ZERO TO THREE

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Stories From the Field 2016

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ZERO TO THREE JOURNAL

Stories From the Field 2016

IN THIS ISSUE

ZERO TO THREE
Early connections last a lifetime

This Issue and Why it Matters

The annual "Stories From the Field" issue of the *ZERO TO THREE* Journal is a particular pleasure to create due to the window it offers into the professional lives of our colleagues and the lived experiences of families. In this issue the authors explore:

- The impact of refugees from around the world as a growing population in primary care settings. Early childhood behavioral health providers, such as Healthy Steps specialists, can support these families and the medical providers who care for them. This article describes a refugee family and their young child who were seen by a Healthy Steps specialist in pediatric primary care.
- The development of early childhood or "baby courts" as a much-needed improvement in the child welfare system for families with the youngest children. This story details how all of the members of the Baby Court team made a difference for a young mother and child. This example illustrates the importance of taking a multifaceted Baby Court approach when working with multiple, complex, and pervasive traumas that are all too common for the parents of children in the welfare system.
- How a trauma-informed parent group intervention for families with young children, the Attachment Vitamins Program, provides a relational psychoeducational intervention based on the principles of Child-Parent Psychotherapy. Its goal is to repair the impact of chronic stress and trauma through strengthening the child-parent relationship.
- The FAN (Facilitating Attuned Interactions) approach to supporting trauma-informed practices in programs where past or present trauma may be affecting a family in some way.
- A set of 21 Parent-Child Relationship Competencies that function as a map for assessment and treatment planning. Each of the competencies is a bi-directional capacity that uniquely promotes child development, relationship satisfaction, and family well-being.

We thank the providers and the families for allowing a glimpse in the challenging, rewarding, and complex work of supporting very young children. We all learn from these personal stories of both struggle and triumph. If you have a story to share, we would love to hear from you.

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Early Childhood Behavioral Health Integration in Pediatric Primary Care

Serving Refugee Families in the Healthy Steps Program

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Abstract
Primary care settings are optimal environments for providing comprehensive, family-centered care to young children and their families. Primary care clinics with integrated behavioral health clinicians (BHCs) are well-positioned to build trust and create access to care for marginalized and underserved populations. Refugees from around the world are a growing population in primary care settings, presenting with unique needs and circumstances. Early childhood integrated BHCs (e.g., Healthy Steps [HS] specialists) can support these families and the medical providers who care for them. This article describes a refugee family and their young child who were seen by an HS specialist in pediatric primary care. Several themes emerge that are relevant to working with this special population in the context of pediatric primary care.

Pediatric primary care is an accessible, comprehensive, nonstigmatizing setting frequented by young children and their families early and often in life. Young children are typically seen for well-child care in the first few days of life and then a minimum of 11 recommended times over the first 3 years (Hagan, Shaw, & Duncan, 2008). Well-child visits offer prime opportunities to support young children's physical, emotional, and social health in the context of their families and communities. Primary care providers promote optimal development, considering multiple impacts on a child's well-being including environmental factors, behavioral health concerns, and psychosocial issues. Families in need of psychosocial support, including refugee families, are more likely to visit their child's pediatrician than they are to access behavioral health services in the community.

Behavioral health providers, integrated into primary care clinics, can augment and enhance routine medical care by extending the breadth and scope of primary care to include a focus on psychosocial well-being and behavioral health issues (Kaplan-Sanoff, Talmi, & Augustyn, 2012; Talmi, Stafford, & Buchholz, 2009). Supports may include screening protocols (e.g., developmental, pregnancy-related depression; Health Team Works, 2014), case consultation (e.g., addressing specific concerns in the context of a medical visit), and health promotion/prevention activities (e.g., providing anticipatory guidance; implementation of the Healthy Steps for Young Children program, Barth, 2010). The combination of these activities creates a comprehensive medical home approach for young children and families, ensuring that their needs are addressed and coordinated.

Even families who are at risk for marginalization by traditional systems of care are likely to bring their young children to the doctor's office. Medical professionals align with traditional norms of most cultures, making accessing medical services a normative and destigmatizing method of seeking care for all aspects of well-being. Traditional mental health treatment, in contrast, is often less common or even stigmatized in many cultures, so families may be less likely to access these services. When a Healthy Steps (HS) specialist is integrated into primary

care, families are more likely to access behavioral health consultation services.

The refugee population is a group that is growing in size and is in need of appropriate, culturally sensitive, accessible, family- and community-centered care. Refugee adults come to this country with a myriad of experiences, many of them traumatic, that shape parenting experiences and approaches (Ater, 1998). The trauma that refugee parents experienced often has an intergenerational impact on their children (Miller & Rasco, 2004), potentially affecting attachment, parenting confidence, and behavior management.

Given the heightened psychosocial risk facing refugee families, often due to circumstances that qualified them for refugee status, this population has unique and complex support needs that are sometimes unavailable or difficult to access. As a result of poverty, language differences, isolation, and mental illness, refugee families face significant health disparities (Berry, Bloom, Foley, & Palfrey, 2010; Cacari-Stone, Viruell-Fuentes, & Acevedo-García, 2007; Semple, 2015). Medical homes, especially those that include behavioral health clinicians (BHCs), are uniquely positioned to address many of these health disparities (Becker Herbst, Margolis, Millar, Muther, & Talmi, 2015; Bunik & Talmi, 2012) and ensure the needs of children of refugee families are identified, addressed, and coordinated within families' communities. Above all, working with refugee families necessitates coordinating care across systems, creating a community "village" that attends to the importance of building supportive relationships around children and families.

The following example describes one refugee family's experience in their newborn infant's medical home. This story exemplifies the need for careful coordination and consideration of cultural nuances that impact the well-being of both the infant and the family. All names and identifying information about the family have been changed to protect patient confidentiality.

Asad's Story

Asad was a 5-day-old Somali boy who came to a primary care clinic for a newborn visit. His mother, father, and a Somali interpreter (provided by the hospital that houses the primary care clinic) accompanied Asad at this visit. Asad's medical provider was a first-year pediatric resident. The provider expected this visit to be straightforward: check his weight, review feeding and voiding, pregnancy-related depression screening, and review family's "questions or concerns." He was surprised to uncover a very complex situation: mother in severe pain from a cesarean delivery, breastfeeding difficulties, problems accessing resources (e.g., Woman, Infants, and Children [WIC]), and a family of refugees from Somalia who had limited social support. The provider was concerned about maternal mental health as Asad's mother was tearful and both parents seemed to have an endless number of questions. The provider struggled to address all of these things in the context of a 15-minute visit with the family. He saw a healthy baby but also knew that the family's complex psychosocial needs posed significant risk factors to continued healthy development. In the interest of time, and recognizing that addressing these psychosocial needs was outside his scope of medical practice, the provider consulted with the HS specialists who were part of the care team. See the Key Concepts for Working With Refugee Families box for information on some of the methods, goals, and tactics the HS specialists use.

Key Concepts for Working With Refugee Families

While working with refugee parents with young children in the context of primary care, Healthy Steps (HS) specialists keep the following key concepts in mind:

Coordination With Medical Providers
It is essential to develop a coordinated approach to working with refugee families and to supporting the medical providers in managing the stress that accompanies the treatment of this population. The provider's decision to consult the behavioral health clinician (BHC) in this case offered both the family and the provider a comprehensive approach to treatment. Had the provider not consulted the BHC, critical information may not have been discovered.

Trust
Establishing trust with a refugee family is critical to successful treatment. This often occurs by providing continuity of care, listening to the family's story, being flexible with the family's needs, and helping with challenges the family may be facing. HS is designed to promote trust and enhance primary care services for all families and can be especially helpful for families with complex psychosocial histories.

Language and Interpretation
Refugee families have the right to communicate in their native/preferred language. Interpretation in the context of medical settings should convey both the intricacies of language as well as the cultural nuances of what is being communicated (Commonwealth of Massachusetts, 2010).

Parallel Processes
Parallel processes often occur when treating refugee families. Providers may experience isolation and desperation in their attempt to meet the needs of their patient while the refugee family experiences their own level of isolation and desperation. It is important to be aware of potential parallel processes to ensure that they don't negatively impact patient care.

Somatic Complaints
Refugee parents have often experienced unthinkable trauma. These experiences may result in increased somatic concerns and a search for explanations that potentially lead to increased health care usage.

Meeting Families in Their Homes
HS allows for home visits with families. Yet entering someone's home involves intimacy and trust. Introducing home visits to refugee families should be approached gently and with humility due to a variety of factors that may make trust of outsiders a challenge. Although it is an opportunity to meet the family in their natural environment, care must be taken to ensure that the family is comfortable with having someone outside of their community into their home.

Coordination With Providers Across Services and Sectors
Coordination with all providers involved in a refugee family's life is important and necessary when delivering care in a medical home. Providers might include social work, parent mental and/or physical health providers, social services, WIC, etc. It is also critical that all providers take into consideration the impact of the family's experiences on their decisions, reactions, and emotional responses.

Photo: © istock/Brainsil

Well-child visits offer prime opportunities to support young children's physical, emotional, and social health.

After discussing the family's background with the provider and rest of the care team, the BHC met with the family. The HS specialist offered to enroll the family in the Healthy Steps for Young Children program (Barth, 2010), and they agreed to participate. The HS specialist began to develop a trusting relationship with the family in order to provide them with comprehensive services within the context of their medical home.

The HS specialist continued to see the family at Asad's second newborn visit and additional medical visits to monitor his weight over the next several weeks. The provider was concerned that Asad was not gaining weight quickly enough. The HS specialist learned more about the parents' refugee status, their exposure to civil war, and their time spent in refugee camps. Asad's mother's mental health history was also disclosed. His mother has struggled with posttraumatic stress disorder for many years and had been receiving psychiatric treatment from a community provider for several years. The HS specialist noted that connection to mental health services was a strength, especially considering the complex system of care that refugees must navigate in order to obtain such services. The parents also disclosed a history of infertility and feelings of exuberance over the birth of their new baby—another strength. However, their excitement was clouded by Asad's mother's "stabbing pain" and "weakness in the legs" that had been worsening since the delivery. Holding in mind (a) the pediatrician's urgent concern (Asad's poor weight gain) and (b) Asad's mother, who often choked back tears and grimaced in pain, the HS specialist was motivated to address both concerns in the context of medical visits. The family disclosed that they have not been successful in scheduling an appointment with the mother's physician, stating that the schedulers they had spoken with did not seem to appreciate their urgent concerns. Language barriers also seemed to be creating a challenge. During Asad's second newborn visit, the HS specialist worked with the live interpreter, provided by the hospital, to help the family schedule a same-day appointment with mother's physician.

Although the live, hospital-provided interpreter was helpful in coordinating care, the more nuanced parts of the discussion—interpretation of medical, cultural, and psychological themes—were often difficult for the parents, interpreter, provider, and the HS specialist to communicate with clarity. Phrases often needed to be repeated, rephrased, and clarified. For the HS specialist, who had worked extensively with interpreters in the past, the flow of communication of this visit felt especially complex. At a time when the need for careful communication is critically important, the HS specialist worried that this interpreter was incorrectly interpreting cultural themes. The interpreter oftentimes seemed disconnected in the room and did not appear to interpret what the parents were saying in full. When asked to provide cultural interpretations, the interpreter struggled with his role as cultural broker, causing many cultural nuances to feel unclear. Asad's parents seemed to rely more on their conversational use of English, but it made for less of an in-depth discussion. Above all, however, words were not needed for the HS specialist to begin to understand and connect with these first-time parents' mixed experiences: exuberance, somatic pain, and anxieties, all which punctuated the visit.

The conversation shifted to a discussion about how feeding was going. Again tearful, the mother explained that—despite previously working with lactation consultants—she was not producing enough milk and was mourning the loss of her expectation to breastfeed. The HS specialist helped the mother name this as a loss and empathized with the difficulty of having to feed and bond with the baby in a different way than planned. Both mother and father had many questions about how to bottle feed. They were unsure about what type of formula to buy and did not have a clear understanding about how to use WIC. Again, with the help of the interpreter and through communication with the WIC specialist, the HS specialist clarified that the family would have to return the breast pump provided by WIC in order to start receiving formula and helped them schedule a next-day visit with WIC. During a clinic visit, the HS specialist watched as the parents demonstrated mixing the formula and reassured them that they were doing it correctly. At each visit, Asad's parents thanked the HS specialist and provider profusely for their time and support. They were comfortable enough with conversational English that the interpreter did not need to translate the spoken good-byes. They often left the clinic smiling and nodding, suggesting increased parental confidence and competence about the next steps. The HS specialist reflected on a parallel process as she herself felt confident and competent in having provided Asad's pediatrician and parents with support during office visits and having connected the family to outside services.

In the weeks that followed, Asad, his family, and the interpreter returned to the clinic for regular weight checks. His parents started to show concerns about bowel movements and worried about constipation. They required multiple reassurances that his stooling patterns were typical and were coached about the frequency and amount of feedings as a priority for his healthy growth and development. Asad's physicians noted that his weight gain was less than optimal and required more frequent weight checks. With each weight check, the HS specialist spoke with the provider and the family, each time hearing concerns about constipation from the parents and concerns about weight gain from the pediatrician. At one point, Asad's mother shared her greatest worry with the HS specialist—that Asad's constipation was causing him terrible pain and that his stomach would "explode." The HS specialist wondered what the mother's fear that her baby's stomach would "explode" could mean for a woman who has experienced significant trauma in war, refugee camps, and moving and adapting to a new country. Both parents seemed increasingly worried with each visit. They did not understand why the doctors were not using medicine to fix the constipation and pain that their son was experiencing. The provider and HS specialist, with the help of the interpreter, tried to help the family understand the baby's condition as "fussiness." The parents insisted that Asad was constipated and were reluctant to explore soothing techniques, other than medication.

Meanwhile, the HS specialist consulted with the provider and learned that he was growing more and more concerned about Asad's poor weight gain. Thorough exams suggested that there were no physical reasons for his somewhat atypical stooling patterns. His poor weight gain was concerning but did not reach the level of requiring hospitalization. The resident confided in the HS specialist that of the many patients he followed, this was the only one who kept him up at night. He and the HS specialist wondered together about how the parents' concerns of constipation may have impacted how they fed him. Of the many worries that the parents expressed in the past, one was about the possibility of overfeeding Asad. The parents demonstrated an understanding of proper feeding techniques. Still, questions remained regarding how the parents' worries were impacting feeding at home and what might be getting lost in cultural and linguistic translation.

Over the next several weeks there was an increase in sick visits to the primary care clinic combined with almost weekly visits to the emergency room for concerns about constipation. Asad's mother presented as completely exhausted at clinic visits and the parents repeatedly asked for help—medicine for Asad and someone like a midwife to provide on-going respite. Asad's parents had limited social support because much of their family were separated and lived in other parts of the world. The HS specialist consulted with the clinic's social worker to determine if respite support was available. The parents rejected child care options and were resistant to participating in a home visiting program where a stranger would come to their home for an hour each week. They explicitly requested more intensive, round-the-clock care. The HS specialist and clinic social worker informed the family that, unfortunately, such services were not available to them. The HS specialist reflected on how this family, new to this country, may interpret the lack of support available to them as an unwillingness of the system to support them.

