

# ZERO TO THREE
# Infant and Early Childhood Mental Health (IECMH) Key Terms and Definitions

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## INFANT AND EARLY CHILDHOOD MENTAL HEALTH (IECMH)

# KEY TERMS AND DEFINITIONS

The following content denotes many key foundational terms currently used in the field of Infant and Early Childhood Mental Health (IECMH). This collection is meant to create some consistent and shared language among staff across ZERO TO THREE. It is certainly not an exhaustive list, nor is it meant to be final, definitive treatment around the descriptions of these key terms. Terminology is subject to the evolving IECMH field and cultural/societal context. It is hoped that this compilation of key terms will serve to expand understanding, promote consistency of messaging, and foster discussion of alternative ways of thinking about and applying these concepts to the diverse roles and teams at ZERO TO THREE.

1. **Infant and early childhood mental health (IECMH):** IECMH is the developing capacity of the infant/young child to form close and secure relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture. IECMH refers to the perinatal period through early childhood (prenatal to 5 years).

   IECMH is a multidisciplinary field focusing on enhancing the emotional and social competence of infants, toddlers, and preschool-aged children. IECMH efforts are aimed at promoting mental health, preventing mental health problems, and providing effective treatment and other supportive interventions. The conceptualization of IECMH must include the perinatal phase of life (prenatal, birth and newborn period) as well as infancy through early childhood (birth through 5 years old).[1]

2. **Advocacy:** Advocacy is speaking out on issues of concern. IECMH advocacy refers to targeted communications with and recommendations to policymakers, policy influencers, and the public with the intention of influencing IECMH-related policy decisions.

3. **Attachment:** Attachment is understood to be a vital component for the well-being and survival of the infant/young child through the development of close, secure, nurturing, and predictable relationships that exist over time with at least one key caregiver (often parents, family members, or consistent caregivers). Attachment has been defined as an emotional, long-lasting bond that a child forms with an attachment figure who is not interchangeable with another person.[2] John Bowlby, regarded as the "father" of attachment theory, describes attachment as an emotional bond with another and believes that the earliest attachments formed by infants and their caregivers play a major contribution to well-being across the lifespan (Bowlby, 1973). Attachment is seen as the infant/young child's tendency to seek comfort, nurturance, and protection by having a "secure base" that allows them to physically check in with, or get close to, their caregiver(s) when feeling anxious or unsure. Attachment

[1] Zeanah, C. H. (Ed.). (2019). *Handbook of infant mental health* (2nd ed.). Guilford Press.

[2] Ainsworth, M. S. (1989). Attachments beyond infancy. *American Psychologist, 44*(4), 709–716.

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is not a sudden or magical bond but a slow social unfolding of these key relationships that begins early in infancy with progression to forming specific preferences in relationships at about 7–9 months. Attachment is considered a vital component of social and emotional development in the early years and a major contributing factor to overall infant and early childhood mental health. Children who experience secure attachment feel secure and safe to explore their world, are better able to learn to self-soothe and regulate, have higher-quality interactions with peers, and are buffered from the impact of chronic stress.

- **Attachment theory:** Attachment theory is a theoretical framework for understanding the parent–/caregiver–child relationship and young children's social and emotional development. John Bowlby and Mary Ainsworth are known to have established attachment theory in the mid-20th century, noting the evolutionary value of this capacity in the survival of the infant. Mary Ainsworth (1978)[3] noted that babies with secure attachments have caregivers who read and respond to the young child's cues of distress, provide comfort, and are emotionally and physically available to the young child. The parent/caregiver(s) are seen as providing a secure base from which the infant/young child can explore and to which he or she can retreat.

