theft, misuse of breaks, quitting

   e) interpersonal symptoms – inability to concentrate/focus, withdrawal from co-workers, dehumanizing and intellectualizing clients

Q. **What is the nature of secondary traumatic stress?**

A. Secondary traumatic stress (STS) has been defined as “the emotions and behaviours resulting from the knowledge of the traumatizing events of others, and the painful and disruptive impact this may have upon the helper” (Howe, 1998). Hearing directly from the victims of trauma, seeing physical suffering and encountering a family’s hopelessness, touches the professional as strongly as having had the first hand experience.

Q. **What are common pitfalls in a therapeutic relationship with parents?**

A. Practitioners are especially vulnerable to taking on too much or becoming overwhelmed by the traumas and heightened emotional experiences of high-risk families. Typically such issues as over-identification, failure to set boundaries for oneself, and the concrete need for assistance with families, place the practitioner at risk for burnout. Setting boundaries is essential not only for the practitioner but it also provides a model from which the family and client can learn to set their own boundaries.

*cont’d...*
Guided Reflection

► When have you felt powerless in your work with a family? How do you cope with your feelings?

► When and in what ways have you been able to role model or coach self-care strategies to parents?

► Under what circumstances do you find yourself growing resentful with families?

► How do you respond in those circumstances when you feel taken advantage of or manipulated?
Overview

There is a great deal of controversy amongst mental health professionals about the definition of psychopathology, especially in young children. It is defined here as an impairment in a child’s functioning at a given developmental period that typically causes problems with social functioning and creates emotional distress.

In the period between birth and 6 years of age, there are two major types of disorders (some children may show an overlap between the two types):

► Developmental disabilities (e.g., Down syndrome, fetal alcohol syndrome, communication disorders, etc.)
► Mental health and behavioural disorders not necessarily accompanied with developmental delays (e.g., attachment disorders, separation anxiety disorders, oppositional defiant disorder, etc.)

Syndromes and disorders of early childhood

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders - 4th Edition (DSM-IV) provides criteria used to define and diagnose disorders and to differentiate one disorder from another. There are a number of developmental disabilities, syndromes, and disorders that can be identified in early childhood:

► Pervasive developmental disorders including autistic disorder, Rett’s disorder, childhood disintegrative disorder, Aspergers syndrome, and pervasive developmental disorder (not otherwise specified) (PDD-NOS)
► Neurologically-based learning disabilities
► Attachment disorders
► Regulatory disorders
► Fetal alcohol syndrome
► Attention deficit/hyperactivity disorder (ADHD)
► Post traumatic stress disorder (PTSD)
► Separation anxiety disorder
► Tourette's disorder
► Oppositional defiant disorder

cont’d...
Developmental Psychopathology

Psychopathology is seen as developing over time from complex transactions among genetic, biological, and psychosocial processes that negatively influence adaptation at particular developmental transition points.

Boyce’s (2001) definition of “symphonic causation” describes the bidirectional influence of context and biology that can lead to normal development or physical or mental disorders.

Practitioners using this framework look at the underlying processes leading to the symptoms rather than at a simple diagnosis and the clusters of symptoms or maladaptive behaviours that characterize a disorder.

The developmental model examines both the influence of the context in which the child lives (see Risk and Protective section) and whether or not a number of developmental capacities have been achieved by the child. These capacities include (Landy, 2002):

- Sense of self or self-esteem
- Capacity for play - particularly symbolic play
- Language and communication
- Attachment
- Behaviour regulation
- Emotion regulation
- Capacity for concentration and problem-solving
- Empathy and social competence

The perspective of developmental psychopathology emphasizes the importance of early and intensive assessment in order to identify the possible contributors to developmental issues and to provide the necessary prevention and early intervention programs.
For disorders of early childhood there are two other primary sources that can be used to diagnose and describe certain conditions and disorders. These are:

- International Classification of Mental and Behavioral disorders; Clinical descriptions and diagnostic guidelines (ICD -10) (World Health Organization, (WHO), 1994), a particularly useful source for developmental disabilities.

- The Diagnostic Classification System (Zero to Three, 1994), which does not use the DSM - IV diagnostic categories but adopts a more descriptive approach to symptoms.

Be aware that an assessment of a child and his environment is a snapshot in time and may change due to the rapid and uneven developmental phases or pathways that characteristic of this period. Diagnosis must be made with caution and the process may either need to be extended or postponed until the child has reached certain developmental milestones.

Be aware that differential diagnosis may also be very challenging in the preschool years and often requires in-depth assessment, e.g., is a child’s problems with behaviour and concentration due to a memory or learning difficulty or an interactional, attachment, or parenting problem?

Early assessment and diagnosis, however, is crucial so that the child can obtain needed services as quickly as possible.

Clear and useful recommendations of ways to work directly with the child and with other issues must be made for parents and other caregivers to enhance the child’s development and eliminate symptoms that are impeding development.

Formulation needs to take into consideration: the developmental level of the child; the interaction between the child, parent(s), and other caregivers; the family system; the parenting knowledge and capacity, attributions of the child, and any psychopathology in the parents that may be affecting the child (See Screening and Assessment section)

Offer approaches to the child and family that are acceptable to the family, available in the agency, and are most appropriate for the issues identified.