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Parenting a newborn is a challenge, especially when the child exhibits fussiness, poor weight gain, and feeding and/or voiding challenges.

In her capacity as an HS provider, the HS specialist considered the opportunity to plan a home visit with the family to further explore their experience of parenting. The HS specialist was aware that a home visit would not allow for interpreter services and thus would rely on Asad's parents' conversational use of English. The HS specialist suggested the home visit option to Asad's parents, explaining, and apologizing, that an interpreter would not be present, and they were agreeable. Although they were resistant to starting a new home visiting program with an unfamiliar provider in the community, they were more open to the idea of welcoming a familiar provider that they trusted into their home. The HS specialist considered carefully the benefits and risks of providing a home visit without the support of an interpreter and ultimately decided that the benefits to the family outweighed the risks. The family had become comfortable with her at their frequent visits in the clinic, and she believed that this relationship would help buffer language barriers.

At the home visit, the HS specialist first met with the father and Asad, as mother was on her way back from her own doctor's visit. The HS specialist used plain language and pictures to converse about Asad's development thus far, while the baby slept nearby. Through his conversational English, the father and the HS specialist were able to communicate. His beaming smile told it all as he discussed the couple's struggles with infertility and how Asad was an unexpected blessing for him and his wife. When Asad's mother returned she was smiling and seemed at ease in her own home. Her health had improved after more regular visits with her own doctors. She described enjoying being home with the baby—but that it was also hard work for her, as the baby kept her busy throughout the day (feeding, repositioning, changing diaper, sleeping). As the home visit concluded, the HS specialist reflected on relationship building,

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Working with refugee families necessitates coordinating care across systems, creating a community "village" that attends to the importance of building supportive relationships around children and families.

trust, continuity, and the importance of using humor to break down linguistic and cultural barriers.

Several weeks later the family continued to express concern about constipation and reported an increase in crying from Asad. The HS specialist offered to do another home visit, this time with a specific focus on the fussiness. Again, this visit was conducted without an interpreter. The atmosphere of this visit was much less positive than the first. The mother could not look at Asad and held intense worry all over her face. The mother was clearly overwhelmed by her role as a new mother and was not confident in her ability to meet Asad's needs by herself. The HS specialist explored maternal mental health during this visit and learned more about Asad's mother's psychiatrist. Mother smiled as she disclosed details of her long-term work with this psychiatrist, a professional highly respected by both parents. The HS specialist suggested future communication with the psychiatrist for care coordination and the parents agreed. The HS specialist obtained a release of information at a later clinic visit when an interpreter was present. At the end of this home visit the HS specialist reflected on the feelings of worry and the look of terror in mother's eyes whenever Asad became fussy. The HS specialist wondered about a history of loss and how crying may have triggered past experiences.

The HS specialist reached out to Asad's mother's psychiatrist and learned more about her history; exposure to trauma, isolation from her community, and chronic somatic complaints. They discussed the potential benefit of connecting Asad and his mother with a dyadic therapist who could support the mother with connecting with her infant in supportive and nurturing ways. In addition, the HS specialist and the psychiatrist discussed challenges with interpretation for this family. The psychiatrist shared information about the interpreter she used when meeting with Asad's mother. The HS specialist reached out to the hospital's interpretation services and the director was very invested in making sure this family had access to an interpreter who would adequately interpret sensitive and critical conversations in the context of Asad's medical visits. They were able to work together to request that the same interpreter the mother used for her psychiatry appointments would also attend Asad's visits in the pediatric clinic.

In the weeks and months that followed, Asad's visits to the clinic appropriately reduced. Both parents' anxiety about constipation had decreased, and they were feeling more confident as new parents. This change was likely due to support from the mother's therapist and the HS specialist working with the family. He and his parents arrived for his 4-month well-child visit and the parents were visibly more relaxed and engaged with Asad. His parents attributed these improvements to his mother's increased psychotropic medications, less constipation, HS specialist home visits, and visits from out-of town relatives. The interpreter the family had used at mother's psychiatrist appointments accompanied them to these clinic visits—an interpreter who appropriately communicated medical information to the family and helped the medical providers decode cultural nuances of the family's questions and concerns. The HS specialist continued to work on arranging dyadic treatment for Asad and his mother (using appropriate interpretation services so that treatment can occur in her preferred language), knowing that her trauma history will likely impact her relationship with Asad as he continues to grow and develop. The HS specialist continued to support the family and build a trusting relationship, keeping in mind their complex history. She also provided support to the medical home and to residents and attending physicians who provided medical care for Asad, emphasizing the importance of using a trauma-informed lens to provide care while always considering their refugee status and immigration history.

Conclusion

Asad and his parents' experiences are not unique. This story describes a refugee family attempting to parent their first child in the context of an incredibly complex psychosocial environment: history of trauma, mental illness, current disparities, and community isolation. Parenting a newborn is a challenge, especially when the child exhibits fussiness, poor weight gain, and feeding and/or voiding challenges. Parenting as a refugee presents a host of additional challenges that may amplify struggles that first-time parents may experience. Some of these challenges may include, but are not limited to, a history of previous trauma and loss, minimal resources for obtaining supports, isolation from family and country of origin, barriers to relying on family supports, and acculturation. Therefore, it is essential to surround refugee families with support that is comprehensive, culturally informed and responsive, family-centered, community-based, and accessible.

Pediatric primary care is an optimal setting for offering support to refugee families in a trusted environment. Although refugee families may need to access care and services from many different agencies and organizations, primary care settings can help coordinate services and facilitate navigation of a complex system of care. In addition, primary care settings with integrated early childhood BHCs are uniquely suited to serve as a medical home (Talmi et al., 2009). As was the case with Asad's

family, BHCs can spend additional time with a family during clinic visits, uncovering important components of their history that will certainly impact parenting. Further, the Healthy Steps for Young Children program (Barth, 2010; Buchholz & Talmi, 2012) takes a strength-based, health promotion approach, which is especially helpful to families who are marginalized, isolated, and lack access to care. The infant mental health approach is inherently culturally sensitive (St. John, Thomas, & Noroña, 2012) and can provide a framework for cultural responsiveness with refugee families.

Numerous themes emerge when working with refugee families: coordination with medical providers, language and interpretation, parallel processes, somatic complaints, meeting families in their homes, and coordination across services and sectors, to name a few. It is critical to serve these families in the context of their communities while keeping in mind complex past experiences, present challenges, and future plans. It is easy for providers to become overwhelmed with the complexity of serving refugee families, yet it is also important to be mindful of the many strengths and resilience factors that families possess. Resiliency was certainly a factor with Asad's family, and this was critical to keep in mind as "the village" worked together to provide high-quality care and to promote Asad's growth and development in the context of his family.

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Learn More

Websites

Healthy Steps for Young Children
www.healthysteps.org

EthnoMed: Integrating Cultural Information Into Clinical Practice
www.ethnomed.org

Centers for Disease Control and Prevention
Guidelines for Mental Health Screening During the Domestic Medical Examination for Newly Arrived Refugees
www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html

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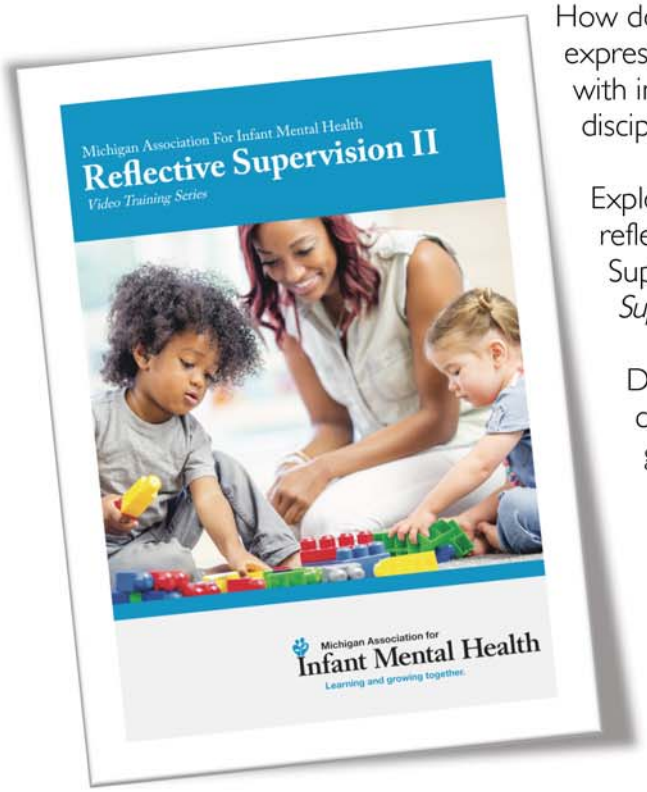

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Meaningful Change for Children in Foster Care

Much More Than Just Reunification

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Abstract
The youngest children in foster care suffer disproportionately. The Adoption and Safe Families Act (1997) attempted to provide greater safeguards for children, which led courts to push for earlier reunifications between foster children and their biological families. Although no one wants young children to languish in the foster care system, early reunification is not always beneficial to the children or their families, particularly when families receive little support. Reunifications should ideally occur only after the family has demonstrated growth and the ability to successfully meet their child's physical and emotional needs. Effective family support entails addressing the caregivers' own trauma and supporting them to make meaningful change.

The development of early childhood courts, also known as "Baby Court" has been a much-needed improvement in the child welfare system for families with the youngest children (Klain et al., 2009; Lederman & Osofsky, 2008; ZERO TO THREE, n.d.). Dependency court judges became discouraged after watching children progress through the foster care system only to see these children return to the same courts years later, having had their own children come to the attention of child welfare. In response, groundbreaking work to help young children in foster care and their families was done more than a decade ago (Katz, Lederman, & Osofsky, 2010; Osofsky et al., 2007) that influenced the development of the Safe Babies Court Teams (ZERO TO THREE, n.d.). Early research on Safe Babies Court Teams has been promising, showing that young children can return home safely without languishing in foster care (James Bell Associates, 2009; McCombs-Thornton, 2012). Further, young children can remain in their homes with caregivers who through intensive work have learned not only how to protect their children, but also how to meet their physical and emotional needs. When biological parents cannot remediate their deficits to adequately meet their children's needs, children are adopted by relative or non-relative foster parents who have demonstrated an adequate attachment relationship and the ability to meet the children's needs so that they are not returned to foster care.

Baby Court teams typically involve an infant mental health team; child protection caseworkers; a community coordinator; attorneys for the child, parent, and state; Court Appointed Special Advocates (CASA) or Guardian ad Litem (GAL); and other relevant service providers such as domestic violence counselors or substance abuse counselors. These teams work in a designated court with a judge who is willing to make substantive changes in processing and providing hearings for young child cases. While each Baby Court team differs in its execution of cases, the teams share common components. Judges hold the hearings for these cases each month or every other month, the multidisciplinary team meets prior to the case hearing to share information toward treatment goals and case progression, the team is much more collaborative versus adversarial in helping families work toward treatment and case goals, there is a strong emphasis on decreasing the number of foster care placements, and there is a focus on addressing all of the family's needs in a more timely fashion to minimize the amount of time the child spends in limbo.

Work with Baby Courts has encouraged shorter timelines to permanency, reduced number of placements, lessening chances of disrupted attachment, and greater percentages of timely reunifications and/or adoptions signaling true permanency for the young child (Dickson, Many, & Osofsky, 2014;

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The early research on Safe Babies Court Teams has been promising, showing that young children can return home safely without languishing in foster care.

James Bell Associates, 2009; McCombs-Thornton, 2012). The work of the Louisiana State University Health Sciences Center Infant Team over more than a decade has indicated that parents can make dramatic and substantive positive changes in their own lives that are worth noting and celebrating whether the parent successfully reunifies or chooses to surrender. In some situations, the parents are able to realize that they are not yet ready to fully care for another as they are still learning how to care for themselves.

The following example demonstrates one parent's struggle. While those who work in foster care with young children will find this story is reminiscent of many that they may have seen, there are so many other variations in these experiences that need to be documented and shared. This descriptive work will not only serve to support one another as clinicians who engage in this demanding and emotional work with such high-stakes outcomes, but also highlight the positive role Baby Court can make in the lives of parents and their young children.

Sam's Story

Sam came to the attention of child protection when police alerted them that Sam had been found unattended in a public playground. Witnesses became alarmed when he was soiled, engaging in semi-dangerous play, and was seemingly unsupervised. Sam, who was 2 years old at the time, could not give his full name. Subsequent news alerts did not result in any parent claiming him so he was placed into a non-relative foster home. Two days later, his tearful mother, Sara, presented to the police to claim her son. Having no plausible explanation for taking 2 days to claim him, Sara was incarcerated for child desertion and was thus separated from her son for several more weeks.

Sam entered into a new foster home of a young single foster mother and her roommate. The foster mother had significant child development knowledge and a strong family support system consisting of her roommate, mother, and sisters, though she was new to caring for a child herself. She was enamored with Sam, who was physically adorable and generally developmentally on track. Sam quickly adapted the routine of his new family and his new day care, and he did not present any obvious or pressing concerns. Although she missed him greatly, Sam's mother did not want him brought to prison to visit her there.

Sara arrived to begin her work with the Orleans Parish Infant Team after her release from prison, which entailed a separation from her son for a total of 6 weeks. Her initial interview revealed a very remorseful woman of higher than average intelligence who openly worried about what her son must be thinking and how he must be experiencing the abrupt separation and his new home. As she spoke in great detail about their life together prior to foster care, the clinician began to suspect Sara was depressed and that there was more to the story of how a loving mother could leave her son for 2 days without claiming him. Sara had clearly been Sam's primary caregiver, was able to detail much of his young life, and expressed her deep connection and commitment to her son.

This interview in no way prepared the clinician for the parent-child observation session. Sam's foster grandmother ("Nana") brought him to his first session. Sam was well-groomed and happy upon arrival. He obviously adored his foster grandmother and enjoyed her company. Sara was waiting in the playroom anxious to start their evaluation, having come early to prepare. From the moment Sam entered the room with his mother, he was near inconsolable. He cried endlessly, approaching the treatment room door repeatedly, throwing himself on the floor, wailing, desperate to return to Nana. Sara, to her credit, was clearly distraught at her son's reaction, but stayed calm and tried one thing after another to soothe him. She tried to hold him and sing to him, she removed his jacket, and tried to interest Sam in various toys, all to no avail. Given that Sara and Sam had already experienced a few visits at the child protection office, the clinician was unprepared for Sam's level of distress. After it was clear that Sam was not going to calm down, the clinician entered the room to end the evaluation. The clinician was able to soothe Sam fairly quickly even though she was a relative stranger to him. He preferred to be in her arms, perhaps anticipating that she would carry him out the door. Sara, surprisingly, asked to continue the evaluation as she did not want anything to delay her case moving forward and she wanted to be with her son. After the clinician stayed in the room for a bit, Sam was calm enough to proceed. Therefore, the evaluation was completed, although Sam remained wary and continued to display his distress at times.