- **Attunement:** Attunement is often described as a "dance" between a caring adult, especially someone to whom the baby or young child has formed an attachment, and the young child. It involves physical and emotional communications between the adult and young child (the ***dyad***). Attuned parents/caregivers are those who can read their baby's cues (emotions and behaviors) and respond in a sensitive and empathic way. Attunement can be reciprocal, meaning that the young child, too, may be attuned to the parent/caregiver's cues, responding to parents' emotions, behaviors, facial and vocal expressions, and touch. There is no such thing as being "perfectly" attuned, and every parent–child relationship goes through periods of rupture and repair when attunement is compromised and then repaired or reinstated. Problems arise when mis-attunements are more the norm than the exception.[4]

- **Classifications of attachment:** Mary Ainsworth described three major types of attachment: secure, ambivalent-insecure, and avoidant-insecure. A fourth classification of attachment was later described as disorganized-insecure.[5]

- **Attachment, culture, and trauma (ACT) model:** The ACT model is an interactive model that examines how attachment, culture, and the experience of trauma shape feelings (especially sadness and anger), behaviors, and thoughts such as "Am I safe?", "Am I lovable?", and "Am I capable?"[6]

[3] Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Mahwah, NJ: Lawrence Erlbaum Associates.
[4] Tronick, E. (1989). Emotions and emotional communication in infants. *The American Psychologist, 44*, 112–119.
[5] Ainsworth, M. S. (1989). Attachments beyond infancy. *American Psychologist, 44*(4), 709–716.
[6] Ghosh Ippen, C. (2009). The sociocultural context of infant mental health: Towards contextually congruent interventions. In C. H. Zeanah, Jr. (Ed.), *Handbook of Infant Mental Health* (4th ed., pp. 135–136). New York: Guilford Press.

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4. **Culturally responsive:** The ability to act and respond in ways that demonstrate a respect for the cultural differences of others and accommodating for cultural identities and practices of those with whom we are engaged.[7]

5. **Developmental trajectory:** Developmental trajectory refers to the progression of behaviors and developmental competencies (toward increasing complexity) as children age. A newborn is completely dependent on his or her caregivers to meet every physical and emotional need. Over time, and in the context of supportive relationships, young children become increasingly competent in all areas of development.[8]

6. **Dyad:** The term dyad means "pair" and as applied to IECMH refers to the relationship between a primary caregiver (often the biological parent, but not always—it may be another key biologically related or unrelated caregiver) and the infant. *Triadic* relationships typically include the child and two caregivers.

    - **Dyadic treatment:** A form of psychotherapy in which the infant or young child and caregiver are treated together, and their relationship is the focus of the intervention. Dyadic treatment can help improve caregiving, the caregiver–child relationship, and the child's feelings and behaviors. There are several evidence-based models of dyadic treatment (e.g., parent–child interaction treatment and child–parent psychotherapy). Clinicians must receive rigorous training and supervision to deliver evidence-based dyadic treatment and achieve desired outcomes.[9]

7. **Family centered:** Family-centered practice is a way of working with families, both formally and informally, across service systems to enhance their capacity to care for and protect their children. Family-centered practice is based on the belief that the best way to meet a person's needs is within their families and that the most effective way to ensure safety, permanency, and well-being is to provide services that engage, involve, strengthen, and support families.[10]

8. **IECMH continuum of services:** A specialized segment of the early childhood system that includes services and supports available for families of infants and young children below 6 years old that support the range of mental health needs, from promotion activities and prevention strategies to developmentally appropriate assessment and diagnosis to intervention/clinical treatment services.

    - **Promotion:** raising awareness of the critical nature of mental health and encouraging positive IECMH development for all infants and toddlers

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[7] Center for Excellence for Infant and Early Childhood Mental Health Consultation. *Center for Excellence for Infant and Early Childhood Mental Health Consultation: Glossary and Definitions for IECMH.* https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/glossary-definitions-iecmhc.pdf

[8] National Research Council & Institute of Medicine. (2000). *From neurons to neighborhoods: The science of early childhood development.* Committee on Integrating the Science of Early Childhood Development. J. P. Shonkoff & D. A. Phillips (Eds.), Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academies Press.