Strategies selected may include: (1) approaches to work directly with the child (2) approaches to enhance the parent-child relationship (3) family therapy (4) approaches to change negative attributions of the child (5) provision of parenting or developmental information, and (5) individual therapy for the parent (See sections on Planning Interventions and Systems and Ecosystems)
Q: Is it not detrimental to “label” a child early in life?

A: Labeling or diagnosing a child at any age may be detrimental if there are no effective services available to intervene with the child and support the parents. It is also important to be aware that because of the difference in rate of development in children and the rapid developmental growth that takes place in early childhood that the assessment and diagnosis process may need to be detailed and extensive. However, it is equally important to understand that in some cases a diagnosis may be necessary in order for the child to get services and can be helpful for parents as well. Early and effective intervention can be crucial for children with disorders with a major genetic or biological component (see fact sheet) as well as those with a major environmental component (see fact sheet).

Q: How can I distinguish between a mother who is simply over anxious about her child and the presence of actual psychopathology in the child?

A: Only a detailed history and careful observation of the child and of the parent-child relationship and interaction can determine whether the problem is with the child’s development or behaviour or the mother’s view of her child. If developmental, emotional, or behavioural difficulties are identified, intervention will need to address them. If the child does not seem to have problems, helping the mother change her view of the child and strategies to reduce her anxiety will be crucial.

Q: Matthew is a 4 year old child who has been referred by his parents because his pediatrician has suggested that he may have ADHD and would benefit from medication. His parents are concerned about this diagnosis but do agree that he does have some behavioural problems. Matthew was adopted as an infant from outside Canada and issues were not identified by the parents until he went to Junior Kindergarten. At this time his teacher was concerned about Matthew’s “severe social and behavioural difficulties”, as well as problems with concentration and following the routines of the classroom. Matthew’s adoptive mother reports that she had a very traumatic upbringing herself. What type of assessment would you carry out in order to make an appropriate diagnosis or formulation of Matthew’s difficulties?

A: This case requires a careful examination of all possible contributing factors and an assessment of Matthew’s development and learning abilities.

**Guided Reflection**

Take time to think about the eight capacities and their different rate of development in different children. Include the way in which environmental factors and particularly the parent-child relationship and interaction can have an impact on their development. Suggest ways to help parents enhance the competencies or capacities in their children.
The path along the continuum of mental health can be either more or less functional. It is important, however, to understand:

- Signs/symptoms of illnesses
- Parent strengths
- Parenting ability
- Associated risks to child development
- Assessments
- Interventions
- Limitations

Two areas affected by a parent’s mental illness are 1) parent-child interactions and 2) the developmental path of a child. Frequently children with mental health problems live with parents who also have mental health issues.

- **Parent-child interactions therefore may (Landy, 2001):**
  - Lack mutuality
  - Tend to be intrusive, disorganized, less responsive and emotionally involved or even avoidant
  - Be more hostile, critical and even sometimes full of rage
  - Lack appropriate soothing or attunement, leaving the child unable to contain intense emotions and negative states
  - Elicit behaviours that frighten the child
  - Direct abusive behaviour at the child
  - Display inconsistency with regard to nurturing and care
  - Lead to increased risk of insecure, anxious or disorganized attachments

- **The developmental path of the child may be affected by:**
  - Increased risk of cognitive and/or speech language delays
  - Poor school performance due to low concentration and/or motivation
  - Difficulties regulating physiological and biochemical reactions to stress
Fact Sheet

Parental Mental Health

➢ Increased sleep disorders and difficulty establishing sleep-wake and eating routines
➢ Difficulties in emotional regulation leading to more aggressive and/or oppositional defiant behaviour
➢ Poor coping strategies
➢ Increased risk for social withdrawal, depressive symptoms such as lethargy, sadness and extreme distress at separation

Mental Disorders: prevalence, severity and disability

• The Canadian Mental Health Association estimates:
  ➢ 1 in 5 Canadians will be affected by mental illness at some time in their lives
  ➢ Approximately 2.5 million Canadian adults or over 10% of the population 18 and older will have a depressive disorder
  ➢ Of the ten leading causes of disability worldwide, five are mental disorders – major depression, schizophrenia, bipolar disorder, alcohol use disorder and obsessive compulsive disorder

• In Evidence Based Practices for Children and Adolescents with Depressive Disorder (Children’s Mental Health Ontario, 2001) the following statistic is quoted:
  ➢ About 60% of the children of parents with a major depressive disorder will develop a psychiatric disorder during childhood or adolescence and they are four times more likely to develop an affective disorder (Lavoie & Hodgins, 1994)

• 1998 Canadian Incidence Study of Reported Child Abuse and Neglect indicates that of the 135,000 reported cases of abuse and neglect:
  ➢ 32,610 involved at least one parent known or suspected to have mental health problems
  ➢ 45,591 involved at least one parent known or suspected to abuse drugs or alcohol to the extent that it poses a problem for the family
  ➢ At least one caregiver functioning/family stressor issue was identified in 89% of emotional maltreatment investigations including among others, substance abuse (49%), childhood history of abuse (38%), and mental health problems (37%).
Resources


Professionals working with young children and families must know the symptoms or indicators of the common parental mental health disorders and the associated risks to children: depression, including postpartum depression and psychosis; anxiety disorders; schizophrenia; and substance abuse.