The child protection caseworker was immediately contacted after the dyadic evaluation session, at which time she revealed that visits between Sara and Sam had proceeded similarly at her office. She added that she had to remain in the room during visits in order for Sam to be calm and be able to stay through the visit with his mother. The caseworker was given tips on how to help the child with his distress in the sessions and educated to contact the clinician the next time that happened. Treatment was initiated and it took Sam some time to gain comfort in the company of his mother; however he

was comforted by the presence of the clinician. Even though Sara was hurt by Sam's reaction to her, she was understanding and followed the clinician's guidance to take Sam's lead. Sara quickly learned to approach only when Sam invited her, as he slowly re-established some security with her in the room. Individual treatment with Sara was also a necessary component of the treatment, and Sara and her clinician began to explore her lifestyle prior to her son's removal. Sara and the clinician processed contributing factors to Sam's abandonment and removal and what feelings and circumstances may be causing Sam's current distress. At the same time, Sam's foster mother contacted the clinician with new concerns. Although Sam had been doing well initially in her home, when he started having regular visits with his mother he began having severe night terrors several times a night. Suddenly, Sam did not want to leave his foster home except to go to school and immediately wanted to return home right after school. Upon his arrival home from school, he would enter the foster home and begin labeling, "Sam's truck, Sam's bed, Sam's house", and so on. Sam's foster mother, who worked full time, was exhausted and understandably concerned by her foster son's sudden behavior change.

Just as Sam needed time to regain trust with Sara, Sara needed time to trust the clinician. Over time, the picture of Sara and Sam's reportedly untroubled life together prior to child protection involvement became more complicated and complex. As the clinician demonstrated Sara would not be judged and any information disclosed was simply to better understand how to help improve matters for her and her son, Sara began to reveal a more realistic picture of their life together. Sara had many strengths. She was bright and capable of having employment, housing, and family support. She reported that she had friends, raised children before, and could read her son's physical and emotional cues well. In time, it was learned that she had not finished college, she did not last in jobs, she strongly did not want her son going to her parents out of town, and none of her reported friends who saw Sam on the news went to retrieve him. These truths were painfully uncovered through gentle exploration. Sara eventually revealed a history of incest that she had heavily buried and was not sure she wanted to explore. Her first husband was violent, and she did not know the identity of Sam's father. Sara was a binge alcoholic whose lifestyle was, as a result, a transient one.

To Sara's immense credit, she began to take ownership of her issues when her clinician repeatedly discussed that her alcoholism is what brought her son into care and that if she could prove to the judge that she could abstain from drinking, then she would likely get Sam back. Sara was able to acknowledge that when drinking she had no idea what Sam experienced and hence why her presence frightened him so. Sara understood why Sam liked the stability of his foster home. With help, she was able to admit he was being given excellent care, and she was able to eventually communicate more openly with Sam's foster mother and family to learn about Sam's new routines, likes and dislikes, and how to work together so Sam felt safer with both her and the extended foster family. Sara was able to become sober, went to Alcoholics Anonymous meetings, obtained a sponsor, and worked on her triggers, finding more stable and suitable support. For the first time in her life, she acknowledged her alcoholism and began to process her incest, her childhood, and how her childhood traumas impacted her in the present and in the choices she made. Sara's strengths were emphasized, and she was routinely praised for the hard work she put forth.

The greatest reward, however, was the developing relationship between Sam and Sara as Sam began to trust his mother. Whether it was again or for the first time is unknown, but Sam began to look forward to seeing her. Sara attended weekly Child-Parent Psychotherapy sessions in addition to her individual therapy with the same clinician in addition to her visits with Sam at the child protection office. In the dyadic therapy, the clinician openly discussed Sam's trauma of having been left alone and not seeing his mother for some time. Sam, who was just learning to talk, listened a great deal, particularly when his mother spoke of how sorry she was for not being there for him and that she would make sure that never happened again. Sam's play changed as the sessions continued as his play themes became more nurturing, the animals less aggressive and more prosocial, and eventually Sara was allowed to care for the animals as well and make them feel better. Sam began including her in his play; their play was nurturing, symbolic, sustained, and enjoyable to them both. In initial sessions, Sam could be triggered into a large tantrum for undetected reasons, but Sara listened to the clinician and worked to give Sam his space and let him know she was available when he was ready. Sam would often choose to hide to help regulate himself. The clinician taught Sara to test when she thought her son was ready to accept her comfort or to interact again. For example, if the car she rolled into the tent to Sam was thrown out, he wasn't ready. If it was rolled back, it was time to engage again. Sam's tantrums stopped. Sam's night terrors stopped. Sam stopped labeling all of his items. At the clinician's request, Sam began spending longer and longer amounts of time with Sara in the community and at her home.

The clinician began to address the foster mother's impending sense of loss as she could see that Sam was likely to reunify with Sara.

While completing dyadic work with Sara and Sam, the clinician was also simultaneously working with the foster mother regarding Sam's night terrors and his anxiety and how to best help him during this confusing and possibly scary time. The clinician gave the foster mother a safe place to address her anxieties about Sam, whom she had hoped to adopt. As the child-parent sessions improved, the clinician began to address the foster mother's impending sense of loss as she could see that Sam was likely to reunify with Sara. It was clear that her sadness would impact Sam and his sense of whether his relationship with Sara was acceptable. Sam's foster mother and Sara were encouraged to spend time together with Sam.

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Work with Baby Courts has encouraged shorter timelines to permanency, reduced number of placements, lessening chances of disrupted attachment, and greater percentages of timely reunifications and/or adoptions signaling true permanency for the young child.

This suggestion was initially begrudgingly accepted by both parties, but then sessions became more frequent as they were mutually beneficial to all. Sam's foster mother and her family became part of the healthier new support system and they felt more at ease knowing Sara was doing better and hence more capable of providing for Sam's needs. Sam's family grew. Sam was reunified with his mother, and he and Sara continued to make important gains during the monitoring period. Sara had worked through much of her violent relationship with her past husband, with whom she was still in contact given the shared custody of their two children, but she had not fully worked through her childhood sexual abuse. As she demonstrated she was able to protect Sam and had remediated what brought him into care, Sara's inability to process her childhood traumas was not going to prevent Sam from returning home. Sara had begun to process the trauma and how it impacted her parenting of Sam, and she conveyed her understanding of how important it was for her well-being to continue the treatment when she was ready.

This story shows how the efforts of the Baby Court team can make a difference. What would have happened to Sam if Sara had shown she was sober for a month and he was given back to her without any other assistance? How did the monthly court hearings help this mother? Why did she need to talk about her past? Sara achieved her goal of getting Sam back, but what other accomplishments did Sara make?

Reflection on Building Meaningful Capacities

Sara's story is just one of thousands that are brought to the attention of the child welfare system each year. Fortunately, Sara lived in an area that used the expertise of a Baby Court team and without their help, Sara would have likely been able to maintain sobriety for a short time in order to regain custody of her son. However, experts understand the danger of a espousing such simplistic thinking, knowing the likelihood for recidivism, and endangering the child yet again would be great. Sara needed not only to establish sobriety, but needed many other supports to maintain her sobriety and reduce the likelihood her son would enter the child welfare system again, which might have resulted in her losing him permanently. In this case example, monthly court hearings gave Sara structure and accountability to the court. In addition, not unlike many mothers in Baby Court, Sara had an upbringing riddled with long-standing, complex trauma that impaired her ability to consistently function appropriately and provide the best support for her son. Merely addressing and treating the negative outcomes of such trauma only masks the symptoms of the underlying issues (Osofsky, 2009). Without addressing Sara's childhood trauma and domestic violence, she would lack the perspective needed to work through the issues keeping her from providing a stable home for her and her son. In Sara's case, she was able to gain this perspective as she was able to process her prior experiences and work through her troubled past and the decisions leading to the current child welfare encounter. Addressing Sara's trauma also brought to light her many strengths, and Sara and the clinician together were able to capitalize and build upon Sara's capacity as a bright, consistent, loving caretaker for her son. Because she was able to talk about her past, Sara was able to draw connections about how her parenting was impacted by her past, and she was able to make multiple, substantial gains in an effort to provide a more consistent life for her son. She was also able to build a healthy and reliable support system for the first time in her life. Only through gentle reflection and support was Sara able to work through her denial that she was previously functioning well and caring for her children adequately.

This complex example illustrates the importance of taking a multifaceted Baby Court approach when working with multiple, complex, and pervasive traumas that all too often encumber the parents of the youngest children in the welfare system. Sara and the foster mother both needed guidance on how to manage Sam's challenging behaviors and how to read his cues as Sam had processed much of his trauma nonverbally and thus expressed himself in the ways he knew how. Sam's foster mother also needed assistance in processing her feelings as she had to relinquish this loved child back to his mother. The foster mother's ability to process her worries and her feelings of loss helped her to better support Sara and Sam's developing relationship instead of impeding it. The infant mental health team was also able to advocate for Sara's hard work in court and to help convince the court that Sara was ready for more time with her son to prove that she could care for him adequately. The team also supported a graduated transition home so Sara could learn what would be challenging and where she needed more assistance or changes to better support their new life together. The team then recommended a brief monitoring period to be able to continue to support Sara and Sam as they lived together full-time and provide any assistance needed while also monitoring that Sara stayed sober. In her treatment with the team, Sara had worked on safety plans should she have a relapse and need greater support so Sam would not

be offended upon or left unsupervised again. By the time Sam and Sara were reunified and the court was ready to exit their lives, the entire team felt better about their new start. Sara had proved her sobriety while parenting, she could verbalize better coping skills, and she presented a new awareness of how her past could trigger her to make mistakes in the present. Sara knew what those mistakes would cost Sam, and she now fully understood her son's needs as well as her own. Sara's journey was just starting, but it was off on better footing. The multifaceted Baby Court team approach allowed the complex circumstances leading up to Sara's involvement with child welfare to be a focus of treatment in order to build meaningful, long-term gains both within herself and in the relationship with her son.

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Early Intervention for Families Exposed to Chronic Stress and Trauma

The Attachment Vitamins Program

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Abstract
This article describes the Attachment Vitamins program, a trauma-informed parent group intervention for families with young children. Attachment Vitamins is a relational psychoeducational intervention based on the principles of Child-Parent Psychotherapy (CPP). Its goal is to repair the impact of chronic stress and trauma through strengthening the child-parent relationship. The authors discuss the history, development, and implementation of the intervention, made possible through a collaborative research and development platform. Two vignettes are presented to highlight unique aspects of the program. Attachment Vitamins is a promising new intervention with the potential to improve outcomes for vulnerable young children and their families on a large scale.

Life with a young child is an enriching and rewarding experience. Babies and young children live in the moment, sharing joy and a sense of wonder about everyday things that adults often take for granted. Nevertheless, becoming a parent marks an enormous shift in the adult's life. A new baby means new responsibilities and priorities—putting the infant's needs and wants over one's own. And as children move from infancy into toddlerhood, new parenting challenges emerge. Toddlers develop personal will alongside of a budding desire for independence. They are often driven by impulse, curiosity, and the need for instant gratification (Lieberman, 1993). These tendencies result in behaviors that parents can find difficult to manage. Parents and caregivers[1] commonly struggle with setting limits and may find themselves at a loss for why their child is upset and how to resolve the problem.

Raising a young child is therefore challenging for any parent, even with a stable life situation including support from a parenting partner or other family members. Consider the additional effects of chronic stress and trauma. Such experiences amplify the challenge of raising a well-adjusted child. In addition, when a young child experiences frequent and prolonged activation of the stress response system as a result of trauma and adversity it can result in a "toxic stress response" (Shonkoff et al., 2012), particularly when parents are physically or emotionally unavailable to provide adequate support. The

1 The terms parents and caregivers will be used interchangeably in this article, and refer to the primary caretakers of the child.

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Babies and young children live in the moment, sharing joy and a sense of wonder about everyday things that adults often take for granted.

toxic stress response disrupts a child's developing nervous system and physiological functioning, resulting in lifelong consequences. Intervention and support for families following identification of early life stress and trauma are therefore critical. In the following vignette, we describe Sara and James (names changed for privacy), the parents of three young children who were referred for family support services because of chronic stress and trauma.

> *Sara, 25, and her fiancé James, 26, were referred to the Attachment Vitamins Program by their Children's Administration social worker. Sara's children, who at the time were 18 months, 4 years, and 6 years old, were transitioning out of foster care and back home. Although James is not the children's biological father, he was committed to co-parenting the children with Sara. Sara and James were completing outpatient drug treatment, starting new jobs, searching for housing, and trying to recover from significant family trauma. Sara's 6-year-old daughter had been molested by the father of Sara's 18-month-old son, something Sara continued to feel painful guilt about; she herself had been abused in childhood. Sara and James were busy, stressed, and exhausted. Despite wanting to do everything they could to help their children, they felt overwhelmed.*

This article will discuss the development and implementation of Attachment Vitamins, a group intervention program for families with children under 6 years old. Sara and James were participants in Attachment Vitamins, and we will use their story throughout the article to illustrate how the intervention was helpful for them. Attachment Vitamins is based on the principles of Child-Parent Psychotherapy (CPP; Lieberman, Ghosh Ippen, & Van Horn, 2015; Lieberman & Van Horn, 2005, 2008), an empirically supported therapy for young children who are experiencing or are at risk for mental health problems following exposure to trauma and other adversities. The overarching goal of Attachment Vitamins is to address and repair the impact of chronic stress and trauma on the family unit, through strengthening the child-parent relationship. The program builds parental emotional attunement to the ways that stress and trauma have affected the child's feelings and behaviors. At the same time, it helps parents become aware of how stress and trauma have affected their own perceptions, feelings, and responses to the child.

The development of the Attachment Vitamins program came about as the result of a collaborative opportunity facilitated by the Frontiers of Innovation (FOI) initiative at the Harvard Center on the Developing Child. In addition to discussing the intervention, this article will describe the partnership with FOI in order to share insights about a unique research and development (R&D) platform for promising new interventions.

Partnerships Leading to the Development of Attachment Vitamins

In 2011, Washington State partnered with the Harvard Center on the Developing Child to seek ways to translate the growing science of early childhood development into effective policies and practices for the state's most vulnerable children and families. Through the Center's FOI initiative, researchers, early childhood practitioners, policymakers, and philanthropists were invited to work together to identify unmet needs and foster science-based strategies to transform outcomes for this population. Since then, several interventions including Attachment Vitamins have been generated and tested through FOI's R&D platform involving multiple, fast-cycle microtrials. The fast-cycle process of testing and re-testing on a small scale allows for continuous feedback to strengthen interventions.

The University of California, San Francisco (UCSF) Child Trauma Research Program joined FOI due to its expertise in trauma. The Child Trauma Research Program is nationally recognized for CPP (Lieberman et al., 2015; Lieberman & Van Horn, 2005, 2008), a dyadic trauma therapy that includes the caregiver in treatment with the young child. CPP is a relationship-based approach with theoretical underpinnings in attachment theory. Attachment is the close emotional bond between parent and child that promotes protection and survival of the child (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1982). CPP is based on the premise that healthy emotional, social, and cognitive functioning in the child is supported through the relationship with the child's primary attachment figures. In the presence of stress and trauma, the child's sense of security is shaken, which increases risk for mental health problems such as posttraumatic stress disorder and anxiety. Parental well-being can be equally affected, undermining the parent's availability to provide emotional support to the child at a difficult time. One of the major goals of CPP is to support and strengthen the child-parent relationship in order to restore the child's sense of safety and improve mental health functioning. An important task of CPP is to help the parent and child process the traumatic experience through the creation of a trauma narrative. Using play as a medium, the dyad gives voice to the trauma. This therapeutic technique helps them identify

overwhelming emotions such as fear, grief, and anger, and learn how to experience and modulate them appropriately. The experience of trauma can be shameful and difficult to talk about. By speaking about what seems unspeakable, CPP allows for healing to take place.