[9] National Center for Children in Poverty. *Dyadic treatment.* https://www.nccp.org/dyadic-treatment/

[10] National Center for Children in Poverty. *Dyadic treatment.* https://www.nccp.org/dyadic-treatment

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- **Prevention:** can involve screening, identifying, and addressing risk factors or mitigating the impacts of adverse childhood experiences (ACEs)[11] for infants and young children and their families who are overburdened and under-resourced (The goal of prevention is to mitigate risk for further distress and/or disorder.)
- **Assessment and diagnosis:** completing a thorough assessment and an accurate diagnosis using a developmentally and age-appropriate classification such as the *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*[12] (It is important to note that the disorder, not the child, is diagnosed.)
- **Treatment:** providing evidence-informed or promising practices and supports intended to directly address mental health and developmental disorders (Treatment is often aimed at supporting or repairing a relationship. Service examples include Child–Parent Psychotherapy, Parent–Child Interaction Therapy or Circle of Security.)

9. **NEAR (neurobiology, epigenetics, ACES, and resilience) science:** a cluster of scientific tools to offer a more holistic understanding of the experiences of trauma over the life course and over generations[13]

10. **Protective Factors:** characteristics, traits, or experiences that can protect children and adults from negative outcomes after experiencing difficult, negative circumstances or traumatic events[14] (The Center for the Study of Social Policy's Strengthening Families™ approach has identified the following five protective factors in their framework: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social/emotional competence of children.)

11. **Protective Shield:** An essential protective factor is the reliable presence of a positive, caring, and protective parent or caregiver, who can help shield children against adverse experiences. They can be a consistent resource for their children, encouraging them to talk about their experiences, and they can provide reassurance to their children that the adults in their lives are working to keep them safe.

12. **Reflective Practice:** the opportunity to examine one's thoughts, feelings, reactions, and biases related to one's work and working relationships with the goal of enhancing self-awareness, cultural sensitivity, professional development, and a position of "wondering" to improving the service provision.

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[11] Felitti, V.J., Anda, R.F., Nordenberg, D, Williamson D.F., Sitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258.

[12] ZERO TO THREE. (2016). *DC:0-5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Washington DC: ZERO TO THREE.

[13] Muller, R. & Kenney, M. (2021). A science of hope? Tracing emergent entanglements between the biology of early life adversity, trauma-informed care, and restorative justice. *Science, Technology & Human Values, 46*(6), 1230–1260. https://journals.sagepub.com/doi/pdf/10.1177/0162243920974095

[14] Center for the Study of Social Policy. (n.d.). *About Strengthening Families™ and the protective factors framework.* https://cssp.org/resource/about-strengthening-families-and-the-protective-factor-framework/

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- **Reflective supervision/consultation (RSC):** a specific and specialized form of reflective practice between supervisee(s) and supervisor or consultant that allows the professional to explore their wonderings, concerns, and interactions with a reflective supervisor from their organization or an outside consultant to improve the quality of service provision and keep the baby and family at the center of focus
- **Reflective supervisor:** a provider of reflective supervision who also may be the supervisee's program supervisor and/or is employed by the same organization as an individual
- **Reflective consultant:** a provider of reflective supervision who is hired contractually from outside the organization to work with an individual and/or a group
- **Parallel process:** The primary notion is that relationships impact other relationships. In optimizing our work with infants/young children and their families, the parallel process must be examined and understood. Parallel process has been defined as the psychological and emotional connection between all relationships within a family or system, including that between community systems and families, between supervisor and practitioner, between practitioner and caregiver, and between caregiver and the infant/young child. Understanding and exploring parallel process in reflective supervision or practice is key to informing services and improving the quality of service provision and relationships.

13. **Relationship-based:** Relationship-based approaches focus on providing support, learning, and change through the relationships that are developed and nurtured between individuals. In IECMH, relationship-based approaches are focused on the relationships between the child, caregivers, and therapists. Infants are best understood, assessed, and treated in the context of their primary caregiving relationships, and children develop in the context of their entire family and caregiving network.[15] Relationships serve as the foundation for child development. Successfully engaging families through multiple services and cross-sector collaborations is essential to support optimal development. Professionals must know current evidence-based and related professional resources to support these relationships and must value, create, and model positive, open, and respectful relationships with children, families, and collaborators.[16]

14. **Resilience:** the process of coping and adapting well in the face of adversity, trauma, or significant and repeated sources of stress and in the aftermath of such experiences (In recent years, issues have been raised around the concept of resilience and there have been calls seeking a more nuanced understanding. There is a greater focus not only on the resilience of individuals, for example, but on thinking of resilient communities. Resilience does not imply the absence of pain; it also refers to experiencing pain in the moment or when triggered by similar events or anniversaries. Resilience is therefore seen as a process not an individual quality or capacity.) (NTCSN as retrieved from https://www.nctsn.org/search?query=Protective+Shield)

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[15] Zeanah, C.H. & Zeanah, P.D. (2019). Infant mental health: The clinical science of early experience. In C. H. Zeanah (Ed.), Handbook of Infant Mental Health (4th ed., pp. 5–24.). New York: Guildford Press.