General interventions which are supportive in nature focus on:

➤ Promoting parent/family strengths and successes
➤ Maintaining stability for the family
➤ Intervening to promote positive parent-child interactions
➤ Teaching parents about establishing stable routines and making environment more predictable and less chaotic
➤ Assessing parent physical and mental health; promoting regular medical care and monitoring/promoting medication/counselling compliance as indicated
➤ Teaching parent skills for reuniting and building relationship at home with child if separation occurred
➤ Giving choices to parents identifying expectations and clarifying consequences
➤ Making referrals to appropriate community agencies
➤ Assessing child risks and promoting child safety and well-being
➤ Determining availability of supports and services close to home and their ability to respond
➤ Building a circle of support for the family

Specialized interventions for:

Depression

➤ Completing routine assessments for early signs of depression and difficulty coping
➤ Teaching parents about early signs of relapse prevention
➤ Teaching and modeling relaxation techniques, cognitive restructuring and behaviour modification for parent and children
➤ Promoting regular medical visits and prescribed medication/counselling compliance
➤ Building a healthy diet and exercise for the entire family
Anxiety Disorders

- Encouraging reduction of stimulants (caffeine and sugar) in parents and children and alcohol in parents
- Teaching parent strategies for self-soothing and for improving sleep
- Teaching and modeling relaxation techniques and cognitive restructuring
- Teaching parent strategies for positive child behaviour management and positive parent-child interactions
- Promoting regular medical visits and prescribed medication/counselling compliance
- Building a healthy diet and exercise for the entire family

For Post Traumatic Stress Disorder (PTSD)

- Teaching parent about situations that may promote further victimization and about establishing stable routines
- Counseling
- Referral for specific trauma related treatments, i.e., sexual abuse groups, EMDR

Substance Abuse/Dependency

- Teaching about etiologies of addictions, appropriate treatments and relapse potential
- Teaching positive parenting skills
- Facilitating mother’s or father’s capacity to develop social supports outside of social milieu that supports her substance use/abuse
- Teaching parent skills for tolerating frustration and negative affect, possible depression and relapse prevention. Referring to programs specializing in addictions including residential programs
Q: What are the major impacts of parent mental health illness on a child’s development?

A: The developmental path of the child may be affected by:

> Increased risk of cognitive and/or speech language delays
> Poor school performance due to low concentration and/or motivation
> Difficulties regulating physiological and biochemical reactions to stress
> Increased sleep disorders and difficulty establishing sleep-wake and eating routines
> Difficulties in emotional regulation leading to more aggressive and/or oppositional defiant behaviour
> Poor coping strategies
> Increased risk for social withdrawal, depressive symptoms such as lethargy, sadness and extreme distress at separation

Q: What role does a children’s mental health staff play in a family where parental mental illness has been identified?

A: A primary role is to create a supportive and trusting relationship with the family. The relationship acts as a model for a new way of interacting for parents with mental illness. It provides containment and security to deal with the traumas that the family has experienced as well as fear about the future of their child’s welfare. In addition to the acceptance and stabilizing effect which the professional-parent relationship brings, the children’s mental health practitioner must deal with specific crisis intervention and ongoing concrete help and problem solving. Parent-child focused interventions and ongoing monitoring also act to provide direct support to the child.

Q: How can the risk to the young child of separating him/her from a mentally ill parent to whom he is deeply attached be assessed against the risk of leaving him in the care of that parent? How may such risks be minimized or ameliorated?

A: While the child’s attachment is important at no time should this consideration be allowed to over ride the considerations of physical harm, and the trauma of emotional abuse and neglect. The child’s physical safety is paramount. Also to be left alone with an abusive parent to whom s/he is deeply attached can be psychologically harmful in that this attachment becomes the child’s whole world. Risks can be minimized if the child is to remain with the parent by ensuring other caring and supportive adults are also reliably present, e.g., to support a mother with depression and ensure she isn’t left alone with her child. If the child is to be removed supervised visiting should be encouraged and facilitated. Very young children should be closely observed with their “attachment figure” and signs of fear and anxiety taken seriously. Older children, age 3 - 6 should have an appropriate opportunity to express their feelings and concerns. Adults may be unaware of how events are actually having an impact on the child.
Q. **What should children ages 2 - 6 be told about parents’ behaviour which is clearly due to severe illness, e.g., talking in response to hallucinations, severe withdrawal due to depression, unpredictable rages. What should be said about hospitalizations and even impending deaths?**

A. First, children need appropriate forums both with and without their parents present to express their own fears and concerns. Information should be given which addresses the child where he is both emotionally and developmentally and in a form which he can understand, e.g., a child with a psychotic parent who talks to herself/himself may be worried for himself and his own safety or conversely for the parent or that the parent will be removed. It is important to find out what the child is concerned about before information is given. A child with a physically ill parent may fear death, hospitalization and loss or may fear exposure and that he/she will “catch it.” Information comes best from someone whom the child trusts and a moment when he is emotionally available and can “hear” it.