CPP has extensive empirical support, demonstrating its effectiveness in helping families of young children overcome the effects of trauma. Samples of high-risk dyads have included toddlers of depressed mothers, anxiously attached toddlers of impoverished Latina mothers with trauma exposure, maltreated preschoolers in the child protection system, and preschoolers exposed to domestic violence (Cicchetti, Rogosch, & Toth, 2006; Cicchetti, Toth, & Rogosch, 1999; Lieberman, Ghosh Ippen, & Marans, 2009; Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Weston, & Pawl, 1991; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002; Toth, Rogosch, Manly, & Cicchetti, 2006). Across studies, findings have consistently shown that CPP results in reduced child and maternal symptoms; more positive child attributions of parents, themselves, and their relationships; improvements in attachment security; and improvements in child cognitive functioning.

Although CPP is an effective treatment for young children who have been exposed to chronic stress and trauma, the UCSF Child Trauma Research Program was interested in developing a complementary, less resource-intensive model that could improve outcomes for vulnerable children and families on a larger scale. By making CPP strategies more accessible, they also hoped that families who required more intensive intervention would be motivated to enroll in CPP or other needed mental health services.

At the same time, Children's Home Society of Washington (CHSW), another FOI partner, was interested in finding new ways to support vulnerable families. CHSW is Washington's largest and oldest nonprofit organization for families, providing services such as home visiting, mental and behavioral health, and early learning. The population CHSW serves is highly diverse and primarily low-income, with significant histories of adversity and trauma. A series of discussions between the UCSF team and CHSW led to an idea for a curriculum delivered by home visitors that would emphasize ways to strengthen the child-parent attachment relationship while raising awareness of the effects of chronic stress and trauma and encouraging engagement in therapeutic services. The central idea—that healthy attachment serves as a protective influence just as vitamins promote healthy development—inspired the name "Attachment Vitamins."

Attachment Vitamins was introduced as a curriculum composed of short 20-minute modules to be incorporated into the existing 90-minute home visiting sessions. Although the modules were meant to promote interactive discussions between home visitor and parent, the short amount of time in which home visitors implemented the intervention (in the context of other home visiting requirements) had the unintentional consequence of a delivery that was didactic in nature.

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In the presence of stress and trauma, the child's sense of security is shaken, which increases risk for mental health problems such as posttraumatic stress disorder and anxiety.

The UCSF team believed that a parent group setting would be a more optimal environment for Attachment Vitamins. Centralia College, another FOI partner based in Centralia, WA, agreed to have the UCSF team adapt Attachment Vitamins as a group model for their parent education program. This proved to be a successful delivery method; parents benefited from the social support they found within the Attachment Vitamins groups and were able to engage with the material in a much more interactive, reflective way. Following this pilot, Attachment Vitamins returned to CHSW, finding a home within its Vancouver, WA, site, where Sara and James receive services.

The Attachment Vitamins Group Intervention Model

The first time the Attachment Vitamins facilitators met Sara and James, it was clear that they did not want to be in the class. They did their best to avoid eye contact with the facilitators and other parents. When welcomed, they responded politely, but coldly. It was evident that this was not their first service referral and that they were completely prepared for another professional to tell them everything they were doing wrong.

The facilitators wanted to set a tone that would help parents feel safe to share and learn. The first question asked of parents is, "Tell me what you love most about your child." It is an instant wall dropper, and for the facilitators it is the first glimpse of the magic they witness during the Attachment Vitamins group. There is intentionality in this question. By asking parents what they love most about their child, the facilitators tell parents that they assume they are in fact loving parents and that the love they have for their child has dimensions and layers. It is a strength-based approach that places the focus on the parent's primary motivation for the class—the relationship with the child.

Photo: © istock/szefei

Healthy attachment serves as a protective influence just as vitamins promote healthy development.

As Sara and James shared what they love about each of their three children, their body language entirely changed. They completely lit up. They transitioned from being slumped in their chairs, arms crossed, legs extended, eyes down, to sitting up, legs unfolded, smiling, and making eye contact. In the first session, Sara and James learned about attachment and how to strengthen their relationships with their children through developing mindfulness about small daily moments of connection. Facilitators also normalized the challenges of parenting a young child, which helped them feel comfortable to share about what was difficult as well. At the end of the first session, Sara approached the facilitator and said, "I won't lie, I didn't want to be here today—but I can tell this is going to help us so much." Sara and James attended every Attachment Vitamins session but one, showing up even on days that they were recovering from terrible colds.

Attachment Vitamins is a 10-week psychoeducation group, designed for parents of children from birth to 5 years old. It provides a supportive environment in which caregivers can learn about early childhood development and the effects of chronic stress and trauma in order to help them attune to their child's needs, set parenting goals, strengthen the attachment relationship, and understand and respond to challenging behaviors. The group is highly interactive, and it encourages parents to engage in a process of active reflection on their relationship with their children and on their own experiences while growing up.

The curriculum aims to increase a number of caregiver skills and capacities:

- **Trauma-Informed Parenting Knowledge.** Attachment Vitamins contains general information about early childhood emotional development, including what to expect during the infancy, toddlerhood, and preschool years. The curriculum is trauma-informed and specifically addresses the effects of chronic stress and trauma on young children and their parents. By building awareness about how stress and trauma affect the child's feelings and behaviors as well as the parent's own perceptions, feelings, and responses to the child, the program helps parents reframe their understanding of challenging child behaviors. Parents find new ways to interact with their children.
- **Emotional Attunement.** One of the main goals of the program is to increase parental awareness of and attunement to the emotional needs of the child. Emotional attunement to the child's traumatic stress responses as manifested in dysregulated behavior is a core focus of the intervention. Parents learn to respond in empathic, sensitive ways when their children express distress or frustration, and they become knowledgeable about the possible roots of these emotional expressions in the child's experience of stress and trauma. They also become more mindful of positive interactions with the child and develop ways to enhance the quality of the attachment relationship.
- **Mindfulness.** The program emphasizes a mindful awareness of the present moment, particularly with regard to positive parent-child interactions. One way this is done is through a weekly exercise in which parents share "moments of connection" with the child. This exercise is designed to help caregivers better attend to the strengths of the child-parent relationship. The curriculum also includes exercises such as mindful breathing and guided imagery to assist participants in bringing awareness to their inner states.
- **Executive Functioning.** The program provides parents with emotion monitoring and regulation skills, including cognitive reframing, relaxation techniques for stress management, and strategies for managing anxiety and frustration in the child.
- **Reflective Functioning.** In addition to teaching specific parenting strategies and skills, the program is designed to provide a space for caregivers to reflect deeply on their parenting experiences. By increasing reflective functioning, parents can become more intentional in their exploration and setting of parenting goals.

Topics discussed within the program include: normative developmental milestones, temperament, understanding and responding to fears that emerge in early childhood (e.g., separation anxiety, the toddler's fear of losing parent love), the impact of chronic stress and trauma on individual functioning as well as the child-parent relationship, developmentally informed parenting strategies for challenging behaviors, and ways to strengthen the relationship—particularly when facing adversity. The curriculum incorporates reflective discussions, handouts, worksheets, video, and an early literacy activity with children's books that emphasize weekly themes.

The curriculum moves in chronological order, starting with infant development then moving to the toddler/preschool years. Whether a participant has a baby or a 4-year-old, the

group model allows for parents to learn from one another's experiences, sharing both successes and concerns. As parents develop comfort and cohesion with each other, more deeply reflective sessions on trauma, toxic stress, and a consideration of their own childhoods are introduced.

Attachment Vitamins is designed to be led by two facilitators (i.e., lead/assistant facilitator or joint co-facilitators). Facilitators for Attachment Vitamins groups to date have been either licensed mental health clinicians or otherwise highly skilled in leading parent psychoeducational groups. Because Attachment Vitamins is a trauma-informed curriculum with a major emphasis on self-reflection, parents often share experiences that require delicate handling and support. For those sites with facilitators who are not clinicians, a licensed mental health clinician has provided regular on-site consultation.

Program Highlight: Moments of Connection

Every week, parents are asked to share a "moment of connection" with the child. It is notable that at the start of Attachment Vitamins, many parents make broad statements about the child's abilities such as, "It was fun to watch my daughter play soccer, she was really good at it." Facilitators help scaffold parents to think of specific times they felt emotionally connected to their child and ask them to describe those feelings, moving them toward such statements as, "Yesterday, my baby looked at me and smiled when she stood up; she wanted me to see it! I felt so proud and connected to her." This exercise helps parents to develop a mindful awareness of the strength of their existing relationship with the child while also encouraging them to develop additional opportunities for connection.

Attachment Vitamins provides a supportive environment in which caregivers can learn about early childhood development and the effects of chronic stress and trauma.

After a discussion of the effects of trauma on the family, Sara shared a powerful moment of connection. She spoke about a moment in which she and her 6-year-old daughter were sitting on their couch at home talking about their day. Her daughter paused and said "Mom, you know how we have pictures of Charlie up in the house? I know that he's Brian's dad… but… he really hurt me and I don't like seeing his pictures. Can we take them down?" Sara told the group how proud she was of her daughter for being willing to ask for this support, and she shared her embarrassment that she didn't realize to take the pictures down on her own.

Sara then recalled a specific memory of her own mother not being capable of support when she was being hurt as a child, and the feelings of loneliness, isolation, and fear that followed. Sara cried with the group as she talked about how proud she was for being able to be present with her daughter in that moment. She recognized her daughter's willingness to seek connection with her, trusting that she would be supportive, as a triumph. She said "I haven't had that with her in a really long time… I didn't know that I'd ever be able to have that with her again."

The next week, Sara shared another powerful moment of connection. She had left her daughters' room after putting them to bed and heard the younger one ask the older one if she had a flashlight. The older one recognized the tone in her sister's voice and the need for a flashlight as a sign that she was feeling nervous. Sara paused, about to re-enter the room, when she heard her older daughter say to her younger sister, "It's okay now. We don't have to be afraid anymore. Mom will keep us safe."

Sara attributed this shift in her children's ability and willingness to trust her to the skills she learned in Attachment Vitamins. At the end of the group session, parents are asked through a written exercise to reflect on their childhoods and consider what aspects they appreciated and what aspects they wish were different, and how they might parent their own children with this in mind. Sara chose to share her hope that she would be different from her own mother. She would be a mother who nurtured, cared, and was emotionally present for her children as they continued healing from trauma.

As Sara and James found, the Attachment Vitamins group offers an opportunity for parents to connect with other parents who are facing similar challenges, with supportive facilitators sharing in their journey. The experience of trauma is often isolating; families do not wish to acknowledge its presence. Discussing chronic stress and trauma in a parent group normalizes the experience and reduces the fear of talking about it. Parents who were previously hesitant to pursue therapy services such as CPP often feel encouraged to do so as the next step in a longer-term change process.

Program Highlight: Promoting Engagement in Therapeutic Services

Nora, 22 years old, is a single mother of a 3-year-old girl, Emma. When Emma was 18 months old, Nora was beaten so severely by Emma's father that she was hospitalized. The father left the family following this incident but recently decided to seek visitation privileges through the court. As a result, Emma's Guardian Ad Litem (a court-appointed individual who represents the best interests of a child) told Nora she needed to take a parenting class. Nora contacted CHSW and was placed in the Attachment Vitamins program.

When Nora first introduced herself, she told the group that her daughter had no problems nor did she in parenting her child. It was apparent to the facilitators that Nora thought her parenting was being questioned as a result of her ex wanting visitation with their daughter; she felt that

she needed to prove that she was a good and better parent than he was. In order to gain Nora's trust, the facilitators knew they would need to validate her relationship and connection with her daughter by highlighting her strengths and insights. Through exercises such as discussing weekly moments of connection and normalizing challenging child behaviors, they were able to engage Nora and bring down her defenses of trying to protect herself from scrutiny about her parenting.

The major turning point for Nora occurred during the sessions on chronic stress and trauma. Nora told the group that she had not previously considered the impact of these on her daughter and realized that her daughter was indeed showing signs of being affected by the domestic violence. Nora told the group about an incident in which Nora and her mother had a loud and angry argument. When the argument ended, they stepped toward one another for a hug, but Emma came between them, yelling, "Don't touch my mommy!" Nora now understood that the argument had reminded Emma of the violence she'd seen. As sessions progressed, Nora began to put other pieces of the puzzle together. She revisited earlier information from the Attachment Vitamins program with a different, trauma-informed, perspective. Although previously she had not recognized it as such, Nora shared that her daughter did struggle with separation anxiety, connecting it to their experience of violence and her child's desire to make sure Nora was safe.

Nora approached the facilitators after group to discuss how therapy could help them process the trauma as well as the recent visitations that had begun with the child's father. Nora told the facilitators that she had previously been afraid to talk about the domestic violence with her daughter—she thought she might make things worse or that she would get in trouble with the court for "talking about something I shouldn't." But, based on the information presented in Attachment Vitamins, Nora understood that pursuing therapy would be beneficial and no longer feared it as a sign of parenting weakness. Nora went on to access CPP services. She and her daughter are thriving.

Conclusions

The Attachment Vitamins program is an exciting new intervention for families of young children. It incorporates many of the elements that make CPP so effective. Just as in CPP, Attachment Vitamins directly addresses the impact of chronic stress and trauma on the family. It allows parents to "speak the unspeakable"—with one another and with their children. This is an enlightening experience for many caregivers who were otherwise afraid to revisit their experiences with trauma.

Although Attachment Vitamins is a psychoeducational group, it does not simply provide education about parenting strategies. Rather, it promotes increased emotional attunement, mindfulness, and executive functioning within a highly reflective setting. Without the capacity to reflect on one's thoughts, feelings, and actions, change is difficult to achieve. Attachment Vitamins enables the space for parents to reflect on their parenting to determine what and how they would like to change about their relationships with their children.

Attachment Vitamins is inexpensive to implement and attractive to a variety of audiences, increasing its sustainability as a program. Research through FOI's R&D platform is currently ongoing to determine its effectiveness and capacity for large-scale replication. Initial results seem promising not only for achieving significant outcomes among participants, but also for stimulating motivation for engagement in ongoing therapeutic services such as CPP. The Attachment Vitamins program has great potential for improving the lives of vulnerable children and families within Washington State and beyond.