[16] Dean, A., LeMoine, S., & Mayoral, M. (2016, 2019). *ZERO TO THREE Critical competencies for infant-toddler educators™*. ZERO TO THREE.

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15. **Social Determinants of Health (SDOH):** SDOH refer to the conditions in the environments where people are born, live, learn, work, play, and develop that affect a wide range of health functioning, as well as quality-of-life outcomes and risks. According to the U.S. Department of Health and Human Services, the five domains of SDOH are (1) economic stability, (2) education access and quality, (3) health care access and quality, (4) neighborhood environment, and (5) social and community context.[17] It is important to routinely screen every family to determine how best to support all their needs, including screening annually for food insecurity; housing instability or homelessness; utility needs; transportation needs; interpersonal safety (e.g., intimate partner violence, interpersonal violence, community violence); substance misuse (alcohol and other drugs); and tobacco use.[18]

16. **Strength-based:** approaches which build upon a family's strengths, recognizing their own resources and resilience (This includes allowing work with families to be family-led, centered on outcomes based on that individual's future strengths. Strength-based approaches allow the child and family to be agents of their own change and to see themselves at their best. With this approach to IECMH work, everyone is seen as possessing unique characteristics, with their own potential, strengths, and capabilities. Strength-based approaches support family engagement and avoid the appearance of targeting families because they have "problems." Instead, the work focuses on building upon the strengths of the family and of the community they reside within.[19])

17. **Stress Response:** the body's physiological and psychological response to threat (There are three types of stress[20]):

    - **Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. An example of a situation that might trigger a positive stress response is the first day with a new caregiver or receiving an injected immunization.

    - **Tolerable stress response** activates the body's alert systems to a greater degree because of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.

    - **Toxic stress response** can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind

[17] U.S. Department of Health and Human Services. *Healthy People 2030: Social determinants of health*. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[18] ZERO TO THREE. *HealthySteps Fidelity Requirements.* https://ztthealthysteps.s3.amazonaws.com/documents/109/attachments/HSFidelityRequirements_04.16.20.pdf?1587052180 ,
[19] ZERO TO THREE. Military Family Projects. Duty to Care curriculum.
[20] Harvard University Center on the Developing Child. (n.d.). *Toxic stress.* https://developingchild.harvard.edu/science/key-concepts/toxic-stress/

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of prolonged activation of the stress response system can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment well into the adult years.

It is important that we look at stress response from an adaptation lens versus concluding that exposure to toxic stress will inevitably lead to maladaptive patterns and psychopathology. It is important to recognize the functionality of adaptations—why we do things to fight, flee, or freeze in the experience of acute stress to survive and cope. The brain is adapting in the environment it is in, when in another environment that adaptation may cause problems. This understanding can be useful in describing why the brain may turn off in the face of overwhelming stress as it's the best possible option in that moment, but it really "messes up when a kid drops a book next to you 5 years later and the response is the same." The power of experience is not just that bad things happen to children and that is bad for them. We can be part of the positive change that allows children to change their developmental paths.