**Guided Reflection**

- What considerations must be taken into account in reconciling the conflicting interests of parent and child?

- What is the role of formal and informal supports in the lives of families where there is mental illness? What forms of support might be detrimental?

- What interventions do you feel comfortable with? Which interventions do you feel less comfortable doing?
Fact Sheet

Multidisciplinary Practice

• Potential Benefits to Families
  ➢ Facilitates holistic view of child and family
  ➢ Decreases duplication and overlap of service providers to family
  ➢ Allows for family input in identifying priorities and intervention planning
  ➢ Increases likelihood of family follow through with intervention
  ➢ Reduces competing or contradicting assessments and intervention priorities

• Potential Benefits for Service Providers
  ➢ Promotes shared responsibility and accountability
  ➢ Reduces costs and workloads
  ➢ Increases appreciation and utilization of competencies of other professionals
  ➢ Promotes rewarding interpersonal relationships
  ➢ Enhances appreciation of family’s strengths
  ➢ Enhances breadth and depth of knowledge and skills

• Characteristics of Multidisciplinary Practice
  ➢ Information and skill sharing across traditional boundaries
  ➢ Relationship among participants is non-hierarchical and power is shared
  ➢ All participants are part of a team and contribute to a common goal
  ➢ Leadership and responsibility are shared and participants are interdependent
  ➢ Planning and decision making done together
  ➢ Respect for autonomous professional judgment as well as choice and decision making of family
  ➢ Communication skills and group dynamics increase and become more effective
  ➢ Work is supported by organizational structures and vision

cont’d...
Fact Sheet

Multidisciplinary Practice

• Professional Barriers
  ➤ Differences in requirements, regulations and norms of profession
  ➤ Differences in history and culture
  ➤ Differing levels of preparation, qualifications and status
  ➤ Differences in accountability, payment and rewards
  ➤ Concerns regarding clinical responsibility
  ➤ Differences in professional jargon, schedules and routines
  ➤ Fears of diluting professional identity through sharing of expertise
  ➤ Preference for independence rather than interdependence

• Enabling Factors to decrease barriers:
  ➤ Viewing families in an holistic way
  ➤ Viewing cross-discipline exchange as an opportunity to develop deeper understanding, respect for and recognition of differences in roles, value bases, mandates and available resources in work with families
  ➤ Advocating for organizational commitment of time and resources to collaborative practice
  ➤ Taking personal and professional risks, e.g., taking leadership in becoming a “change agent”
  ➤ Seeking out opportunities for skill development, e.g., interpersonal communication, conflict resolution and facilitation
  ➤ Exploring personal ability to share power and expertise
  ➤ Exploring personal ability to live with uncertainty and ambiguity that comes from working in a new way
  ➤ Directing team’s energy toward professional learning and meeting needs of the child and family

cont’d...
Resources


- www.frp.ca - website for the Canadian Association of Family Resource Programs

- www.cfc-efc.ca - Child and Family Canada has 50 organizations working for children and families

- www.familysupportamerica.org - website for the National Family Support Mapping Project

**Orientation of a new service to a family**

- Does a strong foundation of trust exist to lessen the intrusion of a new service provider into a family’s life?
- Has timing the introduction of a new service been sensitive to the family’s agenda?
- Are availability and accessibility of services/resources matched to the child’s/family’s needs in a timely fashion? Suggesting a service for which there is a long wait list does not support families
- Have you included the family in a joint discussion with the new service provider for a clear understanding of role and responsibility in the service plan? How will you “sell” the new service?

**Preparation for an integrated case conference**

- Consider the family’s involvement – at what point? How often? What happens if the family is not present?
- Have you prepared the family by working with them to explain why the case conference is happening and the process; which service providers are wanted by the family; to explain the expectations; to explain the family’s role; to discuss what the family would like to say at the conference; to decide whom the family would like to be present as support.
- Has information sharing been discussed and necessary consents obtained?

**Conducting an integrated case conference**

- Clarify the role of the integrated case manager
- Develop the criteria for selecting the case manager
- Identify and inform all relevant service providers
- Get consensus on consistent documentation
- Label pertinent feelings

**Development of an integrated service plan**

- Set a clear agenda and maintain focus on it
- Assign responsibilities and timelines

cont’d...
Identify potential barriers to implementation

**Building the team’s sense of connection**

- Develop a shared vision about the impending process and relationship building before jumping into the task of an intervention plan
- Take time to build rapport, trust and honest communication that will support the team through challenging and sensitive issues
- Frequency of review of the plan to be guided by family’s wishes; setbacks or change in life circumstances; stage of intervention; changes in the team

**Evaluation of the multidisciplinary process and intervention**

- Consider effectiveness of the service plan
- Consider the effectiveness of the case management process
**FAQ’s & Guided Reflection**

**Multidisciplinary Practice**

Q: **What are the best strategies to handle conflict?**

A: Common causes for conflict revolve around differences in service plan recommendations, not sharing key information or differences of opinion among team and family members. Avoidance, exertion of power, and withdrawal from the situation are ineffective approaches to address conflict.