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Using the FAN Approach to Deepen Trauma-Informed Care for Infants, Toddlers, and Families

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Abstract
Erikson Institute Fussy Baby Network® (FBN) leaders from around the country have been considering the importance of building trauma-informed service programs. In this article, they discuss ways that the Facilitating Attuned Interaction (FAN) approach and the core processes used by the FAN can be helpful both when trauma is an unexpected presence in a family and when a provider has foreknowledge of serious concerns. The authors present the FAN's theory of change, the FAN "ARC of Engagement," and FAN Core Processes as a framework to assist providers in staying present and attuned in situations where trauma and high risk exist. In addition, they describe the role of the FAN in supporting trauma-informed practice in relationship-based infant/parent programs and in programs that specifically provide trauma treatment.

Erikson Institute Fussy Baby Network® (FBN) is a national model home visiting prevention program known for its approach to family engagement called the FAN which stands for *Facilitating Attuned Interactions* (Gilkerson & Gray, 2014; Gilkerson et al., 2012). The theory of change guiding the FAN is based on the concept of *attunement*, defined as an individual's sense of feeling connected and understood. Attunement is a kind of resonance, a form of "being with" that does not attempt to change the other. The FAN is both a conceptual framework (see Figure 1) and a practical tool for achieving attunement in relationships and reflective practice. At the center of the FAN are the parent's concerns—worries about the self, about interacting with the infant, about the material world. Co-existing with parental concerns may be those of the provider or the system. The provider supporting the parent uses the FAN to read the parent's cues, matching interactions to what the parent is showing he seems most able to use in the moment, and moving flexibly among the FAN processes based on the parent's responses. Providers also use the FAN to attune to and regulate their own responses within the interaction in order to stay present to the parent(s).

The FAN Core Processes are each used based on reading cues rather than in a prescribed sequence. The processes are:

- Mindful Self-Regulation is used by the providers to track their own responses and, when dysregulated, use intentional strategies to regain balance and attune to the parent

- Empathic Inquiry is used when parents are showing feelings, verbally or non-verbally, or when there is an absence of feelings around a concern that is important to the parent.
- Collaborative Exploration is used when feelings are contained and the parent wants to think together about an issue or concern.
- Capacity Building is used when parents are seeking new information, actively caring for the child, or seeming ready try something new.
- Integration is used to support new insights that parents have about their child or themselves as parents.

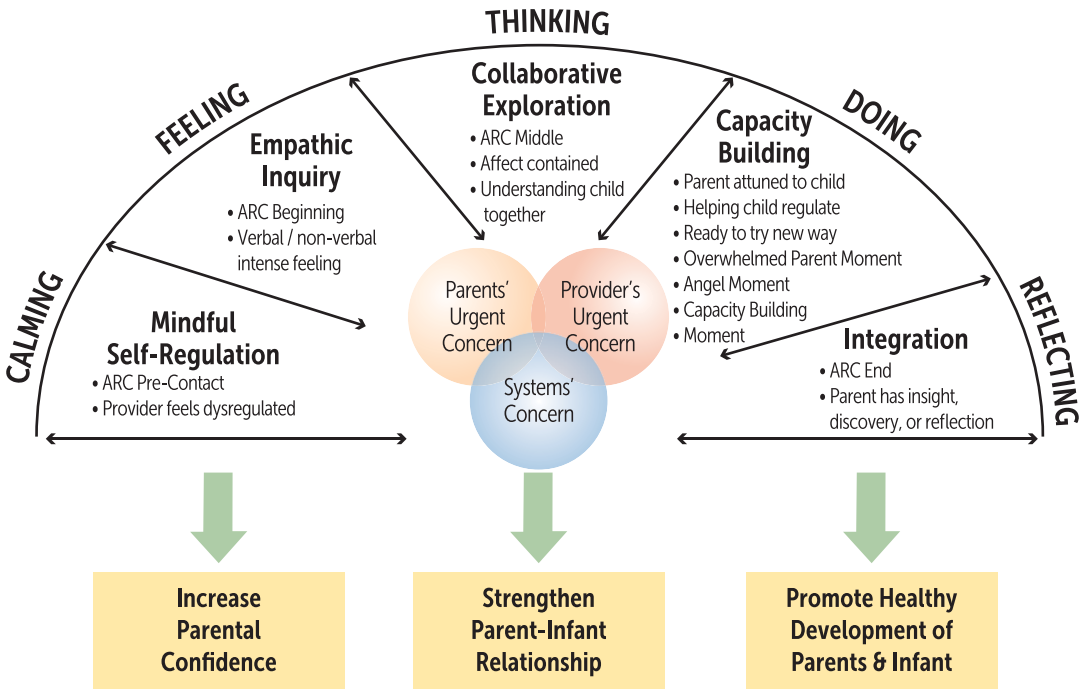
Providers use the FAN in a wide variety of programs operating within different systems and settings including home visiting programs, early intervention, infant mental health services, alternative response services in child welfare, and recovery programs for substance abuse. (See Cosgrove & Norris-Shortle, 2015; Gilkerson et al., 2012; Heller & Breuer, 2015, for examples of applying the FAN in home visiting and shelter programs, and Spielman, Herriott, Paris, & Sommer, 2015, for a description of a recovery program into which the FAN is now infused.)

In this article, we draw on examples from the FBN to describe the specific ways providers can use the FAN approach to support trauma-informed practices in FBN programs in which trauma treatment is part of the mission (e.g., parents in recovery, or alternative response systems in child welfare), as well as in programs that serve families affected by past or present trauma but that do not specifically provide trauma-treatment services.

The FAN and Trauma-Informed Practice

The FAN approach offers providers a grounding framework within which to actualize the kind of safe, holding environment needed for trauma-informed practice. Raja, Hasnaian, Hoersch, Grove-Yin, and Rajagopalan (2015) emphasized that providers must reserve judgment particularly when exploring problematic patterns of behavior or troubled interactions that can evoke parents' feelings of shame and guilt. A provider who takes a nonjudgmental, respectful, empathic stance understands that behavior has meaning and that a parent's maladaptive coping may be related to a disclosed or undisclosed trauma history. FAN promotes careful listening, pacing, and empathic responsiveness to support these processes. The conscious development of Mindful Self-Regulation, another core component of the FAN, builds self-awareness and provides a way for the provider to monitor and hold his own urges, feelings, and judgments. A premise in the FAN approach is the importance of the provider first seeing the world as the other sees it and then working to develop the other's flexibility and expand his perspective over time. During the exploration of a parent's worldview—whether intrapersonal, interpersonal, or cultural—the provider accords meaning to the parent's experience and shows a desire to connect and understand. Taking a respectful approach helps the parent sort out what makes sense for her as she is ready, rather than imposing an interpretation or solution alien to the parent's worldview or one that might increase shame and a desire to distance herself from the provider. The opportunity to refer families to trauma treatment is greatly enhanced by the unhurried, relationship-building approach that the FAN supports. Infusing the FAN into trauma-specific

Figure 1. High-Risk FAN, Facilitating Attuned Interactions



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treatment may help the provider stay internally organized and in touch with the parent, even in the midst of dissociative lapses, enactments, or outbursts.

The FAN ARC of Engagement and Core Processes

Staff and supervisors who embrace the FAN model learn its theory of change based on attunement, use the ARC of Engagement to structure parent encounters, use the core processes to match interactions to the parent's cues about what will be most helpful in the moment, and shift flexibly to respond to changes. A central, defining feature of the FAN is its explicit focus on the provider's experience of the interaction and her use of self, essential to trauma-informed practice. Below we describe the ARC and FAN processes and illustrate how they can be salient in work with families where trauma is a present reality, whether through recollection of past trauma, or through current circumstances.

ARC of Engagement

The ARC of Engagement provides a sturdy frame to organize sessions, particularly for parents who are disorganized or emotionally uncontained during visits. The beginning question—"What has it been like for you to take care of your baby this week?" or "What has it been like for you to be a parent this week?"—deliberately asks about the parent's experience of taking care of the child and supports the provider in bringing the focus to the baby, the parenting role, the parent–infant relationship, or to all of these. The provider's middle question, which asks parents whether we are getting at what is most important for them, demonstrates that the provider is truly interested in the parents and their experience and can refocus the visit in real time, based on their needs. Trauma creates vivid memories that may trigger a reliving of the experience, which can hijack attention from a present need, such as a baby's signal, or incline the parent to avoid a painful topic. With the middle question, the provider explicitly invites the parent to share control, an important element of trauma-informed practice. The last part of the ARC slows down the interaction and offers time for the parent to integrate his thoughts and develop some coherence at the end of what may have been a highly emotional session.

FAN Core Processes

The following sections provide more details about each core process, illustrating its purpose and strategies used.

Mindful Self-Regulation

Through *Mindful Self-Regulation*, providers create a safe holding environment for themselves in the context of difficult feelings and worrisome interactions. For example, a provider who works with families impacted by substance use may have to assess and confront a high level of risk. If the provider questions a parent's alertness, she may also be concerned about the parents' ability to care for their baby or himself.

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Staff and supervisors who embrace the FAN model use the ARC of Engagement to structure parent encounters, use the core processes to match interactions to the parent's cues about what will be most helpful in the moment, and shift flexibly to respond to changes.

Naturally, this state of concern stirs up the provider's emotions, increasing her state of arousal. A parent's trauma story may involve disturbing details of past degradation, suffering, or fear that have endured to the present. Practicing Mindful Self-Regulation helps the provider stay in balance while listening to the parent, so she can be more fully present for the family as a calm, nonjudgmental, unhurried presence. Mindful Self-Regulation also brings clarity and allows the provider to think about what is needed in the moment, for example, taking the time to understand a safety plan or asking a question intended to pull the parent's awareness back to the baby.

Parents who struggle with affect regulation themselves can learn coping strategies from a clinician's slower pace and his own arousal regulation, modeling with a response such as "What you've just told me is a lot. I feel like I need to pause for a moment and take a breath." Some parents who have experienced trauma recount aspects of their stories in graphic and frightening detail, but without the typical emotional response that would be warranted. Such depersonalized responses, or numbing strategies, can also be distressing to providers. Mindful Self-Regulation can help providers figure out, in the moment, how to tolerate this seeming contradiction and decide whether and how to respond. A provider's reactions to a client's trauma history or current worrisome circumstances can be particularly difficult for him to manage if they resonate with the provider's personal experience. In addition, frequent exposure to trauma has a cumulative effect and can lead to

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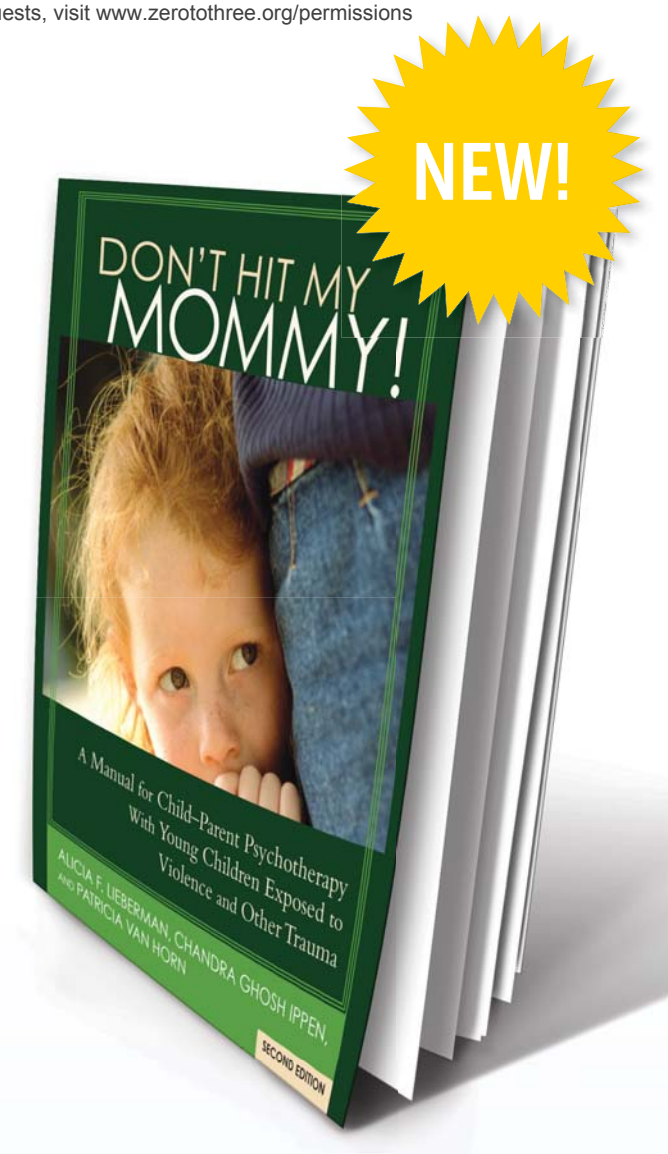
by Alicia F. Lieberman, Chandra Ghosh Ippen, and Patricia Van Horn



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secondary trauma. However, an understanding of trauma, strategies to manage trauma exposure, and strong protective organizational structures such as regular reflective supervision can protect providers against this outcome. Providers who have learned to be sensitive to their own indicators of distress can summon the Mindful Self-Regulation strategies learned in FAN training and reinforced through supervision, and develop individual strategies to help them remain present and able to function under duress. Common strategies include conscious breathing, grounding strategies such mindful walking from the provider's car to the door for a home visit, self-talk, and imagery to center one's attention. With these supports in hand, providers who encounter trauma are less likely to become reactive, or to retreat to numbness or cynicism.

Empathic Inquiry

In the *Empathic Inquiry* process, the provider focuses on a parent's emotional experience and uses a set of interventions designed to compassionately hold, explore, validate, and help contain feelings. Parents with complex trauma histories often present with intense feelings and need others to witness their distress. Using the FAN's Empathic Inquiry reminds providers that listening and validating are as important in trauma work as are concrete support and problem solving. Paying attention to the parent's story—asking, for example, "What was it like for you?"—may shift attention away from the baby, but the process often must take place in order for the parent to focus on the child.

Parents with histories of complex trauma can experience intense feelings of shame and guilt. They may have experienced negative judgments from important people in their lives, including previous providers who inadvertently triggered shame and guilt. When feelings of fear and shame underlie the parent's choices, motivations, and behavior, secrecy and difficulties with trust may be present. Listening with acceptance and respectfully responding without judgment offers a new experience of a relationship in which healing can begin to occur through repeated interactions with a compassionate, regulated other (Ludy-Dobson & Perry, 2010).

When the parent is unable to regulate his own emotional state with these supports, the provider takes a more active role to slow down the interaction and serve as a co-regulator, helping the parent manage his state of arousal, whether a high or a low state of activation. The parent begins to build capacity in containment and self-regulation through the experience of supportive co-regulation.

Mindful Self-Regulation and Empathic Inquiry help the provider stay with the parent's affect during painful conversations. The provider may bear witness to the parent's stories, validate these experiences, and hold the difficult feelings that may overwhelm the parent. Empathic Inquiry models a reflective and curious stance without conveying assumptions about the "truth" or any insistence on getting to the bottom of things. Slower pacing allows for a cocreation of narrative coherence and helps the client to feel known and accepted. The provider then can gain a better sense of the complexity of the parent's experiences

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The beginning question—"What has it been like for you to take care of your baby this week?" or "What has it been like for you to be a parent this week?"—deliberately asks about the parent's experience of taking care of the child.

and the meaning she has made of these experiences. Empathic inquiry sends a message of acceptance which avoids the shame and maladaptive coping that are often a result of trauma. A provider observing a lessening of affect and an opening to move forward might gently move toward *Collaborative Exploration*: "I'm wondering if you might have the space now to begin to think about what might be helpful."