- **Trauma:** an event or events that are unpredictable, overwhelming, and considered a threat to one's physical or psychological safety, often resulting in feelings of intense fear and inability to cope
- **Adverse childhood experiences (ACEs):** ACEs are stressful and potentially traumatic events that occur in childhood that are linked to chronic health problems, mental health disorders, and substance use problems in adulthood. ACEs can also negatively impact education, job opportunities, and earning potential, and they can be prevented. ACEs reflect stressful or traumatic experiences that fall under three general headings—abuse (physical, emotional, sexual); neglect (physical, emotional); and household dysfunction (parental mental illness, domestic violence, divorce, incarcerated relative, parental substance abuse).
- **Acute trauma:** Acute trauma results from a single, specific stressful or dangerous event. Should that event persist, such as child abuse, bullying, or witnessing domestic or community violence, it would be considered chronic or complex trauma.
- **Complex trauma:** exposure to multiple traumatic events that are severe and pervasive such as abuse, neglect, or domestic violence
- **Community trauma:** trauma that is experienced by community members as a collective (e.g., hurricane) or an event that impacts only a few people but has structural and social consequences (e.g., mass shooting, racially motivated violence)[21] (Adverse community experiences such as poverty, violence, racism, and community disruption contribute to community trauma.)
- **Disaster trauma:** trauma associated with natural disasters, accidents, or acts of human intent such as terrorism, murder, mass shootings, etc.

[21] Pinderhughes, H., Davis, R. A., & Williams, M. (2015). *Adverse community experiences and resilience: A framework for addressing and preventing community trauma.* Prevention Institute. https://icjia.illinois.gov/researchhub/articles/individual-and-community-trauma-individual-experiences-in-collective-environments#fn28

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- **Historical trauma:** multigenerational trauma experienced by specific cultural, racial, ethnic, or religious groups[22] (It has also been described as a cumulative emotional wounding over time and across generations emanating from the experience of massive group trauma.)[23]
- **Institutional trauma:** This trauma is linked to the experience of institutional betrayal where wrongdoings (e.g., abuse, neglect, violence) are perpetrated by an institution (e.g., foster care, early childhood education setting, hospital, religious organizations) entrusted with the care of individuals dependent on that institution. It includes the failure to prevent or respond supportively to wrongdoings within the institution.[24]
- **Medical trauma:** a set of psychological and physical responses to pain, injury, serious illness, medical procedures, and frightening treatment experiences that can occur after exposure to one or more medical events[25]
- **Developmental/relational trauma:** the experience of being abused, neglected, or unsupported within the context of a caregiving relationship (When this occurs within the first 3 years, there are often disruptions in the child's cognitive, neurological, and psychological development and in the types and quality of attachments.)[26,27]
- **Trauma-informed/trauma sensitive:** Trauma-informed practice is an approach where the focus is not on what is "wrong" with someone but rather seeks to understand what they have experienced in terms of highly stressful traumatic events or relationships. Trauma-informed practices are those that consider the child/family's trauma and understand how trauma may be seen in young children. Trauma-informed principles include understanding the impact of trauma; promoting safety; ensuring cultural competence; supporting control, choice, and autonomy; and understanding that healing happens in relationships.[28] Trauma-sensitive or trauma-responsive approaches are appropriate for systems and organizations where staff are not experts in trauma but still can have a greater awareness of trauma and its impacts.[29]

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[22] Administration for Children & Families. (n.d.). *What is historical trauma?* https://www.acf.hhs.gov/trauma-toolkit/trauma-concept

[23] Brave Heart, M. Y. H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7–13.

[24] Smith, C. P., & Fryed, J. J. (2013). Dangerous safe havens: Institutional betrayal exacerbates sexual trauma. *Journal of Traumatic Stress, 26,* 119 –124.

[25] International Society for Traumatic Stress Studies. (2006). *What is medical trauma?* International Society for Traumatic Stress Studies Clinical Fact Sheet. https://istss.org/ISTSS_Main/media/Documents/Medical-Trauma-Clinician-Fact-Sheet-2.pdf

[26] Weinhold, B. K., & Weinhold, J. B. (2018). *Developmental trauma: The game changer in the mental health profession* (2nd ed.). CICRCL Press. Colorado Springs, CO.

[27] Heller, L., & LaPierre, A. (2012). *Healing developmental trauma: How early trauma affects self-regulation, self-image, and the capacity for relationship.* Berkeley, CA: North Atlantic Books.

[28] Trauma Informed Care Implementation Resource Center. *What is trauma informed care?* https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

[29] University of Wisconsin. *Translating trauma-informed principles into trauma-responsive practices.* https://uwm.edu/icfw/translating-trauma-informed-principles-into-trauma-responsive-practices

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