Some of the following strategies may be used to prevent or reduce conflict among team members:

- Develop guidelines for group behaviour and information sharing. Challenge people when they deviate from those guidelines that have been reached by consensus.
- Ensure everyone has the same information.
- Get consensus on what should be done in case of conflict or differences of opinion.
- Create an atmosphere of mutual respect and open dialogue in which differences of opinion can be aired.
- Try to identify underlying issues that may threaten the team’s capacity to resolve issues and deal with them, e.g., power imbalances, hidden agendas, differences in communication styles due to culture, gender or education, etc.

Q: **What if an impasse is reached, what do we do then?**

A: Designate a body of last resort that is responsible for hearing and working through conflict situations or for making a decision if necessary. Use an existing structure such as an interagency committee or create a new one. Whatever structure is used, it has to have the capacity and authority to address either an extraordinary service need or a planning impasse.

**Guided Reflection**

- In your own practice what elements of multidisciplinary practice have been the most challenging to incorporate? What has determined successful experiences in working with diverse service providers?
- What are your own personal beliefs about confidentiality? What does your professional code of ethics say about confidentiality? How would the presence of the family contribute to your perspective on confidentiality? How do you put those beliefs and ethics into practice?
- What skills or mechanisms have you found useful for conflict resolution in integrated case management?
Fact Sheet  Engaging Hard to Reach Families

• A far reaching shift in early childhood treatment and intervention is the reconceptualization of the role of the family. The implication of this paradigm shift are:
  ➢ families are now in the centre with services revolving around them
  ➢ attention is focused on individual family stories/meanings, coping and adaptation styles
  ➢ the importance of family diversity requires cross-cultural competence
  ➢ the nature of the parent-professional relationship has shifted from the traditional professionally driven “fix-it” approach to a more collaborative working partnership

• The key characteristics of a family-centred philosophy are:
  ➢ the family is a key participant, equal partner and decision-maker in the assessment and intervention planning process
  ➢ the family’s strengths and resources are identified and built upon
  ➢ the family determines its own level of involvement/participation and makes informed decisions about priorities, goals and types of services
  ➢ informed consent must be part of the entire process
  ➢ the professional’s role is to enhance and support the family’s ability to seek solutions and respond to needs of their child; share their knowledge within the context of a respectful, collaborative relationship so that the child and family competency is strengthened (Dunst et al., 1988)

• Family-centred services require the following skills of professional:
  ➢ collaboration
  ➢ support
  ➢ negotiation
  ➢ self-knowledge and reflective practice
  ➢ active listening
  ➢ non-judgmental attitude
  ➢ knowledge of child development, parenting challenges and trauma

cont’d...
Fact Sheet

Engaging Hard to Reach Families

• **Barriers to engagement – Pragmatic**
  ➢ access to telephone
  ➢ access to transportation
  ➢ travel time required
  ➢ literacy
  ➢ safety risk for home-based interventions
  ➢ day time scheduling

• **Barriers to engagement – Professional**
  ➢ judgmentalness and quickness to label
  ➢ frustration at not being able to connect ends up feeling like a waste of time or rejection
  ➢ inflexibility to make services fit the family’s need
  ➢ triangulation

• **Barriers to engagement – Family/Personal**
  ➢ reluctance to tell family “business” outside the family circle
  ➢ expectation of rejection, criticism and blame from professionals
  ➢ having “secrets” which need to be kept, e.g., substance abuse, family violence, mental health disorder
  ➢ having more pressing needs/issues, e.g., food security, housing and safety
  ➢ lack of readiness
  ➢ trauma suffered early in their family history
  ➢ feeling hopeless and beyond help

• **Barriers to engagement – Family/Service related**
  ➢ fear of involvement with child protection services
  ➢ fear of losing control to an agency; feeling disempowered
  ➢ too many professionals to deal with
engaging hard to reach families

cultural differences
feeling suspicious due to poor previous experience with helper agencies

Motivation for change involves key issues that affect the engagement of families. Motivational factors include:

- The desired change will be of more benefit than the status quo.
- There is a sense that things can change, (hope).
- There is energy to change.
- There are resources to maintain the change.
- The fear of the unknown (change) is manageable and acceptable.
- The belief system supports the need to change.
- The family knows what they need to do in concrete terms.
- The clinician is perceived by the family as trusting that the family can “do it”.

The potential for goals to be reached is great when the family understands how change will positively affect them and when they feel capable of actually achieving the change.

Resources

- www.zerotothree.org
Conceptual Framework

➤ *Reframe the “family as resistant” in light of the barriers outlined,* i.e., family is not capable of having the skill/knowledge to effect the change or there is the existence of transference.

➤ *Examine your belief about the family.* Although you may never actually state your belief that the family cannot change, it will come through in your interactions. Discuss this issue with your supervisor, team, colleague and check the counter-transference issue (see Personal Well-Being).

➤ *Minimize triangulation* by: coordinating efforts among other agencies involved; do not allow secrets and share all issues and concerns openly with each other; clarify roles and stay in your role.

➤ *Make therapy interesting and concrete.* Lecture and/or information/oral-based therapy tends to be less effective with families who are disengaged. Use fun activities, games, role plays. Connect to the kineesthetic and visual senses of family members.