Collaborative Exploration

Through *Collaborative Exploration*, parent and provider develop a shared understanding of the issue at hand; however, engagement in Collaborative Exploration is possible only after they have taken the time to develop an environment of safety and calm. Because of other stresses, parents may be challenged to focus on their child's needs. The invitation to observe and think together sends the message that the parent is not alone in his challenges and has valuable experiences to share. Collaborative Exploration encourages reflective functioning, often difficult for parents with current or past trauma or substance dependence, or both. Yet reflective functioning is considered a key factor in building secure attachments with infants and young children. Collaborative Exploration also helps the provider understand a parent's projections about a child's behavior, his cultural norms, or the nature of the scars that have formed like a hard shell to protect him against future harm. Listening carefully and using attuned questions may lead parents to see their own strengths, to begin to question their own story, and to wonder if their view of their infant as aggressive rather than as just a baby, for example, may be clouded by their own memories of domestic abuse. A core question to invite a discussion of past or present adversity, such as "Is there anything that happened in your family, to you, or to your baby that might be making things more difficult?" may not always be answered, but simply asking delivers the signal that "I am open to your experience."

Capacity Building

Capacity Building aims to support the parents when they are seeking new information, actively caring for the child, or seeming ready try something new. The provider notices Capacity Building moments and supports parents in their own attempts to care for their baby, for example, to soothe their baby or to engage in the self-care that will eventually allow them to be more present for their child. For providers who work with mothers impacted by addiction, Capacity Building acknowledges the very real challenges of parenting a baby with regulatory difficulties. Highlighting "Angel Moments," in which the parent and infant are sharing pleasurable affect, increases the parent's self-esteem and confidence as a parent, in addition to supporting attachment. Capacity Building also invites providers to notice and validate parental interactions and reflections that relate to parents' core concerns or to healthy relationship development in general. The FAN takes a particular approach to information giving, using a model of engaged communication called "Offer and Explore": FAN-trained providers offer small amounts of information ("one drop") and then explore information with the parent, using questions such as "Does that make sense to you?" or "How does that fit with what you know about yourself and your baby?" In some settings providers intentionally link observed positive parent–child interactions with the idea of building resilience as a buffer against future adversities. For example, a provider might say, "She looks so comfortable, and she is using this closeness to build her strength so she will be more ready to handle stress later on."

A provider who takes a nonjudgmental, respectful, empathic stance understands that behavior has meaning and that a parent's maladaptive coping may be related to a disclosed or undisclosed trauma history.

Integration

Integration takes place at the end of each encounter in the FAN approach, as well as whenever parents are ready to reflect on a new idea or perspective about themselves, their urgent concern, or their baby. Integration supports parents in families with multiple risk factors to create a coherent narrative around parenting, trauma, and—sometimes—recovery. This often involves making sense of and working through past traumas, weaving a coherent narrative about a parent's path to addiction, and focusing on recovery and parenting. It supports parents to integrate difficult parts of themselves, an important piece of the therapeutic work around addiction and parenting. Providers aim to help parents understand their parenting style in the context of their own experience of being parented, using questions to promote integration such as "Are there things you want to hold on to from this discussion about Jamie's long stay in the hospital?" and "What has it been like for you to talk about your experiences in jail?" These kinds of questions further support parent engagement, encourage reflection, and build coherence, key challenges for many parents struggling with trauma.

FAN in Practice

The following two vignettes illustrate providers and supervisors in different service settings using the core processes together to support trauma-informed care.

Shauna's Triggers

Shauna and her 2-month-old son, Jason, were referred by the emergency room staff of a local hospital. The social worker explained that Shauna was an anxious wreck and had come to the ER five times since the birth of her son. On each visit Jason checked out as healthy, however, and quickly calmed down with the mother's attentive care. On the first visit, the FBN provider observed that this young single mother was extremely attentive to her much-wanted little boy, but discovered that her life had changed when her brother had been killed shortly before Jason was born. Shauna was close to this brother, who had taken on a protective role when she separated from Jason's father. The provider, herself a young mother, was overwhelmed by this story and used Mindful Self-Regulation to keep herself from being one with the sorrow in Shauna's story. As the provider learned more about her client over time, it became clear that, at night when police sirens shrieked by, Shauna was reliving the horror of losing her brother. She was so filled with fear about losing her own son that she went to the ER, the only place that seemed safe. The provider initially wanted to give Shauna an in-depth explanation why the loss and trauma were causing her anxiety, thinking that this would help her understand why she was rushing off to the hospital with an essentially well baby. Guided by the FAN, however, the provider used Mindful Self-Regulation to slow herself down, match Shauna's emotions, and stay in Empathic Inquiry. Later, with her team, the provider realized that Shauna needed to tell this story more than she needed to hear the reasons behind her behavior. The team wondered if the parallel process of relationship between Shauna and her provider might help Shauna manage the triggers that sent her running to the ER. Through slow-paced, careful work with the provider, Shauna came to reflect on her reactions to the nighttime triggers and her extreme worries about her little boy. Her insights provided an opening for the provider to help Shauna integrate her experiences and appreciate her own capacity to become a strong parent despite the traumatic loss she had endured.

These Mean Streets

Janet, a developmental therapist working in a Part C program infusing the FAN, was well aware of the civil unrest and protest marches that took place in her community the weekend before her planned home visit. Janet really wanted to make an alliance with the single mother of a toddler to whom she was providing

Part C therapy services and was encouraged that she had not gotten a cancellation call. Up to this point, the mother had seemed reluctant to trust Janet and become an active participant in the child's therapy. At this visit, the mother opened the door for her but turned back to the jammed living room and her toddler facing the television, which was showing news coverage of the community disturbance. After a short greeting, Janet asked about the mother's concern and the toddler's progress toward therapy goals, but the mother's eyes returned to the news bulletin reporting community unrest fewer than eight blocks away. Janet understood the seriousness of the events and, using Mindful Self-Regulation, took a deep breath to calm her own anxiety. Following her FAN training, she decided not to focus on her agenda of the child-focused goals, but rather to give the mother the space to express her feelings and concerns about what was happening in the present in her community. Janet recalled the ARC's opening question and provided space for Empathic Inquiry: "What has this last week been like for you?"

The mother launched into describing her fright and worry. She was working at a business that had been impacted by the civil unrest. She feared for her own safety and was afraid of what would happen to her toddler if she were injured. For the next 20 minutes, Janet listened with true compassion to the mother as she agonized over whether she should go to work the next day. Janet used Mindful Self-Regulation to stay in the "hard place" with this mother, gaining a new level of the mother's trust, and, for the first time, the mother walked Janet to the door at the end of the session and cautioned her to be safe as they parted. Janet and the mother had made a solid connection that would carry their work forward in an even more productive manner.

The mother kept the next several appointments, and she became Janet's partner in using Collaborative Exploration to consider therapy strategies for her son that she could adapt and incorporate into their daily routines. The mother became more active in implementing her son's developmental goals (Capacity Building), and her child made significant progress.

A few weeks later, the mother described to Janet how she herself had used Mindful Self-Regulation. While a friend was caring for her son, Janet took a 5-minute walk in the neighborhood to refresh. On this short walk, she was stopped by police and questioned about why she was out. Despite being troubled by the encounter, she was able to stay calm and explain her intent. Janet was certain that that mother felt comfortable bringing up the incident with her only because she had previously been willing to listen to the "hard place things."

Closing Thoughts

Providers in many kinds of home visiting and family support programs encounter children and family members whose lives have been touched by past, present, and often chronic trauma. Because it is so common that children and families experience trauma and its enduring reverberations, we feel that all providers in the infant and early childhood field need at a mimimum three things: (a) information about the effects of trauma on human development, (b) the ability to recognize symptoms, and (c) the elements of trauma-informed practices to address these concerns. Combined with a strong understanding of trauma-informed practice, the FAN offers an essential augmentative framework and set of tools to ground providers and sustain attuned engagement, particularly in times of dysregulation and distress. FAN helps all providers, even those trained in trauma-specific treatment, to sustain empathic communication, collaborate and share control, and enhance self-awareness.

Photo: © istock/cyano66

Parents with histories of complex trauma can experience intense feelings of shame and guilt. Listening with acceptance offers a new relationship experience in which healing can begin.

This review of trauma-informed work in the FBN has allowed the network to consider additional ways to infuse trauma-informed approaches into FAN training for providers, supervisors, and programs, as well as to build partnerships with programs and organizations interested in increasing awareness, developing trauma resources, and providing education about trauma-informed care.

Acknowledgments

While considering how the FAN is being used to address trauma in various settings, we recalled the initial work undertaken in 2011–2012 with Patricia Van Horn, who served as a consultant and guide to help the FBN network to more fully infuse into the FAN appropriate approaches for families at high risk.

Mary Claire Heffron, PhD, is the former director of Fussy Baby Network at Oakland Children's Hospital and Research Center and presently is a consultant, mentor, and medical staff at UCSF Benioff Children's Hospital Oakland. She is working on multiple projects to build transdisciplinary early childhood mental health and reflective supervision capacity. She is an adjunct faculty member in Erikson's Infant Mental Health Certificate Program.

Linda Gilkerson, PhD, is a professor and executive director of the Fussy Baby Network. She is the developer of the FAN and works with the Fussy Baby Network team to support its national and international sites in launching Fussy Baby Network programs or infusing the FAN into existing programs and systems of service. Her scholarship and program development focus on relationship-based, reflective practice. She is a long-time Board Member of ZERO TO THREE.

Kimberly Cosgrove, LCSW-C, is the director of PACT's Therapeutic Nurseries and has been instrumental in developing an attachment-based therapeutic child care and Early Head Start program for very young homeless children. She has more than 25 years of clinical experience providing home-based services to high-risk families through the Kennedy Krieger Institute and works to infuse the FAN into their programs, including collaborating on a state-funded pilot to infuse the FAN into early intervention.

Sherryl Scott Heller, PhD, is director of Fussy Baby Network New Orleans and Gulf Coast program. Dr. Heller served as the research director for the Louisiana Quality Start Mental Health Consultation to Childcare Centers Program and provides reflective supervision to mental health consultants in this and other state-wide programs. She presents and consults regionally and nationally on mental health consultation, the Fussy Baby Network model, and reflective practice/supervision.

Jaci Imberger, RN, is the program manager for First Steps in Taos, NM, where she leads her team in infusing the FAN into their home visiting program. With her colleague Jana Bailey, she started the grass roots coalition Latch On to support breastfeeding mothers. Ms. Imberger received her Infant Mental Health Level 2 endorsement and is a Circle of Security Parenting facilitator. She brings extensive nursing experience to her role as a program manager and reflective supervisor.

Audrey Leviton, LCSW-C, is an assistant vice president at the Kennedy Krieger Institute and the executive director of PACT: Helping Children With Special Needs, an agency that provides a therapeutic nursery for homeless infants and their parents, a day care for medically fragile children, and program for parents with intellectual disabilities. She co-led a successful state-funded pilot to examine the impact of FAN training on family engagement in EI services.

Mary Mueller, LCSW-C, is the director of Kennedy Krieger Institute's Child and Family Support Program (CFSP) and a clinical social worker who provides mental health services to families who have a child with developmental disabilities, mental health needs, or both. Ms. Mueller's interests are in early intervention and family-centered service delivery. With Ms. Leviton, she co-led the pilot of the FAN in CFSP's early intervention program and is working to expand its use in other agency programs.

Carole Norris-Shortle, LCSW-C, LCMFT, is a faculty member in the Taghi Modarressi Center for Infant Study, Department of Psychiatry, University of Maryland School of Medicine. Her work focuses on the integration of infant mental health, attachment and trauma theory, and FAN into her mindfulness play and family therapy with homeless babies and their families at PACT's Therapeutic Nursery. She collaborated on the early intervention pilot, supporting Child and Family Support Program early intervention therapists in learning the FAN.

Caroline Phillips, DClinPsy, MPhil, is a parent-child clinician in the Center for Early Relationship Support at the Jewish Family and Children's Service in Boston. She trained as a clinical psychologist in the UK and specialized in working with young children impacted by neurodevelopmental disabilities. Since moving to the US, she completed Parent-Infant Psychotherapy training and currently has infused the FAN into dyadic therapy for newborns exposed to substances and their parents.

Eda Spielman, PsyD, is the clinical director of the Center for Early Relationship Support and faculty at the Infant-Parent Training Institute of Jewish Family and Children's Service of Greater Boston (JF&CS). She came to JF&CS to develop Early Connections, a program of home-based mother-baby psychotherapy for dyads facing early relationship challenges. She supports the use of the FAN in two projects on the dual challenges of early parenting and substance use recovery.

Kate Wasserman, MSW, LCSW-C, serves as the lead clinician at the University of Maryland Center for Infant Study where she provides mental health treatment for young children under 6 years old and their families with emotional and behavioral concerns. She leads the infusion of the FAN into their infant mental health clinical and consultation services. Kate is a member of the Governor's Family Violence Council as well as the Mayor's Domestic Violence Coordinating Committee.

Learn More

Facilitating Attuned Interactions: Using the FAN Approach to Family Engagement
L. Gilkerson (2015) *ZERO TO THREE* Journal, *35*(3), 46–48.

Learn more about Fussy Baby Network sites in Arizona, California, Colorado, Florida, Illinois, Louisiana, Maryland, Massachusetts, New Mexico, Washington, and Wisconsin
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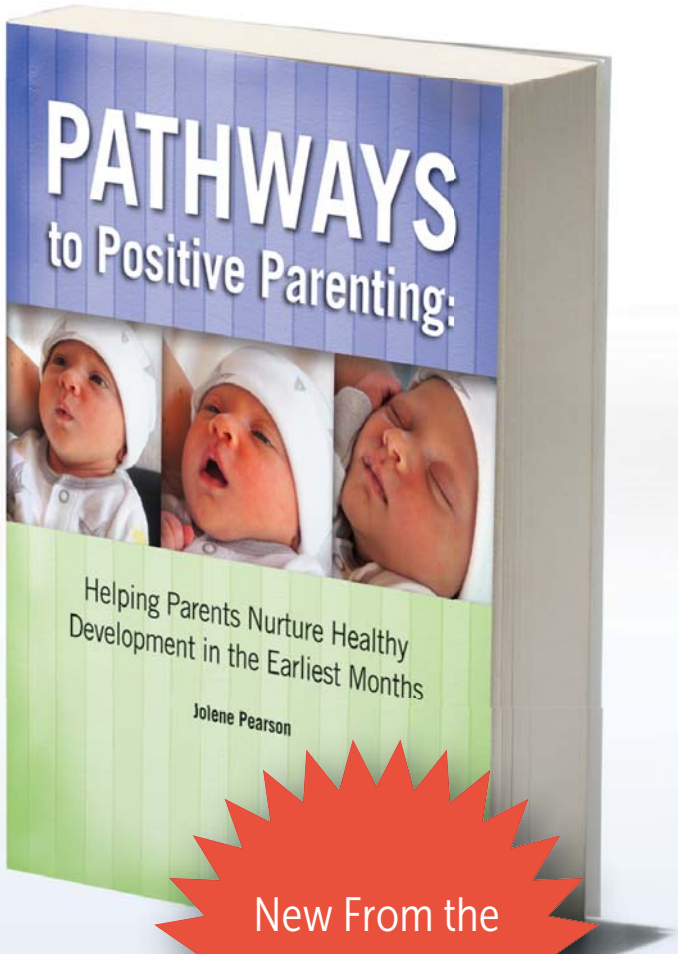

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The Parent-Child Relationship Competencies

How Three Infant-Parent Psychotherapists Find Paths Into Diverse Infant-Family Landscapes

Maria Seymour St. John
University of California, San Francisco

Abstract
This article weaves the stories of three practitioner-family relationships and describes how the Parent-Child Relationship Competencies (PCRCs; St. John, 2010) function as a map for assessment and treatment planning. The PCRCs are a set of culturally variable yet universal bi-directional (parent-to-child and child-to-parent) relational capacities that emerge spontaneously under ordinary circumstances, but can be strained, impaired, or absent as a result of various difficulties. The PCRC framework helps practitioners join collaboratively with families to tap the power of the inherently healing and growth-promoting parent-child relationship.