➤ *Maximize safety.* Many families feel they have been “burned,” “betrayed” or victims to hidden agendas and surprise decisions in past experiences with agencies. Keep issues on the table. Do not have hidden agendas. Deal openly with the issue of confidentiality and any sub-issues of child protection or authority roles. Be honest.

➤ *Understand the belief system.* When things are stuck, there is usually a belief system at work and until that belief is altered the chances of change are limited, i.e., if parents believe you are really out to get their child apprehended you will get nowhere with them.

➤ Maximize mutual respect and trust

➤ Maximize use of family strengths

➤ Maximize expertise of the family

➤ *Maximize the relationship you have with the family*
Steps to creating a working alliance rests on the groundwork of empathy, respect, caring and genuine understanding:

1. Observing and inviting the family to share their story
2. Listening and responding non-judgmentally
3. Permitting the family to identify their strengths
4. Proactive problem solving
5. Building connections
6. Creating equal participation and a sense of hope
7. Minimizing triangulation
8. Clarifying role and having clear goals
9. Ensuring there are no surprises or secrets

Ongoing Relationship Building

Respect:
- That the family is doing the best they know how
- The goals and values of the family
- The honesty of the family and your own
- The difficulties and traumas families have experienced

Remember:
- The family has ultimate control over the intervention’s direction
- To provide personal continuity and consistency
- To be available in times of crisis
- To persist in the face of rejection
- To be clear about the boundaries of clinical work
- To acknowledge and empathize with a family’s positive and negative experiences
- To acknowledge factors that maybe hindering the parent-professional relationship

*cont’d...*
Strategies Engaging Hard to Reach Families

Empower:

➢ parents to be agents of change in the life of their family, i.e. the child
➢ by ensuring information is shared and open

Actively Listen:

➢ summarize or paraphrase to ensure you have heard information correctly
➢ ask the client to tell you what they heard and understood
➢ don’t triangulate or become triangulated

Resources

◆ Ages and Stages Questionnaire
◆ Nipissing District Developmental Screening
◆ Invest in Kids Years Before Five Resource Kit
◆ Hincks-Dellcrest (2000). Learning Through PlayCalendars: From Birth to Three Years; From Three to Six Years
◆ www.infolnks.com - offers information on Dr. Louis Rossetti’s work, and video Enhancing Services to Infants, Toddlers and Their Families.
◆ www.play-therapy.com - is the site for the family enhancement and play therapy centre
◆ www.capt.com - site for Canadian Association of Play Therapy
Q: How is the need to “fix” the child’s problem balanced with family need?

A: Often parents have multiple personal needs that compete for attention with the child’s needs. Different strategies may have to be put into place simultaneously in order to support both the child and the parent. Where possible embed information about the child’s needs when planning strategies with the parent, e.g., designing bedtime routines for a parent who is feeling overwhelmed and stressed, allows for greater consistency in patterns for the child as well as stress reduction for the parent.

Support the parents and guide them in times of crisis. Build in activities that assist families to develop the foundation skills for learning. You are helping them to learn how to learn at the same time as expecting them to learn how to parent.

And finally, you may have to focus on the needs of the parent prior to focusing attention on the needs of the child, as long as the child is not in danger for safety or compromised development.

Q: How do we maintain an appropriate relationship with child protection?

A: Many professionals who work with families encounter situations where they are either providing court ordered services or believe that consulting with a child protection agency prior to speaking with a parent is betraying the relationship they have with a family. It is important to understand that the professional’s role never supercedes legislated reporting requirements. A clear statement needs to be given and reviewed with a family at any initial meeting about the legal responsibilities to consult with child protection when there are concerns over a child’s safety, protection and well-being. Educate the families about child protection rather than casting them in a villainous role. It is advised to develop protocols when working with child protection that clearly delineate the process, responsibilities, communication and conflict resolution between the two agencies. Don’t be reluctant to schedule regular meetings with senior management of any community agency involved to resolve issues that are impeding work with overburdened families.

Q: Is there a point at which you give up?

A: Sometimes it is necessary to step back and give the family time to decide how they need things in their life to be. If you decide to withdraw services it may feel as though you have “physically given up”, however, you can still be emotionally connected if you leave the door open for them to return and check in on them from time to time. This sends a clear message that you care, are concerned and bear no grudges.

cont’d...
Q: How do you empower a family when they seem to be making the “wrong” choices?

A: Service providers must respect and honor decisions that families make even if it is not possible to agree with them. The only bottom line is when a child’s safety and protection is placed in jeopardy. For other situations, it is important to be upfront about the fact that other options exist. You can help a family to explore other choices and then build in some accountability for the path they have chosen to follow.

Guided Reflection

➢ If a professional were calling you on the telephone to set up a meeting what aspects of his/her communication style would influence your response? If you felt particularly vulnerable in some aspects of your life how might this affect the meanings you attach to the call?

➢ What techniques do you use to make a connection with a family?

➢ What creative strategies have you encountered within your agency or others to engage families in a meaningful working relationship?
EFFECTIVE CONSULTATION TO CHILDCARE CENTRES AND SCHOOLS

• **Effective Consultation Means…**
  > Understanding young children and their development within the context of the family, childcare and school.
  > Building rapport and working in partnership with families
  > Understanding the culture of both childcare and school settings
  > Building rapport and working collaboratively with teachers

• **Principles Of Mental Health Consultation**

  Consultation is…
  > a voluntary process.
  > an interdependent relationship.
  > temporary.
  > clarifying the problems and causes thereby refocusing the relationship.
  > helping the consultee find and evaluate solutions to identified problems.
  > supporting the consultee in gaining knowledge that may be applied in future situations.

• **Ethical And Legal Issues To Consider…**

  > Consent form must be signed by parent or legal guardian in order for consultation to proceed.
  > Confidentiality is key to a family’s privacy and to building trust amongst all parties.
  > Reporting child abuse or suspected abuse is everyone’s legal responsibility – be clear about the reporting protocol.
  > Observed inappropriate practices should be addressed – be clear about the protocol for discussing these practices.

cont’d…
COMMON CONSULTATION AGENDA: CHALLENGING BEHAVIOUR

The ABC’s or Functional Assessment approach to working with challenging behaviours is often helpful.

**A** is for antecedent - both internal (a child’s emotions, medical or physical conditions, etc.) and external (environmental factors such as noise, inconsistent expectations, frequent change of caregivers, etc.) can trigger behaviours.

**B** is for behaviour - identify the behaviours the child demonstrates and determine the function of the behaviour - i.e. to get something positive, to avoid something negative to increase or decrease stimulation.

**C** is for consequences – these can increase or decrease the behaviours – set up the environment to increase desirable behaviours.
Strategies

Effective Consultation

THE ART OF CONSULTATION

Step 1: Consent Form Signed

Click to view larger image

The consent form is signed, yet staff state that they are unsure about whether or not they will keep the child in the program.

Strategy:
Consultant tells the centre that a decision must be made before consultation can begin.

Roadblock # 2:
The parent has refused to sign the consent form, yet the centre has asked you to come in.

Strategy:
The consultant observes the program and offers general program suggestions that may be helpful. Confidentiality is maintained – the name of the child in question is never revealed.

Step 2: Initial Contact With The Childcare / School

Gather / Clarify Relevant Background Information

Helpful information may include

- age of the child
- length of time the child has been enrolled in the program
- family composition and lifestyle
- significant events or changes in the child’s life

Work With The Consultee To Define The Problem

Questions that may help the consultee define the problem:

- What is the behaviour?
- When does the behaviour occur?
- Where does the behaviour occur?
- Who is involved in the situation?
- Why does the behaviour occur?
- How often does the behaviour occur?

cont’d...
Strategies

Effective Consultation

Roadblock:
The teacher does not want to work with the child and is very negative as you try to define
the problem.  Her response to the questions you ask about the frequency of behaviours
is “all the time!”

Strategy:
Allow the teacher some time to vent, but refocus the teacher and be optimistic that the
child and the teacher can benefit from consultation.

Step 3: First Assessment Visit

- The purpose of this visit is to observe the child.
- The visit should occur at a time of day specified by the teacher (usually a time when the
  behaviour is most likely to occur).
- The visit should occur on a “typical” day.
- The consultant should try to be “invisible “during the consultation.
- The consultant should give feedback to the consultee (or arrange for a time to do so).

Before the consultant leaves it is important to

  > clarify the next steps
  > set a date for the next visit
  > “check – in” with the supervisor

Roadblock # 1:
It’s not a typical day – e.g. an assembly, a community walk.

Strategy:
The consultant speaks with the supervisor / principal to be clear about the need to observe
on a typical day.

Roadblock # 2:
The child doesn’t exhibit behaviours during the observation visit and the teachers worry
that the consultant does not believe them.

Strategy:
Reassure the teacher that the child will eventually show the behaviours. Identify aspects
of the child’s temperament or behaviour that were observed that are indicative of the
difficulties as defined by the teacher.

cont’d...
Step 4: Consultant Contacts Parent

- The purpose of the contact is to introduce yourself and to provide feedback to the parent after the first observation visit.
- It is important to provide positive feedback while being honest about your observations.
- The parent(s) must be invited and encouraged to articulate any concerns and to share observations of the child in the home setting.
- Before ending, next steps should be reviewed with the parent(s).

Roadblock:
*Parent is not forthcoming with information.*

**Strategy:**
*Be patient, relationships take time to develop, don’t push it – this helps build trust.*

Step 5: Continuation Of Assessment

- The consultant will visit the classroom 2–3 more times or until (s)he feels they have enough information. She will identify the child’s strengths and needs.
- During these observation visits the consultant will continue to seek teacher input and provide feedback to the teacher.

Roadblock # 1:
*Program lacks quality.*

**Strategy:**
*In a school setting, this issue is not addressed.*
*In a childcare centre, you may discuss it with the supervisor, depending on your relationship. Remember you are there for the child, not to evaluate the program.*
*In both settings, as you plan for the child, you can make suggestions that will improve the program.*

Roadblock # 2:
*Inconsistent staffing.*

**Strategy:**
*Speak to supervisor / principal about the need for consistency for the children. Recognize that staffing issues may be beyond anyone’s control. Once the relationship is established, you might explore reasons for staff turnover.*
Step 6: Feedback Meeting Between Parent(s), Teacher And Consultant

The purpose of the meeting is for

- The consultant to share observations and child’s strengths and needs.
- The teacher to share observations and strategies tried or currently used.
- The parent(s) to share their perceptions of the problem and strategies they are using.
- An Action Plan to be developed which may include ongoing classroom consultation; counseling directly to the parents or referral to additional services.