This article uses the stories of three children–Alejandra, Tyrell, and Claire—to illustrate how a particular framework for clinical assessment and treatment planning can be helpful to multicultural clinicians navigating the complexities of multicultural infant-family work.

Alejandra is 4 months old. A public health nurse who had been visiting Alejandra and her mother, Alma, since Alejandra was born contacted the Infant-Parent Program because the baby was not gaining weight in keeping with expectations. "I had her admitted to the hospital where she gained weight right away, but when she returned home she fell way down again. Alma can tell me how much formula she is supposed to give her and I see her prepare it correctly. I don't know what is going wrong," she stated.

Tyrrell is 20 months old. He, his mother, Tracy, and his new baby sister, Jade, were referred to the Infant-Parent Program by a hospital social worker. Jade's father had been shot and killed just weeks before Jade was born. "Of course I'm worried about how this will affect Jade down the line," the social worker explained, "but it is Tyrrell I am concerned about right now. He is totally out of control, and Tracy can't handle him at all. They need some serious help."

Claire is 13 months old and was born methadone-dependent. She and her father, Joe, were referred to the Infant-Parent Program by a child welfare worker. "This isn't reunification," the worker stated. "This is *unification*." After spending a month in the hospital while she was weaned off of methadone, Claire had been discharged to a foster home for medically fragile children and then transferred to another foster family 3 months later. From there she had been reunified with her mother in a residential substance abuse treatment facility, only to be removed again from her mother's care when she relapsed recently and was asked to leave her program. Now Claire is to be placed with Joe, who has never lived with Claire nor raised any children. Joe also has a history of substance abuse but has graduated from a program and is actively in recovery. "This little girl has been through a lot," the child welfare worker continued. "I hope I'm not making a mistake by placing her with Joe."

Treatment Context

The Infant-Parent Program (IPP) is an infant mental health program of the University of California, San Francisco located at San Francisco's county hospital. Started in 1979 by infant mental health pioneer Selma Fraiberg together with colleagues Jeree Pawl and Judith Pekarsky, IPP serves infants, toddlers, and preschoolers and their families and caregivers, as well as consulting to and partnering with other professionals and agencies similarly dedicated to helping families. IPP has maintained a multidisciplinary clinical training program since its inception; practitioners-in-training across the mental health disciplines come to learn to practice infant-parent psychotherapy as well as other intervention modalities (Pawl, St. John, & Pekarsky, 2000). IPP's mission statement reads:

> *The Infant-Parent Program is a unique San Francisco resource that works to protect and support the natural capacity of very young children to grow up valuing themselves, caring about others and competent to contribute to society. These capacities are shaped in the first few years of life by the way in which children are treated by those responsible for their care. From these relationships, they learn how to feel about themselves, how they fit into the world, and what the world has to offer them. The Infant-Parent Program is dedicated to nurturing these shaping relationships at home and in settings where young children and their families reside or receive care. (University of San Francisco Infant-Parent Program, 2014)*

It was clear from the start that the most effective place for the three families described in this article to receive services would be right where they lived.

Initial Visits

The three referring providers—the public health nurse, the hospital social worker, and the child welfare worker—all have long-standing, mutually respectful collegial relationships with IPP, and each is able to convey to families a sense that IPP may be able to help them. Still, when IPP trainees first visit families, such as those described above, they are met in every instance with some degree of wariness and often with resentment as well.

Alejandra

Laura, a bilingual, bicultural family therapy trainee from Argentina, visits Alejandra and Alma in the apartment that they share with two other families—Alma's cousin's family and a co-worker and her children. Their conversation takes place in Spanish. Alma states that she doesn't understand why the public health nurse is so worried. The baby is fine. She would bring her to the hospital if she needed help. And she doesn't want any trouble with her roommates from all these people knocking on the door. They are sitting in the living room (which also serves as Alma and Alejandra's bedroom) and Alejandra is awake but quiet in a baby carrier. The baby carrier is on the floor at the far end of the daybed from where Alma sits. The 4-year-old son of a roommate is in the room, too, watching television. He approaches Alma once and she is short with him, telling him not to interrupt adults. Alma has been taking care of him, Laura learns, since Alejandra was born and she stopped working at the taqueria where she had previously been employed. When Laura inquires about Alejandra's father, Alma says "We are not together. I don't even think he is still in California. And I don't want to be with him anyway." Laura also learns during this visit that Alma immigrated from a village in Guatemala just over a year ago, leaving a 4-year-old daughter, Daniela, in Guatemala with Alma's mother. "I meant to send money," Alma says bitterly. "Now I'm here taking care of my cousin's son in exchange for a roof."

Laura returns to the office feeling sad and overwhelmed. The difficulties Alma described seem insurmountable. Alma has no hope that Laura can help her—in fact she is clearly concerned that contact with Laura might endanger her or the people she lives with, perhaps bringing them to the attention of the immigration authorities and exposing them to risk of deportation. And Alma endorses no concern about Alejandra, and resents the suggestion that she is not taking adequate care of her. Laura thinks about the 4-year-old boy in Alma's care who isn't even her client, but whose fleeting expression of need was responded to with harshness. And Laura thinks of Alejandra: slight, wakeful, and unnervingly quiet, all alone in her carrier. "How can I possibly be useful here?" Laura wonders.

Tyrrell

Lenore is an African American woman and a psychiatry resident. She is buzzed into Tracy's building and starts to climb the stairs to their apartment. "Come ON!" comes a little voice from the top of the stairs. When she gets to the landing she is greeted by Tracy (an African American woman in her mid-20s), holding Jade and holding the door open, and Tyrrell standing next to her with a pacifier in his mouth wearing nothing but a diaper. "Come ON," he repeats out of the side of his mouth that is not holding the pacifier in place like a cigar. As soon as Lenore sits down on the couch as Tracy gestures for her to do, Tyrrell scrambles onto a chair opposite her, raises the Venetian blind on the picture window, and puts his tiny index finger on a bullet hole in the center of the big pane of glass. His cheeks hollow as he sucks hard on his pacifier, locking eyes with Lenore. "Get back from that window!" Tracy commands, but Tyrrell stays put. Tracy turns to Lenore shaking her head. "He will not listen to me."

During this first visit Lenore learns that Tracy fears that Jade's father's shooting was not a random act of violence, but rather an instance of targeting. "I'm not talking about a gang," she clarifies quickly. "I'm just saying somebody knew who he was shooting." Lenore also witnesses what the hospital social worker had described: Tyrrell's high level of energy, frenetic activity, and unresponsiveness to Tracy's admonitions. Lenore sees also that Jade is in some important ways out of the fray. Tracy seems to take comfort in keeping Jade close to her, moving fluidly in and out of nursing, cradling, and cooing to her while intermittently scolding Tyrrell. During this initial visit

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Lenore sees Tyrrell dump a potted plant on the floor, pull a lamp over, and—when this led to the cord being jerked from the socket—attempt clumsily to plug it back in, and hurl a heavy, fish-shaped ashtray across the room, narrowly missing Lenore's head. "It's like this all day long," Tracy complains wearily. "All day long!" Tyrell repeats somberly out of the side of his mouth that isn't holding the pacifier in place.

When Lenore sinks down in the chair across from her supervisor that afternoon, she opens with "I cannot go back there and I cannot *not* go back there." She describes the sense of danger that the bullet hole in the window aroused in her and the plea—almost the demand—for help that Tyrrell conveyed, as well as the despair and defeat that Tracy communicated. Lenore feels depleted and irritable. How is she supposed to be able to support this mother if someone is picking off family members, and how is she supposed to help this little boy if his mother can't even stop him from putting his finger in an electrical socket? And Lenore feels angry at her supervisor: "You are asking something impossible of me."

Claire

Daniela, a Mexican American social work trainee, enters Square One, the transitional housing program where Joe resides, and asks for him at the front desk. "Right here," says a tall, thin white man standing at the end of the desk. Daniela introduces herself and asks where might be a good place to talk. "How about the courtyard?" Joe asks. "I need a cigarette. And I know I can't be smoking around Claire, so don't you worry about that." Claire is in emergency foster care out of county at this time so is not present for this first visit. The child welfare worker's plan is that Claire will quickly begin spending increasing amounts of time with Joe now that he has housing—as long as Daniela reports that he is doing well with parenting. "So I guess this is basically all up to you," Joe says to Daniela in the courtyard. She senses something more than anger behind his words—a bit of sarcasm or derision. "Seems like a hell of a place to raise a kid, right?" Joe asks, looking around at the other residents in the courtyard. Daniela asks what he means. "Among all these addicts!" Joe answers.

When Daniela recounts this first meeting in supervision later that week, her anger is quickly rekindled. "He was so sarcastic with me," she tells her supervisor. "He made it obvious he has no respect for me. And is he forgetting *he's* an addict himself?" Daniela and her supervisor discuss the strain Daniela feels attempting to make an empathic connection with this white man when she had imagined herself serving Latina women in this field placement. They also discuss how hard it indeed is to picture Claire residing at Square One with Joe. "I can't believe he's going to get all these resources and support to parent her just because he impregnated somebody 2 years ago!" Daniela finds herself saying.

Assessment and Treatment Planning

In each of these instances the clinician was contending with a complex swirl of thoughts and feelings that resulted from the interplay between her own background, experiences, and identity and those of the families she met with. Reflective supervision is a necessary element of the work of infant-parent psychotherapy because it is only in the context of a relationship dedicated to attending to all of this complexity that a clinician can make sense of and make use of this unique "swirl." Part of what led each practitioner described here to feel overwhelmed (and in some instances angry and despairing) was the multiplicity of challenges faced by each family. It is hard to identify discreet problems and to formulate reasonable objectives when the families' troubles seem so crushing.

The Parent-Child Relationship Competencies (St. John, 2010), or PCRCs, aid in this process of identifying specific areas of focus for infant-family practitioners. The PCRCs are a set of 21 bi-directional (parent-to-child and child-to-parent) capacities developed during the first few years of life (see box "The Parent-Child Relationship Competencies"). The PCRCs are culturally variable but universal and occur spontaneously under ordinary "good enough" conditions. The key feature is that both partners in the relationship—the child and the parent—make a contribution, and the development and well-being of each is enriched by the contribution of the other. Whereas many models emphasize things parents may do to support child development, each PCRC articulates something that infants and small children bring to the world and to relationships that helps their caregivers to take care of them, enjoy being with them, and grow and develop alongside them. When a PCRC is operating without impingement, the parent's and child's contributions are mutually reinforcing. In situations of undue stress resulting from internal sources (e.g., parental mental illness, child congenital difficulty) or external sources (e.g., trauma, barriers to accessing resources) particular PCRCs may be strained, impaired, or absent. Infant-family practitioners can evaluate clinically (via nondirective clinical conversations with and observation of families, as well as reflective conversations with supervisors, consultants, or colleagues) which PCRCs are functioning well or "firing" well and which need to be strengthened or "ignited."

Focusing on the PCRCs offers a strengths-based, culturally attuned framework for assessment and treatment planning. In some instances the actual language of the PCRCs is used exclusively between practitioners and supervisors as they strive to formulate the areas of struggle between parent and child that may benefit from intervention. In other instances a practitioner may share one or two PCRCs explicitly with parents toward arriving together at forging meaningful treatment objectives. And occasionally a practitioner will present the entire set of PCRCs to a parent for consideration and exploration together.

Each of the 21 competencies is a bi-directional capacity that, in its own unique way, promotes child development, relationship satisfaction, and family well-being. The PCRCs draw on decades of partnerships between parents and practitioners defining together how the field of infant mental health can best support infant-families to thrive. Among the many influential contributions to this framework are the work of Anna

Freud (1936/1966, 1965) defining the developmental lines of childhood; Melanie Klein (1975a, 1975b, 1975c) positing the powerful role of unconscious processes in infant psychology; John Bowlby (1969/1982, 1973, 1980, 1988) and Mary Ainsworth (1969) identifying the interplay between attachment and caregiving behavioral systems; D. W. Winnicott (1965) bringing attention to the exquisite complexity of "ordinary good enough" parenting; Selma Fraiberg (1980) and colleagues identifying the phenomenon of "ghosts in the nursery" and developing the practice of infant-parent psychotherapy; Urie Brofenbrenners's (1979) insights regarding the role of the environment in child development; and Stanley Greenspan's elaboration of the stages of social-emotional development, which have been codified in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (ZERO TO THREE, 2005).

The fields of developmental and clinical psychology have historically been monopolized by dominant-culture writers, and research has historically been normed on white, middle-class populations. Theories purporting to be universal have extrapolated from Eurocentric experiences. In delineating

Parent-Child Relationship Competencies

The PCRCs (St. John, 2010) are a set of culturally variable yet universal bi-directional (parent-to-child and child-to-parent) relational capacities that emerge spontaneously under ordinary circumstances, but can be strained, impaired, or absent as a result of various difficulties. The key feature is that both partners in the relationship—the child and the parent—make a contribution, and the development and well-being of each is enriched by the contribution of the other. When a PCRC is operating without impingement, the parent's and child's contributions are mutually reinforcing.

PCRC # 1 Child is able to signal needs clearly AND parent is able to register and respond effectively to child's needs.

PCRC # 2 Parent is able to maintain his or her own health and well-being, promote child's health, and access pediatric (or other culturally appropriate) care as needed AND child is able to grow and maintain physical health.

PCRC # 3 Child seeks out and accepts comfort and protection from parent and has a developmentally expectable ability to discern safety and danger AND parent has the capacity to provide safety, protection, and comfort for child.

PCRC # 4 Parent is able to be emotionally attuned to/empathize with child AND child is able to experience and express a full range of human emotion.

PCRC # 5 Child is able to participate in mutual regulation with the parent and is developing the capacity to self-regulate AND parent has the capacity to self-regulate and to engage in mutual regulation with child.

PCRC # 6 Parent has the capacity to identify, act on, and control impulses sufficiently to have rewarding relationships and life experiences and can foster these abilities in child AND child demonstrates an age-expectable capacity to identify, act on, and control impulses.