Roadblock # 1:
Parent is in denial (my child doesn’t do that at home, it’s the centre’s problem).

Strategy:
Explain to the parent that your observations are based on seeing the child in a group setting. Acknowledge that the child’s behaviour may be different at home than it is at school. Be aware not to get into a power struggle with the parent.

Roadblock # 2:
During the feedback meeting, as the parent discloses stressful personal information, the teacher reacts by saying “oh your child is really improving,” when in fact the consultant has already identified that the child’s difficulties are serious and additional services will be required to support the child. The teacher’s emotional reaction is an attempt to make the mother feel better.

Strategy:
The consultant should prepare the teacher before the meeting, reviewing what might occur.
In response to this situation during the meeting, the consultant must diplomatically, acknowledge the improvement but stress the need for further services.

Step 7: Consultant And Teacher Meeting To Develop Strategies

The purpose of this meeting is to develop strategies that will support the child in the classroom, i.e., using the child’s strengths to support his needs.

The consultee must retain ownership of the situation.

cont’d...
Strategies

Sub steps include:

- Review original problem and revise if necessary
- Identify Goals
- Develop a Plan of Intervention

The consultant must work WITH the consultee to develop strategies and be open to hearing when a strategy is not realistic.

Strategies must be documented in “friendly” language and shared with all team players and parent(s).

Roadblock # 1:
Supervisor / principal has not arrange coverage for a staff to meet with the consultant.

Strategy:
Consultant speaks with supervisor / principal to reschedule. Consultation needs to stress the importance of having directly involved staff available for the meeting.

Roadblock #2:
Though discussion and goal setting, it becomes apparent that the teacher(s) are taking the child’s behaviour personally, e.g., when the child hits the teacher, she assumes that the child is doing it deliberately to make her life miserable.

Strategy:
The consultant needs to help the teacher understand the context of the behaviour and to recognize that the behaviour is not aimed at her but at anyone or anything that is close to the child when the behaviour occurs.

Roadblock # 3:
As the consultant proposes strategies, the teacher continually asks “How will I meet the needs of the other children?”

Strategy:
The consultant needs to reinforce that when a quality program is offered, it will meet the needs all of the children (when this is true of the program – praise it). Then the consultant needs to explain that children learn from other children. When one child requires more help, the other children learn valuable life skills about differences and helping others.

cont’d...
Step 8: Consultation Visits To The Classroom

The purpose of consultation is twofold – to monitor the child’s progress and to support the teacher.

Roadblock:
Staff have not implemented the Individual Program Plan.

Strategy:
The consultant seeks clarification from the staff about why the plan was not implemented – was it too ambitious, did something unexpected come up to prevent implementation, etc.? The consultant then ensures that the staff are prepared to follow through.

Step 9: Ongoing Communication With The Parents

The purpose of the ongoing contact is to:

- Update parents on the child’s progress
- Provide parents with revised action plans
- Provide parents with an opportunity to identify additional or ongoing concerns
- Provide parents with support and resources

Roadblock # 1:
The parent does not return phone calls.

Strategy:
Continue to try to make phone contact, when this fails send a letter or a note with the child.

Roadblock # 2:
The parent is ambivalent and not truthful in her communication with the consultant.

Strategy:
Continue to support the parent and to listen actively. This may help to continue to build trust and eventually the parent may disclose.

cont’d...
Step 10: Review Meeting With Parents, Teacher And Consultant

- The purpose of the meeting is to review the child’s overall progress and modify the Action Plan as appropriate.
- Revised Action Plans must be forwarded to teachers and parents.

**Roadblock:**
At the case review meeting, it’s clear that the consultation is not sufficient to meet the needs of the child. The consultant recommends additional services that the parent refuses. The teacher later expresses anger about this to the consultant.

**Strategy:**
Consultant helps the teacher to understand that the parent has the final say and that eventually the parent may come to recognize the need for additional services. Teachers need to recognize that there is nothing that can be done to force a parent to accept services.

Step 11: Case Closed

- The case is closed ...
  - when the teacher reports that she can meet the child’s needs
  - if the parent wishes, for whatever reason, to discontinue service.

**Roadblock:**
The teachers are reluctant to close the case even though the consultant has identified that the teachers can meet the child’s needs at this time.

**Strategy:**
The consultant reviews the child’s progress and provides positive feedback about the skills of the teachers. The consultant reminds the teachers that the door is always open.

* It should be noted that the consultant should be available to speak to or to meet with teachers and/or parents between arranged visits.

cont’d...
Resources


◆ www.circleofinclusion.org

Information covering a wide range of topics related to inclusion – benefits and barriers, educational and social value of inclusion, initiating programs, parent’s perspective, including families, identifying the stakeholders, building collaborative early childhood teams, resources and more!