PCRC # 7 Child demonstrates a developmentally expectable capacity for shared focus/mutual attention and is on a path toward being able to focus and attend on his or her own AND parent possesses and promotes these capacities.

PCRC # 8 Parent talks to child and otherwise facilitates child's entry into language and literacy (including multilingualism as appropriate) and confidence in communication AND child is developing at age level the capacity for two-way gestural and/or verbal communication.

PCRC # 9 Child demonstrates age-expectable problem-solving capacities and confidence that things can be figured out/worked out successfully AND parent possesses and promotes these sensibilities.

PCRC # 10 Parent is able to take satisfaction from symbolic activities and may use narration, play, or other interactions to promote these capacities in child AND child is able to use symbols in developmentally expectable ways to express thoughts and feelings.

PCRC # 11 Child is able to make use of resources accessed by parent AND parent is able to access resources on behalf of child and family.

PCRC # 12 Parent is able to maintain and enjoy a network of family and/or friends, that may include a co-parent, and to support child's relationships with this circle AND child is able to enjoy developing relationships with this network of people.

PCRC # 13 Child is able to make good use of limit-setting interactions in working toward internalizing the ability to avoid danger, consider others, follow rules, defer gratification, etc. AND parent is able to set limits with child in ways that promote development.

PCRC # 14 Parent is able to manage frustration and channel aggression in appropriate directions, and to promote these capacities in child AND child is developing these capacities at age level.

PCRC # 15 Child displays an age-expectable capacity to manage and benefit from separations from parent AND parent has the capacity to plan for and support the child around separations in ways that promote development and well-being.

PCRC # 16 Parent takes pride and pleasure in his or her (or family) culture(s) and has the capacity to promote a sense of cultural identity in child AND child is able to take pleasure and pride in family culture(s).

PCRC # 17 Child is able to be helped to restore a sense of safety, hope, trust, and well-being following a distressing, disturbing, or traumatic event AND parent is able to restore a sense of safety, hope, trust, and well-being for self and child following a distressing, disturbing, or traumatic event

PCRC # 18 Parent is able to mourn losses and support child in mourning losses AND child is able to mourn losses in keeping with developmental level.

PCRC # 19 Child shows developmentally appropriate signs of a sense of efficacy, confidence, and competence AND parent possesses an intact sense of self-worth, sees that avenues are available for him or her to make contributions in the world, and supports the development of a sense of self-worth and the capacity to contribute in the child.

PCRC # 20 Parent's perceptions of child are reality-based and attributions toward child are growth-promoting AND child exhibits an age-expectable sense of self-awareness and is able to protest, insist, differ, and otherwise assert independent personhood.

PCRC # 21 Child shows developmentally appropriate signs of experiencing him or herself as a unique person with interest in and concern for others as separate people AND parent is able to reflect upon/think about his or her own experience, including how his or her past experiences may be impacting his or her experiences as a parent and can conceptualize the child's experience as that of a separate person

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Each of the 21 competencies is a bi-directional capacity that, in its own unique way, promotes child development, relationship satisfaction, and family well-being.

a more inclusive picture of parent-child relationships, therefore, the PCRC framework is equally influenced by research, theory, and practice emanating from postcolonial, queer, feminist, and intersectionality theories that expand conventional constructions of "family" and also expose the forces that mitigate *against* infant-family well-being. This body of work includes Louis Althusser's (1971/2001) analysis of the ideology of the family; Franz Fanon's (1952/1967) elaboration of the psychological damage of colonialism; Adrienne Rich's (1976/1986) critique of the heteronormative institution of motherhood; Judith Butler's (2004) deconstruction of gender; Derald Wing Sue's (2010) exposé of the omnipresent operation of racial microagressions; Cherrie Moraga's (1981/2015) queer theorizing of the institution of the family in Latino cultures; Maria Yellow Horse Brave Heart's (1998) unearthing of the impact of historical trauma for indigenous people; and Joy DeGruy's (2005) elaboration of post traumatic slave syndrome in African American individuals and families. These scholars and practitioners likewise influenced the development of the Diversity-Informed Infant Mental Health Tenets (St. John, Thomas, & Noroña, 2012), a set of aspirational principles guiding practitioners to ethically engage with infant-families. The PCRCs can help practitioners to accurately perceive infant-family strengths and needs, and the framework is most potent when practitioners take it up together with the Tenets (see Tenets website: www.imhdivtenets.org).

In reflective conversations with their supervisors during an assessment phase of work, Laura, Lenore, and Daniela considered what they were learning about the families. They reviewed the PCRCs and discussed how each seemed to be manifesting (or not) in each dyad. These conversations included discussion about possible blind spots, areas of ignorance, or personal struggles that restricted or distorted what the practitioner could see. In order to talk openly about such things, practitioners need to know that the supervisor is likewise prepared to think about, expose, and take responsibility for her own blind spots, areas of ignorance, and personal struggles as these play out in the supervisory relationship.

A Starting Point for Each Practitioner-Family Partnership

Through these reflective conversations with supervisors, each infant-parent psychotherapy trainee settled on one or two PCRCs that seemed to offer a meaningful starting point for intervening with the family. The best starting point may be the most urgent concern and the PCRC that is the most impaired or absent, or conversely, may be a PCRC that is present but strained and at-risk. For example, a family may be struggling with PCRC # 11 ("Child is able to make use of resources accessed by parent AND parent is able to access resources on behalf of child and family.") due to systemic oppression that blocks access to resources. In such instances the practitioner might take on an advocacy role with other institutions or systems of care in order to clear the way for the parent's innate capacity to access needed resources and the child's innate capacity to benefit from this.

Alejandra, Alma, and Laura

Alejandra and Alma clearly need help around PCRC # 2 "Parent is able to maintain his or her own health and well-being, promote child's health, and access pediatric (or other culturally appropriate) care as needed AND child is able to grow and maintain physical health." Laura and her supervisor consider cultural issues that may be at play, including Alma's fear that accessing pediatric care exposes her or others to deportation, pediatric health care delivery being foreign to Alma, and the cultural meanings of formula versus breast milk. In the weeks that follow, Laura gradually inquires about these matters with Alma, who confirms that she had felt judged and criticized by the pediatric providers. Alma relates bitterly that she had no difficulty feeding her older daughter back in Guatemala.

This line of discussion brings into focus PCRC # 18 "Parent is able to mourn losses and support child in mourning losses AND child is able to mourn losses in keeping with developmental level." Immigration has entailed countless losses for Alma, including relationships, belongings, a sense of identity, an experience of competence as a mother, and a sense of continuity of being. Laura and her supervisor conceptualize Alma's depression, which leads to emotional distance from Alejandra, as impeded mourning. Laura devotes herself to gently supporting Alma in cataloguing and grieving her losses, expressing her profound guilt over leaving her older daughter in Guatemala, and her shame about having unintentionally become pregnant. As Alma comes to trust Laura and venture into these conversations, her depression gives way to grief and anger, including anger at Alejandra for coming! As these thoughts and feelings come to light and Alma finds that Laura receives them with empathic understanding, the distance between Alma and Alejandra closes. Alma holds and interacts with Alejandra

more and more—and Alejandra not only gains weight, but also becomes an animated partner in interactions with her mother.

Tyrell, Jade, Tracy, and Lenore

The PCRC framework is helpful in the face of overwhelming situations such as the one Lenore encountered in her first home visit with Tracy, Tyrell, and Jade. There is so much to be concerned about, including community violence, which is beyond the scope of an infant-parent psychotherapist to directly combat. The first order of business is signaled by Lenore's anger at her supervisor: her sense that too much is being asked of her. Lenore and her supervisor identify PCRC # 3 as an immediate area of focus: "Child seeks out and accepts comfort and protection from parent and has a developmentally expectable ability to discern safety and danger AND parent has the capacity to provide safety, protection, and comfort for child." Lenore needs to engage Tracy in assessing whether another bullet is likely to come through that picture window, and thus whether the home is a safe enough meeting place. Lenore feels guilty about talking to Tracy about her own—Lenore's—safety. But her supervisor says, "I can't let you make home visits without some further clarification from Tracy about her ideas about the circumstances of the shooting."

It turns out when Lenore calls Tracy that Tracy does not believe that she or the children are at more risk than anyone else in their neighborhood. "I'm saying that bullet was for HIM," Tracy says adamantly. "That's not coming my way." Lenore does continue to meet with Tracy and the children in their home, and addresses the issue of community violence directly and regularly with Tracy, including rehearsing safety plans should there be a shooting in the neighborhood. In the course of these conversations Tracy relays her fear that Tyrell will ultimately "go to the streets." She says one day, "My baby cannot be acting like this! He is black and male—he already has his two strikes. The next one is the last one." As Lenore speaks with Tracy about the omnipresent threat of racism, and the particular vulnerability of black boys in this context, it emerges that PCRC # 16 is in need of strengthening: "Parent takes pride and pleasure in his or her (or family) culture(s) and has the capacity to promote a sense of cultural identity in child AND child is able to take pleasure and pride in family culture(s)." Lenore and Tracy talk about how a sense of pride in African American cultural identity can help inoculate children against some of the insidious effects of racism.

Claire, Joe, and Daniela

The PCRCs are likewise helpful to Daniela and her supervisor as they work to make sense of Daniela's upsetting feelings in relation to Joe. Eventually Daniela identifies what was the hardest for her in this first exchange with Joe; he acted like he (unlike the "addicts" he lived among) didn't need any help, but was simply complying with requirements. They hypothesize that registering need may be hard for Joe, and that if it is hard for him to acknowledge that he has needs, it will likely be hard for him to accurately identify and then meet Claire's needs. Equipped with this hypothesis, Daniela goes into the first dyadic meeting with PCRC # 1 in hand: "Child is able to signal needs clearly AND parent is able to register and respond effectively to child's needs." She proposes to Joe that they take their time to go through the PCRCs, beginning with this one, and use them as a map for exploring the joys and challenges of parenting as Joe and Claire get to know one another.

The Ultimate Goal: Getting Out of the Way

Although PCRCs are potentially spontaneously present in all parent-child relationships, they may be strained, impaired, or absent when families face challenges such as systemic oppression, trauma, or mental or physical illness. PCRC-focused treatment planning enables parents and practitioners to tap the power of the parent-child relationship, drawing on well-functioning competencies in order to strengthen those that are underdeveloped. The infant-family practitioner steps in to support the development of needed PCRCs. Sometimes the lion's share of the practitioner's efforts is devoted to identifying external impediments to the smooth functioning of the PCRCs and advocating for families accordingly. While the PCRCs are universal in theory, each family manifests them in unique ways in practice, so the practitioner strives to recognize, honor, and support the particular expression of each PCRC inherent to each child-parent dyad. Ultimately, the practitioner gets out of the way and the PCRCs fire away, promoting child development, relationship satisfaction, and family well-being.

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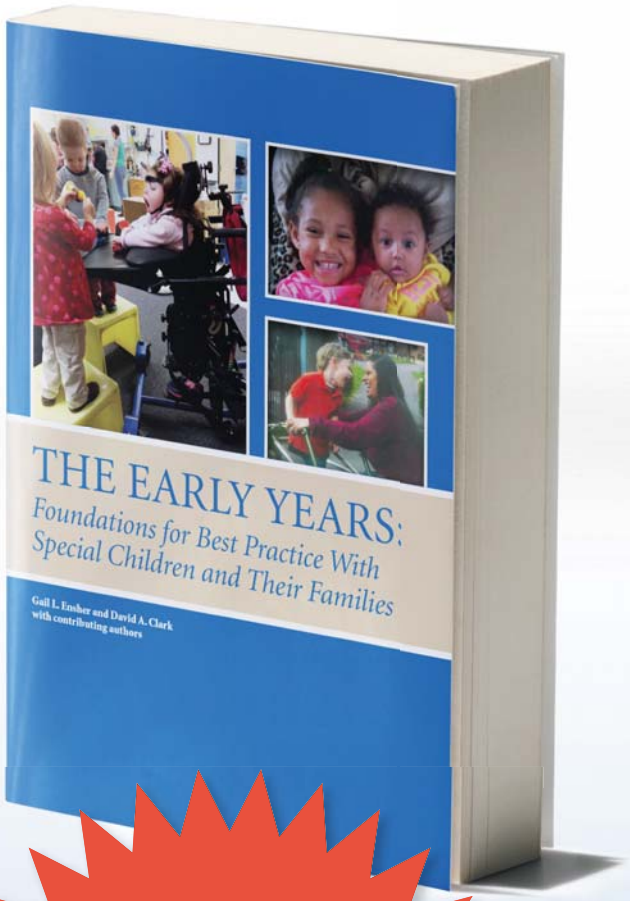

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Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *ZERO TO THREE*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

The Attachment Vitamins Program	The Attachment Vitamins program is a trauma-informed parent group intervention for families with young children. Attachment Vitamins is a relational psychoeducational intervention based on the principles of Child-Parent Psychotherapy. Its goal is to repair the impact of chronic stress and trauma through strengthening the child-parent relationship. [Find it in Hulette, Dunham, Davis, Gortney, & Lieberman, page 19]
Baby Court	"Baby court" teams typically involve an infant mental health team; child protection caseworkers; a community coordinator; attorneys for the child, parent, and state; Court Appointed Special Advocates (CASA) or Guardian ad Litem (GAL); and other relevant service providers such as domestic violence counselors or substance abuse counselors. These teams work in a designated court with a judge who is willing to make substantive changes in processing and providing hearings for young child cases. While each baby court team differs in its execution of cases, the teams share common components. [Find it in Dickson, Callahan, & Osofsky, page 13]
Early Childhood Behavioral Health	Behavioral health providers, integrated into primary care clinics, can augment and enhance routine medical care by extending the breadth and scope of primary care to include a focus on psychosocial well-being and behavioral health issues. Supports may include screening, case consultation, and health promotion/prevention activities. The combination of these activities creates a comprehensive medical home approach for young children and families, ensuring that their needs are addressed and coordinated. [Find it in Buchholz, Fischer, Margolis, & Talmi, page 4]
The FAN Approach	The Erikson Institute Fussy Baby Network® is a national model home visiting prevention program known for its *facilitating attuned interactions* (FAN) approach to family engagement. The theory of change guiding the FAN is based on the concept of *attunement*, defined as an individual's sense of feeling connected and understood. The FAN is both a conceptual framework and a practical tool for achieving attunement in relationships and reflective practice. [Find it in Heffron et al., page 27]
The Parent-Child Relationship Competencies (PCRCs)	The Parent-Child Relationship Competencies (PCRCs) are a set of culturally variable, yet universal bi-directional (parent-to-child and child-to-parent) relational capacities that emerge spontaneously under ordinary circumstances, but can be strained, impaired, or absent as a result of various difficulties. The PCRC framework helps practitioners join collaboratively with families to tap the power of the inherently healing and growth-promoting parent-child relationship. [Find it in St. John, page 37]

Upcoming Issues

September — **Selected Topics in Professional Development**
November — **Measuring Reflective Capacity**
January — **Building Powerful Connections: The ZERO TO THREE Annual Conference**

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To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

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